

Targeted Grants to Increase the Well-Being of, and to Improve the
Permanency Outcomes for, Children Affected by Methamphetamine or
Other Substance Abuse: Fourth Annual Report to Congress

Representing the initial grant period of September 30, 2007, to September 30, 2012

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau



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HIGHLIGHTS IN BRIEF

The Child and Family Services Improvement Act 2006 (P.L. 109-288) established the broadest federal program ever launched—the Regional Partnership Grant (RPG) Program—to address the well-being, permanency, and safety of children affected by a parent’s substance use disorder.

The 53 regional partnerships that participated in this large-scale effort stepped up to share responsibility and resources to achieve shared positive results for families that no single agency could accomplish alone. They did so at a time of unparalleled changes in the state and local fiscal climate, and they did so for some of the hardest to serve families in the child welfare system.

The legislation appropriated \$145 million for the initial five-year grant period (September 2007 to September 2012). The 53 grantees spanning 29 states received multi-year grants to establish or enhance a collaborative infrastructure that built their region’s capacity to meet the many needs of families with substance use disorders who are involved with the child welfare system.

The RPG Program used an unprecedented cross-systems performance measurement system with 23 measures that assessed grantees’ progress in improving safety, permanency, recovery, well-being, and systems collaboration.

Much was learned about improving outcomes for children and families in the child welfare system who are affected by substance use disorders. The results and key lessons highlighted here show that the 53 partnerships—through their strengthened cross-systems collaboration—greatly improved the lives of thousands of children and families in their regions. Their collective experiences advance the field’s understanding and evidence base of what works for these families and why. Their lessons can inform collaborative policy and practice shared by substance abuse, child welfare, and family court systems in communities across the nation.

IMPROVED SAFETY, PERMANENCY, RECOVERY, AND WELL-BEING: SELECTED PERFORMANCE MEASURE RESULTS

Grantees served more than 15,000 families, including more than 25,500 children and 17,800 parents or caregivers during the five-year grant period. Their performance measures make clear that the time, resources, and effort invested to develop broad-based interagency partnerships and integrated services resulted in positive child, parent, family, and system outcomes.

- The majority of children at risk of removal remained in their parent’s custody. The majority of children in out-of-home placement achieved timely reunifications with their parent(s). After returning home, very few children re-entered foster care.
- Parents achieved timely access to substance abuse treatment, stayed in treatment (on average, more than 90 days), and reported reduced substance use and gains in employment. They received essential clinical treatment and support services, including continuing care,

transportation, parenting training, mental health and trauma services, and housing assistance, to promote and sustain their recovery and facilitate reunification and family stability.

- Overall child, adult, and family well-being improved from RPG program admission to discharge (for the subset of grantees who measured child well-being). However, the grantees' experiences in measuring well-being reflected a field in development and the inherent challenges associated with assessing change in such complex constructs. Their efforts, perhaps best viewed as an important and ongoing learning process, provide several important insights for strengthening future measurement of this critical outcome area.
- Selected performance measures improved steadily over the course of the grant period, indicating it takes adequate time to establish effective, broad-based cross-systems collaboration and comprehensive, integrated services to facilitate positive family outcomes.

ENHANCED COLLABORATIVE CAPACITY TO SERVE CHILDREN, PARENTS, AND FAMILIES

The active engagement of core partners from the child welfare, substance abuse treatment, court and other service systems was essential to the partnerships' overall success. Grantees learned several key lessons about meaningful collaboration in serving these families.

- Families involved in child welfare affected by parental substance use disorders have multiple and complex needs that typically have compounded over time. This required more intensive services and for a longer duration than originally anticipated.
- Treating the family system—rather than an individual child or parent in isolation—is far more effective in addressing a family's underlying and complex issues. Over the course of the grant period, grantees moved from individual-focused services to more comprehensive family-centered treatment. To expand direct services to children and other family members, grantees needed to develop linkages with other community partners and leverage existing community resources.
- No one provider or service system alone can address families' multiple needs. The new systems collaboration and improvements developed predominantly with RPG funds resulted in an increased number of partners working together to provide a more coordinated and comprehensive service array and increase families' timely access to these services.
- To build and sustain the necessary cross-systems collaborative infrastructure requires a shared commitment of both financial and human resources, which most funding streams typically do not reimburse. It also requires ongoing technical assistance and support, and continued attention to partners' evolving needs. The payoff for this investment, however, was increased access to a broader array of services often supported by other community resources rather than the grant, and new ways of doing business beyond traditional system silos.
- The importance of staffing issues in building collaborative capacity must not be underestimated, particularly for programs working in sparsely populated, remote, rural areas.

Staff training and development need to be a key project component in project implementation and sustainability plans. Experienced and consistent project leadership were critical to grantees' overall success.

- Sufficient time, funding, and staff are required to develop collaborative performance monitoring and program evaluation capacity. The cross-systems communication and information sharing begun with the RPG project helped lay the foundation for sustained collaborative efforts that will extend beyond the grant.
- Both quantitative and qualitative data are essential to capture the full breadth, depth, and scope of grantees' programs and cross-systems collaborative progress. Qualitative information provided further evidence of families' challenges and complexities and the RPG project's important role in improving the lives of children and families.
- Collaboration across agencies can extend beyond a single project to address larger system-wide barriers to working together effectively. The RPG projects evolved into changed practice models that reached beyond the scope and duration of the RPG initiatives. The partnerships adopted new norms as standard ways of doing business. They established what they referred to as a culture of collaboration in serving child welfare families affected by parental substance use disorders
- Nearly three-fourths of the major services and activities provided through the RPG program will be sustained after the grant.

EXECUTIVE SUMMARY

The preceding Highlights in Brief illuminate key lessons learned by the Regional Partnership Grant (RPG) Program about improving outcomes for children and families in the child welfare system who are affected by substance use disorders. This Executive Summary provides additional detail on the RPG program, performance measurement results, and implementation barriers, successes, and lessons experienced during the course of the five-year project period.

THE REGIONAL PARTNERSHIP GRANT (RPG) PROGRAM

The Child and Family Services Improvement Act of 2006 (P.L. 109-288), signed into law on September 28, 2006, was designed to improve the lives of abused and neglected children and their families. It included provisions that specifically address children affected by a parent's substance use disorder.

The law authorized and appropriated \$145 million over five years for a new competitive grant program: "Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Abuse." Funded grants support regional partnerships in establishing or enhancing a collaborative infrastructure to build the region's capacity to meet a broad range of needs for families involved with both substance abuse treatment and the child welfare system. The U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Administration on Children, Youth and Families (ACYF), Children's Bureau administers the program, referred to as the Regional Partnership Grant (RPG) Program.

The legislatively mandated reports to Congress must address three key RPG Program areas:

- The services provided and activities conducted under the RPG Program
- The progress made in addressing the needs of families with methamphetamine or other substance use disorders who come to the attention of the child welfare system, and in achieving the goals of child safety, permanence, and well-being
- The set of performance measures established to assess the performance of RPG Program grant recipients

Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Abuse: Fourth Annual Report to Congress (herein referred to as the Fourth Report to Congress) is the final in a series of congressional reports for the initial five-year grant period (September 30, 2007, to September 30, 2012). It summarizes the activities of the first set of 53 regional partnerships grants. The prior

three reports to Congress provide additional information on early RPG Program implementation and grantee activities.¹

The Child and Family Services Improvement and Innovation Act (P.L. 112-34) of 2011 reauthorized a second round of regional partnership grants for fiscal years 2012 to 2016. HHS will publish an evaluation report for those 17 grants in December 2017.

This Executive Summary briefly:

- Recaps the 53 regional partnerships funded during the initial grant period
- Highlights grantees' key program services implemented and the major program modifications and enhancements grantees made over the course of the grant period
- Summarizes certain key RPG Program performance measure results on the more than 15,000 families served during the grant period²
- Identifies key program implementation lessons related to cross-systems collaboration and performance monitoring and evaluation

OVERVIEW OF THE REGIONAL PARTNERSHIP GRANTEES

The lead agencies for the 53 grants awarded in September 2007 spanned 29 states and included 6 tribes (see map below). While most grantees targeted a single county, nearly half of the grantees broadened their reach to serve a region encompassing multiple counties or their larger state. Most grantees (72 percent) provided services both to families with children who have been placed in out-of-home care and those whose children are at risk of removal, but are still at home in the custody of their parent(s) or caregiver(s). The remaining grantees focused primarily on either in-home (15 percent) or out-of-home cases (13 percent). In addition, most grantees did not limit their focus to methamphetamine, given the predominance of polysubstance use among most clients and varying and shifting drug use patterns across the country.

¹ The First Report to Congress (for the period October 1, 2006, to July 31, 2008) focused on HHS's activities to implement the legislation, grantees' major program implementation activities, and development of the RPG Data Collection and Reporting System. The Second Report to Congress (for the period September 30, 2008, to March 31, 2010) focused on grantees' preliminary performance measure results and introduced key collaborative lessons learned during the first half of the five-year grant period. The Third Report to Congress (representing the period April 1, 2010, to September 30, 2011) provided interim performance measure results and updated implementation lessons learned to date. All prior reports are available at: <http://www.cffutures.com/projects/rpg>.

² The main body of the report discusses all of the RPG Program measures.



The RPG lead agencies represented the following 29 states: Alaska, Arizona, California, Colorado, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Massachusetts, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin. See Chapter I for a full listing of all 53 sites.

All 53 regional partnerships extended well beyond the required two-partner minimum (one of which must be the state child welfare agency). Over the course of the grant period, the partnerships expanded as families’ needs and the environment in which the grantees operated continued to shift and evolve. By the end of the grant period, approximately three-fourths (75.5 percent) of the partnerships consisted of 10 or more member agencies, organizations, and providers representing child welfare, substance abuse treatment, the courts, mental health, health, criminal justice, education, early childhood development, employment, housing, and other community-based organizations that provide various child and family services (see Chapter I). Over the course of the grant, 39 grantees reported the addition of more than 430 new partners.

GRANTEE SERVICES, ACTIVITIES, AND PROGRAM ENHANCEMENTS

The breadth of grantees’ interagency relationships enabled them to implement a wide array of integrated services responsive to the needs outlined in the legislation and gaps in current service delivery systems. Grantees’ RPG program models and target populations were diverse. Yet, all grantees provided a comprehensive set of treatment and support services to meet the needs of children, parents, and families. Grantees had to demonstrate a clear understanding of their target populations’ identified needs. In doing so, many partnerships implemented various evidence-based practices, frequently in the areas of trauma services and parenting, as part of their overall approach to providing grant-funded services. Further, as the legislation intended, grantees bolstered these direct services with specific activities to strengthen cross-systems collaboration and service integration (see snapshot below and Chapter II for more detail).

At-a-Glance Snapshot: Grantees' Major Program Strategies and Activities, by Program Area*

Systems Collaboration and Improvements

- 100% conducted cross-systems training on clinical treatment as well as program and policy issues
- 98% convened regular regional partnership meetings to discuss collaborative program, policy, and management issues
- 94% held regular joint case staffing meetings to discuss families' case plans or other treatment issues
- 93% implemented improvements in cross-systems information sharing and data collection
- 87% developed formalized cross-systems policies and procedures to improve communication, identification, referrals, and service delivery
- 62% co-located staff to assist with screening, assessment, referral, and/or service provision
- 59% used a formal multidisciplinary team decision-making process (e.g., Family Group Decision Making)

Substance Abuse and Mental Health Treatment Services and Linkages for Parents/Caregivers

- 96% implemented specialized outreach, engagement, and retention services
- 93% screened or assessed adults for substance use disorders
- 81% implemented trauma-informed and/or trauma-specific services
- 78% provided family-based substance abuse treatment services
- 74% conducted specialized screening or assessments to identify other needed services (e.g., mental health, trauma)
- 73% provided outpatient substance abuse treatment services
- 72% engaged in one or more substance abuse prevention activities
- 64% provided mental health services or psychiatric care
- 39% provided residential substance abuse treatment
- 34% developed a new family drug court (FDC) and/or expanded or enhanced an existing FDC

Services for Children and Youth

- 93% screened or assessed for child welfare issues
- 76% conducted specialized child screenings or assessments to identify other needs (e.g., developmental, behavioral, mental health)
- 53% provided early intervention and/or developmental services
- 45% provided mental health counseling or therapeutic services and interventions
- 35% screened or assessed children for trauma
- 34% implemented trauma services for children
- 19% provided remedial or academic supports to school-aged children
- 6% provided substance abuse treatment for youth with substance use disorders

Family-Strengthening Services

- 87% provided some type of parenting training and education or family-strengthening program
- 57% provided family therapy or counseling
- 43% conducted screening or assessments for parenting or family functioning issues
- 37% provided supervised or supportive or therapeutic supervised visitation services
- 34% conducted targeted outreach and/or provided a specialized program or services for fathers

Other Clinical and Community Support Services for Children, Parents, and Families

- 87% provided intensive/coordinated case management
- 68% provided wraparound and/or individual in-home services
- 64% provided aftercare, continuing care, and recovery support services
- 64% provided housing services

* This reflects services and activities grantees provided to a majority of their target population(s). For selected interventions (e.g., housing, supportive or therapeutic supervised visitation services, child and adult mental health and trauma services), a substantial number of additional grantees may have provided services to a smaller percentage of their families or on an as-needed basis. See Chapter II.

The partnerships' extensive cross-systems collaboration also built their region's capacity to serve families, leverage other available community resources, and maximize and sustain the RPG program impact (see Chapter II):

- The majority (81.3 percent) of program strategies grantees implemented represented new services for families, or an expansion and/or enhancement of existing services to increase the number of families served or improve existing service quality and delivery (e.g., provide a more intensive or higher level of service).
- By the end of grant period, on average, 64.8 percent of grantees' major program services and interventions were supported primarily by other community funding or a combination of RPG and other community funding (as opposed to solely RPG funding).

As the grant was ending, the regional partnerships indicated nearly three-fourths (73.2 percent) of their major services and activities would be sustained.

Over the course of the grant period, the 53 regional partnerships continually modified and refined their programs to meet families' multiple and complex needs:

- 81.1 percent improved their original program models further by adding other new services or strengthening already established RPG program components. These enhancements typically encompassed trauma and mental health services for children and parents, parenting and family-strengthening services, expanded substance abuse treatment capacity, and continuing care and recovery supports.
- 34.0 percent expanded the scope of their target population—for example, to serve a wider age range of children, incarcerated parents, fathers (custodial and non-custodial), or families receiving voluntary child welfare services.
- 28.3 percent expanded RPG services to another, new site (beyond their original proposed scope).
- 20.8 percent extended the duration of services for families. This modification typically was due to the increasingly complex needs of families and a trend toward serving families longer than originally anticipated. (The mean duration of RPG services was 8.2 months, yet 14 grantees provided services to families, on average, for more than a year.)

In addition to the above service enhancements, grantees adopted new or revised protocols, procedures, or policies, modified project staffing, or made other types of systems-level changes to improve overall service delivery (see Chapter III).

RPG PROGRAM PERFORMANCE MEASURE HIGHLIGHTS

RPG Program Performance Measurement Approach—Brief Overview

HHS used multiple quantitative and qualitative data sources to provide a comprehensive descriptive and analytical picture of the 53 grantees' performance. This mixed-methods performance measurement approach enabled HHS to track grantees' ongoing progress against program goals and identify how grantees modified their proposed projects as they learned what worked and what needed strengthening. This analytical approach thus provided valuable information across the varied programs regarding effective approaches for families affected by substance use disorders.

To capture the full breadth, depth, and scope of grantees' systems collaborative progress required a mixed-methods research design that included qualitative process evaluation data and quantitative outcome measures. HHS used all of the information collected across all grantees to assess progress toward the broad, common RPG Program goal: "To increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse.

Grantees had flexibility and discretion in developing both their program models and local project evaluation designs. They only reported on the measures that aligned with their partnership's activities, goals, and intended outcomes. As such, a cross-site evaluation study that allowed HHS to test for and establish a definitive causal link that attributed improvements in child, adult, and family outcomes to the RPG initiative was beyond the scope of the original grant program design.³

The performance measurement results provide the necessary basis for examining the RPG Program's progress in building capacity to serve families, achieve systems and organizational changes, and affect desired outcomes. Further, through multiple quantitative and qualitative data sources, HHS is able to draw valuable programmatic and evaluation lessons learned to inform future efforts to serve these families.

This Fourth Report to Congress includes:

- Grantees' performance measure results for the more than 15,000 families, including more than 25,500 children and 17,800 parents or caregivers, served during the initial five-year grant period (September 30, 2007 through September 30, 2012). The 23 performance measures established assess grantees' progress in improving safety, permanency, recovery,

³ A cross-site evaluation requires that all sites in a given project implement the same model and seeks to answer if that particular model is effective across all sites and can be replicated. In contrast, the 53 grantees did not implement or test the same set of services, interventions, or program models. Grantees' local project evaluation approaches also varied. Sites were responsible for developing their own evaluation plans responsive to their overall program approach and model, specified outcomes, and local community context. HHS encouraged, but did not require, grantees to include a control or comparison group in their evaluation design. However, grantees still had to propose a rigorous approach to evaluate their programs' influence on their selected outcomes.

well-being, and systems collaboration. (See Chapter IV for full list and operational definitions of all the performance measures.)

- Qualitative and quantitative information from the nearly 500 grantee Semi-Annual Progress Reports submitted over the grant period, as well as grantees' Final Progress Reports.⁴

Overall, the results highlighted below show that children and adults in the RPG programs achieved positive outcomes and many of these outcomes improved over time. Chapters VI through X of the report describe all RPG performance measures more fully.

Selected Safety and Permanency Performance Measure Results

- Nearly all (92.0 percent) of participating children at risk of removal from the home remained in the custody of their parent/caregiver through RPG program case closure. The percentage of children who remained at home significantly increased through program implementation from 85.1 percent in program year one to 96.4 percent in program year five.
- The majority (95.8 percent) of participating children did not experience child maltreatment occurrence or recurrence within the first 6 months following RPG program enrollment.
- Longitudinal analysis of maltreatment occurrence at 12, 18, and 24 months post RPG enrollment showed slight increases in the occurrence of substantiated child maltreatment over time. The cumulative percentage of children maltreated at any point within 24 months was 10.4 percent.
- Children in out-of-home care had a median length of stay in foster care of 11.1 months. However, approximately one-fourth (24.7 percent) were discharged in less than 6 months.
- More than 3,600 children reunified with their parent(s) over the course of the grant; their median length of stay in foster care was 9.5 months.
- Nearly two-thirds (63.6 percent) of children were reunified within 12 months, with 17.9 percent reunified in less than 3 months.
- Timely reunification rates (i.e., within 12 months) increased significantly over the course of the RPG Program, from 55.4 percent in program year one to 72.9 percent in program year four.⁵

⁴ HHS was able to review 27 Final Progress Reports for inclusion in this Fourth Report to Congress. At the writing of this report, 18 grantees had no-cost extensions and planned to submit their Final Progress Reports by December 31, 2013. The remaining eight grantees will submit their Final Progress Reports at the end of their two-year continuation grants (that extend through FY 2014).

⁵ The trend analysis does not include children enrolled in program year five due to the proportionately small number of reunifications compared to the other program years. Information regarding foster care status may not have been available by the reporting period cutoff date for children enrolled in the last year of the program.

- Children less than one year of age had significantly higher timely reunification rates (72.7 percent) than children of all other ages (61.5 percent).
- After returning home to their parent(s), only 7.3 percent of children re-entered foster care within 24 months following reunification.
- In general, grantees' program models focused on reunification efforts, where appropriate. Only a very small number of children (approximately 464) were discharged to a finalized adoption or legal guardianship. Nearly three-fifths (58.8 percent) achieved such permanency within 24 months.

Selected Recovery Performance Measure Results

- RPG adults accessed substance abuse treatment, on average, within 13 days of entering the RPG program; well over one-third (36.4 percent) enter treatment within 3 days.
- The vast majority (91.6 percent) of adults who entered substance abuse treatment received the level of care for which they were assessed.
- Adults remained in substance abuse treatment an average of 4.8 months, with nearly two-thirds (65.2 percent) staying in treatment more than 90 days.
- Approximately 45.0 percent of adults completed treatment.⁶

From substance abuse treatment admission to discharge:

- Between 61.1 and 76.2 percent of adults (depending on the substance) reduced their use of alcohol, marijuana, cocaine, methamphetamine, and heroin.
- The percentage of adults employed (full or part time) increased significantly from 22.8 percent to 41.3 percent, an 81.1 percent rate of change.⁷
- 80.0 percent of adults showed decreased criminal behavior.⁸

Analysis of key supportive services that facilitate treatment engagement and retention, promote sustained recovery, and help parents reunify with their children, found:

⁶ Includes discharges for treatment completion (all parts of treatment plan or program were completed) and transfers to another facility when the individual was known to report and expected to continue further treatment. Federal treatment outcome reporting also considers such transfers a successful discharge.

⁷ Percent change is calculated by subtracting "old" data from "new" data, dividing that result by old data, and multiplying it by 100 $[(41.3-22.8)/22.8] \times 100 = 81.1$ percent change.

⁸ As measured by the number of subsequent arrests among adults with any arrests in the 30 days prior to treatment admission. See Chapter VIII for full operational definition and additional information.

- The vast majority of adults received needed continuing care and recovery support services (87.1 percent), transportation (86.8 percent), parenting training and education (85.9 percent), and mental health services (84.4 percent). More than three-fourths (78.7 percent) received primary medical care.
- About 7 in every 10 adults received needed dental care (70.1 percent), employment or vocational training and education (69.4 percent), housing assistance (69.2 percent), and domestic violence services (68.7 percent).

Selected Child, Adult, and Family Well-Being Results

Grantees measured child well-being, adult mental health, parenting capacity, family functioning and relationships, and risk and protective factors using valid and reliable instruments they identified as appropriate for their specific program model and target population.⁹ The well-being findings presented below reflect data from subsets of grantees using the same screening and assessment instruments. See Chapter IX for more information.

At RPG program entry:

- Approximately one-third of young children 5 years and under were identified as at risk of developmental delay and requiring a more in-depth evaluation or further monitoring in the areas of physical development (33.8 percent) or cognitive functioning (31.0 percent).
- Up to 22.4 percent of young children were identified as having or at risk of social or emotional behavioral difficulties.
- Nearly half (49.1 percent) of school-aged children 6 to 18 years old were identified as having clinical or borderline clinical behavioral issues.
- 37.2 percent of parents exhibited mild to severe depressive symptoms.

Analysis of key supportive services to help improve child well-being indicated:

- The majority of children received needed supportive services that included substance abuse prevention and education (91.1 percent), primary pediatric care (85.3 percent), educational services (82.3 percent), and mental health or counseling services (80.0 percent).
- Further, three-fourths (75.0 percent) of children received developmental services and more than two-thirds of youth (69.2 percent) received substance abuse treatment, if identified as a need.

⁹ HHS did not require grantees to use specific clinical instruments or the same instruments to measure well-being.

From RPG program entry to discharge:

- The percentage of children for whom overall child well-being was rated a strength significantly increased from 24.8 percent to 53.0 percent. Children made the greatest gains in the areas of mental health, behavior, and parent relations.
- The percentage of adults for whom overall parental capabilities was rated a strength significantly increased from 14.9 percent to 46.5 percent. Parents showed the most progress in the areas of substance use (e.g., no or decreased substance use, or use that does not impair their ability to parent) and age-appropriate supervision of children.
- The percentage of parents for whom overall family interactions was rated a strength significantly increased from 21.8 percent to 47.0 percent. Parents made the greatest gains in age-appropriate expectations for and bonding with children, as well as mutual emotional and physical support within the family.
- Families also showed improvements in their overall environment (e.g., a family's overall stability and safety in their home and community) and family safety. At program admission, the percentage of families with a strength rating in these areas was less than one-fifth (18.4 percent and 17.2 percent, respectively). By program discharge, this had increased to 41.5 percent and 41.0 percent, respectively.

Selected Systems Collaboration Performance Measure Results

- The regional partnerships showed significant improvement in all key areas of collaborative practice over the five-year grant period.¹⁰ Their progress in building collaborative capacity directly reflects the legislation's emphasis on developing and strengthening interagency collaboration and services integration.
- Grantees' greatest strengths were consistently in the underlying values and principles of their collaborative relationships, screening and assessment practices, and client engagement and retention.
- The partnerships showed the most amount of improvement in the areas of children's services and cross-systems information sharing and data systems.
- Most grantees also demonstrated progress regarding their total number of children and families served. Twenty-seven grantees (52.9 percent) reached 90 percent or more of their total projected number of children to be served, while 29 grantees (54.7 percent) reached 90 percent or more of their projected number of adults to be served. The median percentage met across all grantees was 97.6 percent for children and 92.9 percent for adults.

¹⁰ See Chapter X for detail on the 10-element collaborative framework and the Collaborative Capacity Instrument used to measure grantees' progress.

- Contributing factors associated with grantees’ success in reaching or exceeding their projected targets most often included enhancement of the RPG program model, increased and strengthened collaboration, and specialized client engagement and outreach strategies.

Additional markers of success in how grantees increased their region’s capacity to serve child welfare families affected by parental substance use disorders included the comprehensiveness of available services, the accessibility of services provided, the development of a well-trained and well-qualified workforce, and the program’s impact on the partners and their larger service systems. While there are no RPG performance measures to quantify these domains, grantees’ accomplishments in these and related collaborative practice areas are reflected in the implementation lessons below.

HIGHLIGHTS OF GRANTEE’S COLLABORATIVE EFFORTS—KEY PROGRAM IMPLEMENTATION LESSONS

HHS conducted detailed qualitative reviews of grantees’ Semi-Annual Progress Reports and Final Progress Reports to gauge the regional partnerships’ progress over the course of the five-year grant period in strengthening cross-systems collaboration to serve families. A set of 11 key implementation lessons emerged (summarized below) that emphasize the complexity of cross-systems collaboration and convey important insights about how grantees’ collaborative experiences have improved their ability to meet families’ multiple needs.

1. Collaboration is essential to address the complex and multiple needs of families and sustain integrated service delivery.

Families who are involved in the child welfare system and affected by a parent’s substance use disorder have complex and multiple needs that cannot be adequately addressed by one provider or service system alone. At its core, the RPG Program recognizes that effective service coordination and timely access to treatment and related community support services are needed to address the full spectrum of challenges these families face.

The active engagement of core partners from the child welfare, substance abuse treatment, court, and other service systems was essential to the partnership’s overall success (see also Lesson 6). To meet the unique needs of families and facilitate their positive outcomes, grantees said personal *relationships* needed to evolve into meaningful and formalized *partnerships*. Meaningful collaboration and full partner buy-in were critical to sustain integrated services and a full continuum of care for families.

Grantees stated that the collaboration they developed and strengthened with their core partners and other community organizations during the grant was one of the most important contributing factors to their overall success. It established a foundation on which to build other current and future community projects to serve families with complex needs who are involved in multiple systems.

2. Collaboration to establish cross-systems linkages and effective sustainability planning takes time and is developmental and iterative in nature.

Collaboration can become increasingly challenging as partners move beyond the beginning stages of collaboration (sharing basic information about each other’s systems, convening partnership meetings) to more advanced levels (implementing practice, policy and systems changes, sustainability planning). Agencies develop and acquire collaborative capacity through experience and by applying lessons learned. Grantees agreed five years was the minimum needed to work collaboratively with a diverse set of partners to achieve the broad scope of RPG Program goals.

Grantees found that the collaborative process ebbs and flows, partnerships evolve and sometimes devolve, and relationships must be cultivated and re-cultivated with new and existing partners. The need for continued nurturing of the collaborative was particularly important given the budget cutbacks, staff layoffs, and leadership and administration changes that grantees endured throughout the grant period.

The RPG projects evolved beyond a “special project” into accepted practice models and new norms adopted as the standard way of doing business. The partnerships established what they referred to as a culture of collaboration in serving child welfare families affected by parental substance use disorders. Grantees successfully brought the collaborative voice to the larger community and created a collaborative model to inform other initiatives. Many expanded to other populations and settings.

Key Factors that Facilitate Advanced Levels of Collaboration

Among partnerships that moved to more advanced levels of collaboration, more than two-thirds shared these common facilitating characteristics:

- Consistent and dedicated leadership who supported the project over time (85.4 percent)
- Sustainability planning that did not rely on one agency to pick up funding, but instead involved various partners contributing in-kind, matching, or other resources (70.8 percent)
- Collaboration that extended well beyond child welfare, substance abuse, and the courts to include other critical stakeholders that provided necessary project support and resources (68.8 percent)
- An oversight body that prioritized and addressed collaboration regularly at partnership meetings (66.7 percent)

3. *Intensive multi-faceted outreach is needed at the client, partner, agency, and community levels.*

Intensive multi-faceted outreach at all levels impacts multiple practice and systems areas. It improves cross-systems collaboration, client engagement and retention, program sustainability, working with other community agencies, and building supports for families. Such outreach provides continuity and coordination between systems and providers, facilitates early intervention and timely access to treatment, and helps families navigate multiple and often conflicting systems. It also builds trust with families, enhances program visibility and credibility, and helps establish the RPG program as an essential community resource, among other things.

Grantees said the same vigor that goes into client and partner outreach needs to extend to the broader community and potential funders. Data and client stories were an integral and fundamental part of grantees' marketing and information dissemination efforts. Through continued and proactive outreach and marketing, grantees succeeded in translating their lessons into action. They worked to convey the RPG lessons and inform broader practice and collaborative efforts in their communities and regions.

4. *The collaborative must continually assess its progress and adapt its program and services to meet families' unmet and emerging needs and facilitate client engagement and retention.*

The RPG Program authorizing legislation envisioned that families would receive a comprehensive and integrated service array to meet their needs. To fulfill this legislative intent, grantees continually assessed their overall collaborative progress (e.g., through continuous quality improvement and related activities) and refined their program models over the course of the grant. Nearly all grantees (92.5 percent) made new program changes to serve their children, adults, and families more effectively and efficiently.

The Network for the Improvement of Addiction Treatment (NIATx) change process made a significant difference for several grantees. Grantees used NIATx to increase treatment participation and retention rates, decrease treatment dropout rates within the first 60 days, and reduce out-of-home care re-entry rates (from 23 percent to 0 percent in one county).

Throughout the grant, program evaluation was integral to ongoing program development and improvement. Grantees conducted case reviews, agency walk-throughs, drop-off analyses, and evidence-based systems improvement processes. They used feedback from client, staff, and stakeholder satisfaction surveys, interviews, and focus groups. As one partnership stated, they became "a data-driven decision-making collaborative." Their project team measured everything and used the data at each partner meeting to build a story of what was going on with services.

5. *A comprehensive family-centered approach is needed to break the intergenerational cycle of substance abuse and child maltreatment and effectively address a family's complex, underlying issues.*

Over the course of the RPG Program, grantees experienced a major paradigm shift: They moved from individual-focused services to more comprehensive family-centered treatment. The partnerships, and the families they served, came to recognize that treating the family system—rather than an individual child or parent in isolation—is far more effective in addressing a family's underlying and complex issues.

During the initial stages of the RPG Program, grantees tended to focus first on meeting the parents' substance abuse treatment needs. Beginning in program year two, grantees worked to develop the direct children's services component of their programs. To build this capacity often required establishing new relationships with other community partners. Grantees then moved to integrate parent and child services to provide a more family-centered continuum of care. At the end of the grant period, the partnerships had begun to broaden their scope further to engage and support other family members, particularly fathers.

However, grantees often found the shift from a person-centered mode to a family-centered approach challenging. To move to family-centered treatment, partners across all systems and levels of care must be involved and ready to do things differently (e.g., practice, staffing, and funding).

6. *Broadening the partnership beyond child welfare and substance abuse treatment to work with other community agencies is critical to securing important core treatment and supportive services.*

New relationships must be cultivated on an ongoing basis to establish true collaboration, strengthen program and partnership effectiveness, and increase program sustainability potential. The regional partnerships continually evolved over the five-year period, with the member agencies becoming more diverse as services progressed and community awareness increased. With the addition of each partner, the reach and scope of the grantees' projects broadened. Their overall capacity strengthened as they added new ideas, expertise, and services.

The specific types of new partners beyond child welfare and substance abuse treatment that were needed, and why, varied by grantee, depending on their geographic location, target population, availability of other community resources, fiscal climate, local priorities, and other issues.

As the RPG Program progressed, the role of ancillary services in facilitating and sustaining positive outcomes only increased. Grantees noted the importance of mental health services, safe and affordable housing, and continuing recovery supports, in particular.

Linking families to other community supports (e.g., housing, transportation, employment services, health care) fills gaps in current systems of care, facilitates clients' engagement,

retention, and promotes families' sustained recovery and self-sufficiency. As grantees moved into their last grant-funded year and families completed RPG services and transitioned to other community-based supports, connections with local agencies and organizations that provide these needed support services became even more critical.

7. Clear roles, responsibilities, and expectations are required of partners, providers, and families to promote both individual and shared accountability.

The regional partnerships are dealing with complex family situations and multiple providers responsible for monitoring families' progress. As such, clear roles, responsibilities, decision-making processes, and client and partner expectations about the respective systems are essential. Without such clarity, diffusion of responsibility can lead to conflict, fragmentation, duplication of services, ineffective collaboration, and unproductive sustainability planning.

Agreement on roles and responsibilities needs to extend beyond the local level partners and include state level partners. It also extends to sustainability planning. Making sustainability a stated objective is important, but not sufficient without dedicated staff and specified roles.

Families, too, need clarity and consistency on the various systems' roles and expectations. They need to understand the respective role of each partner providing services to support them. Setting clear client expectations increased engagement, retention, and successful program completion. It also provided a structure of accountability and support that empowered parents.

8. Ongoing communication, information sharing, monitoring, and supervision are crucial at both the systems and direct service levels.

Ongoing communication, information sharing, and regular monitoring of client and partnership activities are essential to identify and respond to both direct service (e.g., client engagement and retention, continuity of care) and larger collaboration challenges (e.g., maximizing available resources, ensuring joint accountability for project goals). An infrastructure of consistent communication and regular monitoring was especially important to ensure effective integrated service delivery and program fidelity as the partnerships dealt with significant community and contextual events (e.g., budget cuts, staff turnover, fiscal, policy, and leadership changes, shifts in child welfare and substance abuse trends).

Grantees' experiences suggest the communication and information sharing started with the RPG project has helped lay the foundation for sustained collaborative efforts that will extend beyond the grant.

Ways in which the partnerships promoted communication included regular partnership meetings at various levels (e.g., leadership, management, front-line workers and providers), multidisciplinary case planning processes, formalized communication protocols, and a dedicated or central staff person to coordinate information among multiple partners and providers.

9. *Ongoing staff training and development is needed to enhance collaboration, increase service coordination, and build capacity for the array of services and supports families need.*

Recruiting, training, developing, and retaining qualified staff are key ingredients for comprehensive collaborative programs. Staffing impacts all program aspects and is key for cross-systems data collection and performance monitoring (see evaluation lessons below). Sufficient time and resources to support and institutionalize staff training and development need to be essential project components in larger project implementation and sustainability plans. This is even more critical given the increased emphasis in the field on providing evidence-based practices and monitoring their fidelity.

The need for qualified staff extended beyond those in clinical positions. A strong and consistent project director with adequate knowledge of families' needs and leadership and management abilities is important to advance the collaborative.

Cross-systems trainings for staff, partners, and the community on various clinical, programmatic, and evaluation issues were a central focus of grantees' overall efforts. Underlying grantees' staff training and development efforts was the need to maintain a fully staffed, skilled, and trained workforce with a high level of accountability. Such trainings served to improve service coordination, increase appropriate referrals, create shared values and goals, educate staff and the larger community about families' needs, build local capacity to address those needs, and achieve larger systems change.

Comprehensive, ongoing trainings also enabled grantees to respond to emerging family needs and broader contextual issues, maintain the program's standard of care, and ensure fidelity to evidence-based practices. Institutionalizing ongoing staff training and development became essential in light of continued high turnover of RPG project and partner agency staff, particularly child welfare.

Over the course of the five-year grant period, the 53 grantees provided or participated in more than 6,100 training events involving more than 86,400 project staff and community partners representing child welfare, substance abuse treatment, the courts, other service systems and providers, and their larger communities. Trainings covered a wide range of clinical treatment issues, as well as program policies, procedures, and operations.

Grantees stated that the extensive and ongoing trainings ultimately changed the way service systems and others think about families with co-occurring substance use disorders and child maltreatment issues.

10. The partnership and program need to be integrated into other existing systems' efforts and infrastructures and leverage all available resources to facilitate sustainability.

To institutionalize and sustain the RPG interventions, a grantee's overall program needs to be integrated into existing efforts or infrastructures rather than operate as a stand-alone model or project. This requires an understanding of how the grantee's program and partnership align with other agency goals and their role in the broader community's child welfare, substance abuse treatment, and other service systems. The lesson of integration applies not only to direct services, but also to agency-level collaboration.

Grantees integrated their efforts with other related program and policy initiatives in various ways. They integrated with their state's child welfare system improvement processes (e.g., Child and Family Services Review or Performance Improvement Plan). They joined with larger health care reform and care coordination efforts to establish a permanent medical and behavioral health care home for their RPG families. They transitioned RPG staff positions, services, and knowledge to partnering agencies that will continue to serve families beyond the grant. In addition, grantees connected with other related grants or community initiatives to leverage additional resources. Finally, some grantee lead agencies incorporated the RPG-specific efforts with complementary efforts within their own larger agency or organization.

Sustainability Lessons from the 53 Grantees

The experiences of all 53 grantees offer valuable insights about what it takes to institutionalize and sustain the RPG efforts. Their collective experiences point to the following common factors that helped support sustainability:

- Investment in and commitment to strong, broad-based collaboration that enabled partners to share financial and other resource needs
- Early, proactive, and formalized sustainability planning inclusive of all major stakeholders
- Demonstrated effectiveness in serving families and positive child, adult, and family outcomes and documented cost savings
- The ability to develop new billing or contract structures, or modify existing ones, to support the provision and reimbursement of RPG services
- Extensive and resourceful program marketing and information dissemination to key stakeholders, potential funders, and the larger community to demonstrate how the program changed families' lives
- Key program and policy leadership, including support from the state legislature
- A detailed sustainability plan with concrete action steps and the flexibility to revise the plan in response to political, fiscal, leadership, and other contextual changes

11. The larger economic and fiscal environment has a notable impact on collaborative service delivery and sustainability planning efforts.

Grantees reported the challenging fiscal climate that persisted throughout the grant period adversely affected their regional partnerships' services, outcomes, and collaborative capacity.

They noted state and county budget cuts reduced substance abuse treatment capacity, affected child welfare staffing patterns, impacted contract service dollars, and decreased collaborative activities. In addition, the level and type of available community support services (outside of RPG-funded services) that families rely on diminished. Acknowledging these contextual impacts is important in understanding grantees' progress and challenges, and in interpreting the RPG child, parent, and family outcomes.

Grantees repeatedly emphasized the difficulty of planning for sustainability in the given economic and fiscal climate. The partnerships said they began the grant project fully aware of the critical need to develop sustainability plans as early as possible. However, they did not anticipate how drastic the economic downturn would be at both the state and local levels. The number of grantees experiencing federal, state, and county budget cuts as a major sustainability challenge rose steadily over the course of the grant.

The grantees' performance measure results are all the more impressive given the many external obstacles that occurred during the majority of the grant period. Given the collaboratives' strength, resilience, perseverance, and commitment to families, they were largely able to respond and adapt to these significant challenges.

KEY PERFORMANCE MONITORING AND PROGRAM EVALUATION LESSONS— INSIGHTS FROM THE 53 GRANTEEES

The capacity and capability of grantees to combine comprehensive, integrated service delivery with rigorous performance monitoring and local project evaluation varied across sites. Though the learning curve was steep, the partnerships made substantial progress over the course of the grant. Grantees' collective experiences in monitoring and assessing progress across agencies provide important lessons for future initiatives.

The eight key lessons below emphasize the inherent complexity of examining child, adult, and family outcomes across multiple service systems. These lessons parallel the above collaborative program implementation lessons.

1. Collaboration, broad-based partner support, and shared values are prerequisites for establishing cross-systems information sharing.

Collaborative partnerships create an essential infrastructure to support and maintain cross-systems data and information sharing. Only through cooperative working relationships can the regional partnerships effectively track families' involvement across systems and monitor the partnership's progress.

Extensive and well-established collaborative relationships and networking are needed for a program of this scale to measure and achieve shared outcomes and systems reforms. Grantees stressed that extensive support for performance monitoring and program evaluation at all levels—community partners, program staff, and agency leadership—is imperative. Regional

partners must view data collection as more than just “a requirement of the grant.” They need to see it as part of standard best practice to support continuous quality improvement and program monitoring.

2. Considerable staff and financial resources are needed to implement cross-systems information sharing and performance monitoring.

Cross-systems information and data sharing involving multiple agencies takes considerable time and resources. Both adequate staff time and funding are needed to develop and sustain a data collection and reporting infrastructure that can support comprehensive, high quality program evaluation and ongoing performance monitoring.

In addition, successful cross-systems performance monitoring and evaluation hinges on having an evaluation team sufficient in both number and experience. Grantees stressed that front-line, direct care staff often lacked adequate evaluation experience and training. The importance of working with evaluators who understand both child welfare data and substance abuse data, as well as the context of the project, should not be underestimated.

Sufficient financial and human resources also are important to mitigate the impact of broader contextual issues outside the RPG programs’ control. Despite having initial data sharing agreements, severe staffing shortages, management information system issues, and changes to state or county child welfare or substance abuse treatment data systems often prevented grantees from getting needed data (in a timely fashion or at all). Larger system and agency budget cuts throughout the grant exacerbated the problem.

3. Program and evaluation staff must establish a close partnership and effective communication.

Program and evaluation staff must have a close, mutually respectful working relationship and open, two-way communication. Evaluation and program staff need to be integrated to ensure that evaluation activities reflect a thorough understanding of the project’s day-to-day practices, and evaluation results are translated into continued program improvements. An onsite evaluation team can help improve communication and coordination and strengthen overall data collection and analysis.

Evaluators need to be proactive, timely, responsive, and actively engaged in the larger project and partnership. They need to have a thorough understanding of all program components and the needs of staff, partners, and the families served. As one grantee stated, the evaluator should be someone who is “invested in telling the story of the RPG program.”

4. Process and outcomes evaluation data need to be communicated to partners and key stakeholders on a regular basis.

Sharing data for ongoing program management and continuous quality improvement positively impacted collaboration between partners. Not only did project staff and key partners communicate case-specific information for treatment planning purposes. They used their outcome and process evaluation data to strengthen overall program development and the specific services for families. They used it to guide sustainability planning. They also used data to develop new policies and procedures, or modify existing ones, for how the RPG program or larger service systems operate.

The lengthy duration of many grantees' program models may require two or more years to document longer-term outcomes and assess the project's broader success. Still, projects such as the regional partnerships need to identify, disseminate, and use interim process and outcomes evaluation findings for continued program development.

5. Data collection roles and responsibilities need to be clearly defined and agreed upon for both individual staff and partner agencies.

The regional partnerships collected and linked data from multiple providers and systems. When dealing with such complex cross-systems data efforts, all partners need to be clear on their individual and larger agency data collection responsibilities. Lack of shared accountability and consistent, systematic guidelines can affect data quality and, ultimately, the ability to use data for program improvements and sustainability. Formal data-sharing agreements, particularly with state or county agencies needed to extract case-level data, should be established early on to facilitate data collection and reporting.

6. Ongoing training and monitoring are needed to ensure data quality and consistency.

Ongoing oversight is needed to ensure data quality and consistency. Project management needs to understand the evaluation design, conduct regular quality assurance and data checks, and communicate regularly with program and evaluation staff responsible for data collecting and reporting. The need for close and constant supervision of data collection processes intensified with frequent and continued program and evaluation staff changes. Data quality and consistency issues often were closely intertwined with turnover of both RPG evaluation and state agency staff.

7. A mixed-methods research design is needed to capture the regional partnerships' full impact on the families and communities served.

Grantees acknowledged that the quantitative RPG Program performance measures were important to gauge their progress. Yet the partnerships emphasized qualitative process evaluation information that described the experiences of families and RPG partners were equally

essential. Both quantitative and qualitative data were essential to capture the full breadth, depth, and scope of grantees' programs and cross-systems collaborative progress. Qualitative information provided further evidence of how grantees had increased capacity to serve families and served to reinforce the RPG mission and experience.

As one grantee stated, qualitative information enabled the partnership to better portray families' challenges and complexities and the role the RPG project played in helping them reunify with or retain custody of their children. Another grantee explained, "Often in child welfare, outcomes are not black and white, successful or unsuccessful, but various places in between." Qualitative information thus provided important, additional context for interpreting the performance measures.

8. Program evaluation and performance monitoring in a real-world setting are inherently difficult.

Conducting research in an applied or real-world setting where families' complex and multiple needs require flexibility in service delivery is inherently difficult. As one grantee explained, the RPG program was not a "one-size fits all" intervention. The partnerships often struggled with how to balance the tension between implementing a rigorous program evaluation design and delivering direct services to families. It is important that the evaluator be involved early in the grant application and program development process to ensure alignment of the service delivery approach and evaluation design.

Grantees also increasingly recognized the importance of conducting a cost study as part of their overall program evaluation and sustainability efforts. Yet many partnerships found they lacked the knowledge, capacity, collaborative relationships, and financial and human resources to develop and complete such an analysis. Grantees stressed the need to design a cost analysis at the project's outset and dedicate sufficient resources to carry it out successfully.

CONCLUSION

This final report to Congress for the initial five-year RPG Program period illustrates the successes and challenges in establishing and sustaining cross-systems collaboration and service integration. Over the course of the grant, grantees' programs continually evolved and their partnerships expanded and matured. Through broad-based collaboration, grantees strengthened the range and types of services they provided to families and how they delivered those services. Grantees used their data to increase awareness about the complexity of families' needs, communicate their programs' effectiveness in producing positive family outcomes, and make the case for sustaining collaborative practice and integrated services.

Grantees implemented, operated, and sought to sustain their programs in one of the most challenging fiscal environments our nation has recently experienced, with the onset of the Great Recession in 2008. Yet the strength of the partnerships enabled them to adapt to the many associated contextual obstacles (e.g., budget cuts, staff turnover, leadership changes, child welfare system reorganizations) that occurred during the majority of the five-year grant period.

By the end of the grant, key partners and stakeholders said they had gained a much better understanding of what it means to collaborate and the positive impact it has on child welfare families affected by parental substance use disorders. Grantees stated increased collaboration has been the most important catalyst for improving services and shifting ideology on how best to serve these families. Grantees succeeded in bringing their collaborative voice, accrued expertise, and collective experiences to the larger community to inform other initiatives. They established a foundation, grounded in cross-systems collaboration, on which to build continued community efforts to serve these families.

Considering the promising results reflected in the performance measurement of the RPG grants, the level of collaboration that most grantees achieved, and the extent to which most sites will sustain their services and collaborative activities, the RPG Program fulfilled the goals envisioned in the authorizing legislation.

CHAPTER I: INTRODUCTION

THE REGIONAL PARTNERSHIP GRANT PROGRAM—LEGISLATIVE INTENT AND BROAD PROGRAM GOALS

On September 28, 2006, the Child and Family Services Improvement Act of 2006 (P.L. 109-288) was signed into law. The legislation was designed to improve the lives of abused and neglected children and their families, and included provisions that specifically address those children who are affected by a parent's¹¹ methamphetamine and other substance use disorders.¹²

The legislation had many provisions. Among them, it reauthorized the Promoting Safe and Stable Families (PSSF) program through federal fiscal year (FY) 2011 and amended Section 437 of the Social Security Act (42 U.S.C. 629g[f]) to include a new competitive grant program: “Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Abuse.” The U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Administration on Children, Youth and Families (ACYF), Children’s Bureau administers the program.

The legislation provided grant funding to help states, tribes, and communities across the nation develop regional partnerships “to provide, through interagency collaboration and integration of programs and services, services and activities that are designed to increase the well-being of, improve permanency outcomes for, and enhance the safety of children who are in an out-of-home placement or are at risk of being placed in an out-of-home placement as a result of a parent’s or caretaker’s methamphetamine or other substance abuse.” Thus, the program is referred to as the Regional Partnership Grant (RPG) Program.

The legislation responds to parental substance abuse as a key factor underlying the abuse or neglect experienced by many children in the child welfare system. Studies indicate that between one-third and two-thirds of all substantiated child maltreatment reports involve substance abuse.¹³ For example, in a national study of children in out-of-home placement, caseworkers reported that nearly 61 percent of infants and almost 41 percent of older children had a caregiver

¹¹ This report uses the term “parent” to refer to parent or caretaker (which is the language used in the legislation).

¹² The new Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published in May 2013, combined the prior criteria for substance abuse and substance dependence into a single substance use disorders diagnosis. This report, however, may use the terms substance abuse and substance use disorder interchangeably.

¹³ While figures vary for methodological reasons, most studies find that for one-third to two-thirds of children involved with the child welfare system, parental substance abuse is a contributing factor. The lower figures tend to involve child abuse reports; higher ones most often refer to children in out-of-home care. Sources: U.S. Department of Health and Human Services (1999). *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*. Washington, D.C.: U.S. Government Printing Office, 1999; Semidei, J., Radel, L.F. & Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare* 80(2): 109-28; and Young, N.K., Boles, S.M., & Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlap, gaps, and opportunities. *Child Maltreatment* 12(2): 137-149.

with active alcohol and/or drug abuse.¹⁴ The rise of methamphetamine use during the late 1990s and early 2000s, in particular among women of childbearing age, focused attention on the need to provide comprehensive, integrated family-centered treatment services to affected families. While the proportion of substance abuse treatment admissions for methamphetamine and other amphetamines has slowly declined since its peak of 9.1 percent¹⁵ in 2005, methamphetamine use continues to be a concern. In 2011, women accounted for 47.5 percent of all admissions for methamphetamine/amphetamine. The proportion of such admissions was 8.6 percent for women, in contrast to 4.7 percent for men.¹⁶ The proportion of methamphetamine admissions among pregnant women was 13.9 percent.¹⁷

Grants funded under this program support regional partnerships in establishing or enhancing a collaborative infrastructure capable of building the region's capacity to meet a broad range of needs for families involved with both substance abuse treatment and the child welfare system. Too often, the provision of child welfare services and substance abuse treatment is uncoordinated and fragmented due to:

- Difficulty identifying, engaging, and retaining parents/caregivers in substance abuse treatment
- Differing perspectives, policies, and funding between child welfare services and substance abuse treatment providers
- Lack of appropriate and comprehensive family-centered treatment services for families involved in both the child welfare and substance abuse treatment systems

The legislation authorized and appropriated \$145 million over five years for this grant program. It also authorized multi-year grants, with descending levels of funding: \$40 million in FY 2007 with a 15 percent grantee match; \$35 million in FY 2008 with a 15 percent grantee match; \$30 million in FY 2009 with a 20 percent grantee match; \$20 million in FY 2010 with a 20 percent grantee match; and \$20 million in FY 2011 with a 25 percent grantee match. This program design was intended to facilitate grantees' active sustainability planning from the time of award.

The September 30, 2011 passage of the Child and Family Services Improvement and Innovation Act (P.L. 112-34) reserved a total of \$100 million (\$20 million each year) to extend funding for the RPG Program from FY 2012 to FY 2016. The legislation removed the specific focus on methamphetamine abuse, but retained the overall focus on substance abuse. It also allowed

¹⁴ Wulczyn, F., Ernst, M. & Fisher, P. (2011). *Who are the infants in out-of-home care? An epidemiological and developmental snapshot*. Chicago: Chapin Hall at the University of Chicago.

¹⁵ Methamphetamine accounts for approximately 90 percent of the total.

¹⁶ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. *Treatment Episode Data Set (TEDS). 2011. National Admissions to Substance Abuse Treatment Services*. BHSIS Series: S-65, HHS Publication No. (SMA) 13-4772, Rockville, MD, 2013.

¹⁷ Substance Abuse and Mental Health Data Archive. Treatment Episode Data Set - Admissions (TEDS-A) 2011 Computer File. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor]. Retrieved December 3, 2013 from <http://www.icpsr.umich.edu/icpsrweb/SAMHDA/>.

current grantees to apply for a two-year extension of their current grant; eight grantees received continuation awards.

BRIEF OVERVIEW OF THE RPG PROGRAM

On September 30, 2007, HHS awarded multi-year grants to 53 regional partnerships; 44 grantees (83 percent) opted for the five-year program funding, while 9 grantees applied for three-year funding¹⁸ (Table 1). Funding was as follows:

- For the first year (FY 2007), annual grant awards were \$500,000 or \$1 million and totaled approximately \$32.5 million.
- For FY 2008, annual grant awards were \$500,000 or \$825,000 and totaled \$30.4 million.
- For FY 2009, annual grant awards were \$500,000 or \$750,000 and totaled \$29.5 million.
- For FYs 2010 and 2011, annual grant awards were \$500,000 or \$1 million and totaled \$19.5 million.
- HHS spent approximately \$2 million per year towards contract support activities during FY 2007 through FY 2011.

Table 1: Regional Partnership Grantees by Program Funding Option (Listed Alphabetically by State)*			
Grantee	City	State	Congressional District Served by Project
Program Option 1: Three-Year Projects \$1 million Annual Award			
Denver Department of Human Services	Denver	CO	1
North Range Behavioral Health Center ¹⁹	Fort Collins	CO	4
Pierce County Alliance	Tacoma	WA	6
Program Option 2: Five-Year Projects \$1 million Annual Award			
County of Santa Clara, Social Services Agency	San Jose	CA	10, 13-16
SHIELDS for Families, Inc.	Los Angeles	CA	37
Idaho Department of Health and Welfare	Boise	ID	1, 2

¹⁸ Grant applicants selected from one of four program options designed to fulfill the legislative requirements while allowing for grantee program flexibility. The grant program announcement provided detailed program option tables outlining the project timeframes and federal award and grantee match amounts per award year. The majority of the three-year grantees received no-cost extensions for an additional year and completed their projects by September 30, 2011. The full program announcement and supporting materials developed by the Federal Interagency Workgroup are available on the Children’s Bureau Discretionary Grants Library Website at http://basis.caliber.com/cbgrants/ws/library/docs/cb_grants/GrantHome. Brief abstracts and contact information for the 53 programs are available on the National Center on Substance Abuse and Child Welfare (NCSACW) website at <http://www.ncsacw.samhsa.gov/files/RPG-Proposal-Abstracts-by-State.pdf>.

¹⁹ Former lead agency was Island Grove Regional Treatment Center, Inc.

**Table 1: Regional Partnership Grantees by Program Funding Option
(Listed Alphabetically by State)***

Grantee	City	State	Congressional District Served by Project
Children’s Research Triangle	Chicago	IL	12
Kentucky River Community Care, Inc.	Jackson	KY	5
One Hope United - Hudelson Region	St. Louis	MO	Statewide
Multnomah County	Portland	OR	3
State of Nevada	Carson City	NV	1, 3
Child and Family Tennessee	Knoxville	TN	2
Program Option 3: Three-Year Projects \$500,000 Annual Award			
State of Arizona	Phoenix	AZ	4
Butte County Department of Employment and Social Services	Oroville	CA	1, 2
Supreme Court of Georgia	Atlanta	GA	3, 9, 13
Omaha Nation Community Response Team ☼	Walthill	NE	1
University of Rochester	Rochester	NY	28
County of Lucas	Toledo	OH	9
Program Option 4: Five-Year Projects \$500,000 Annual Award			
Cook Inlet Tribal Council, Inc. ☼	Anchorage	AK	1
Center Point, Inc.	San Rafael	CA	6
County of San Diego, Health and Human Services Agency, Child Welfare Services	San Diego	CA	50-52
County of Santa Cruz, Health Services Agency, Alcohol and Drug Program	Santa Cruz	CA	17
Mendocino County Health and Human Service Agency	Ukiah	CA	1
Sacramento Department of Health and Human Services	Sacramento	CA	3, 5
WestCare California, Inc.	Fresno	CA	9
Clarity Counseling P.C. ²⁰	Dolores	CO	NM-3
AspenPointe Health Network ²¹	Colorado Springs	CO	5
Hillsborough County Board of Commissioners	Tampa	FL	11
Juvenile Justice Fund	Atlanta	GA	5
Judicial Branch State of Iowa	Des Moines	IA	Statewide
Upper Des Moines Opportunity, Inc.	Graettinger	IA	5
Kansas Department of Social and Rehabilitation Services	Topeka	KS	Statewide
Kentucky Department for Community Based Services	Frankfort	KY	Statewide
Massachusetts Department of Public Health	Boston	MA	1, 2

²⁰ Although Clarity Counseling is officially located in Dolores, Colorado, its regional partnership program operated and served families in New Mexico.

²¹ Lead agency was formerly known as Connect Care, Inc.

**Table 1: Regional Partnership Grantees by Program Funding Option
(Listed Alphabetically by State)***

Grantee	City	State	Congressional District Served by Project
White Earth Band of Chippewa ☼	White Earth	MN	7
St. Patrick Center	St. Louis	MO	1
Apsaalooke Nation Housing Authority ☼	Crow Agency	MT	1
Second Chance Homes ²²	Billings	MT	1
Westchester County	White Plains	NY	18
North Carolina Department of Health and Human Services	Raleigh	NC	7
Butler County Children Services	Hamilton	OH	8
Choctaw Nation of Oklahoma ☼	Durant	OK	2
Oklahoma Department of Mental Health and Substance Abuse Services	Oklahoma City	OK	5
Baker County/Northeast Oregon Collaborative	Baker City	OR	2
Klamath Tribes ☼	Chiloquin	OR	2
OnTrack, Inc.	Medford	OR	2
Children's Friend and Service	Providence	RI	1, 2
Tennessee Department of Mental Health	Nashville	TN	4, 6
Aliviane, Inc.	El Paso	TX	16
Houston Council on Alcoholism and Drug Abuse	Houston	TX	7
Travis County	Austin	TX	21
Lund Family Center	Burlington	VT	1
Wisconsin Department of Health and Family Services	Madison	WI	Statewide

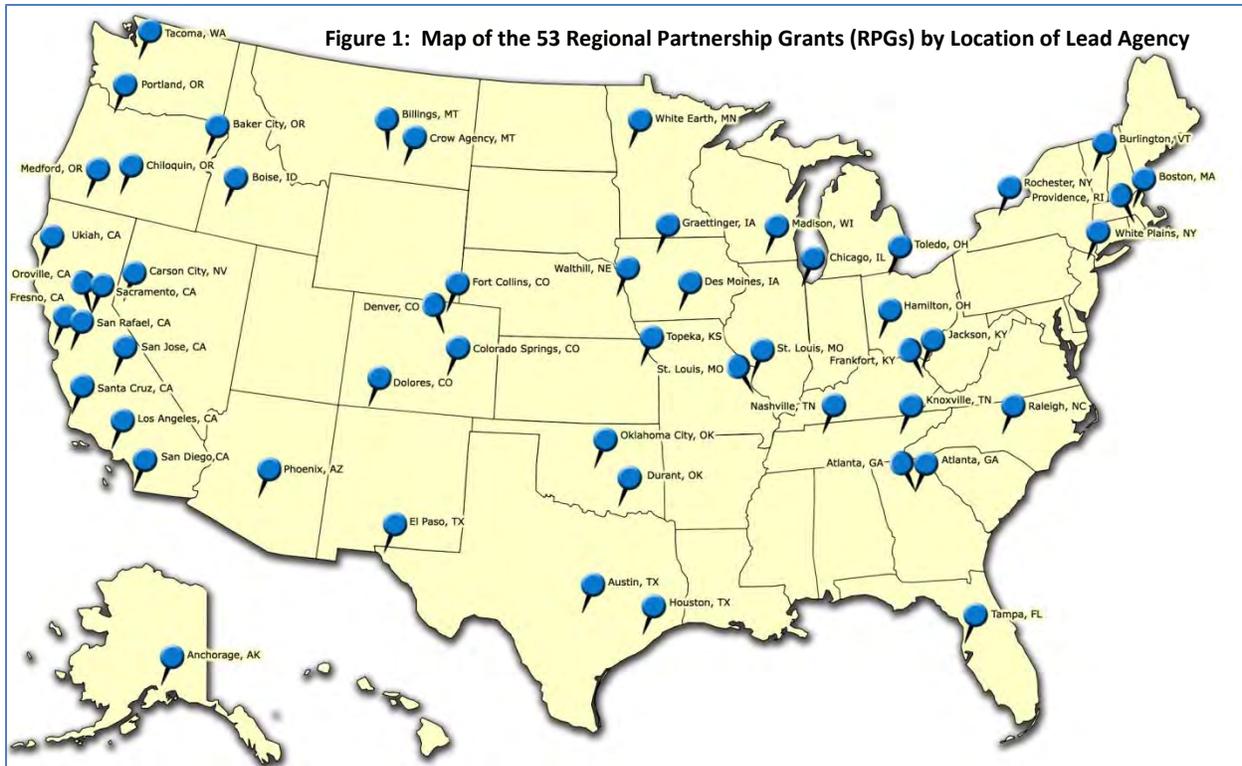
* The city represents the location of the grant's lead agency. However, the lead agency location was not always the same as where the partnership implemented its program and provided services. The majority of grantees provided services to families in multiple counties or regions throughout a state.

☼ Tribal grantee

Geographic Areas Served

The lead agencies (applicants) for the 53 grantees were based in 29 states and included 6 tribes (Figure 1 below). The majority of grantees served a single county (47 percent) or a region encompassing multiple counties (43 percent). A small number served a city (6 percent) or their larger state (4 percent). Regions served by grantees varied in scope, from 2 to 25 counties; they also differed in population demographics, topography, and remoteness. According to the 2010 Census, 28 percent of the more than 180 RPG targeted counties have a majority (75 percent or more) rural population. This may pose certain challenges (e.g., lack of available treatment and supportive services, difficulty finding and retaining qualified staff).

²² Former lead agency was The Family Tree Center - Billings Exchange Clubs' Child Abuse Prevention Center.



Note: One of the lead agencies was located in Dolores, Colorado, but its program served families in Farmington, New Mexico.

Regional Partnership Composition

A wide range of governmental and private sector organizations representing child welfare, substance abuse treatment, the courts, and other child and family services entities served as the lead agency for the RPG projects:

- 30.2 percent were a child welfare agency (state, county, or tribal)
- 22.6 percent were a substance abuse treatment and/or mental health services provider or organization
- 17.0 percent were a child welfare services or other type of family and child services provider
- 13.2 percent were a substance abuse treatment agency (state, county, or tribal)
- 5.7 percent were a tribe, tribal consortium, or tribal social services provider
- 3.8 percent were a joint child welfare and substance abuse treatment agency
- 3.8 percent were judges or court personnel
- 3.8 percent were some other county board

The diversity in lead agencies reflects the RPG Program’s collaborative nature. Further, the overall regional partnership composition was quite broad for all grantees and extended well beyond the two-partner minimum requirement in the legislation (see Table 2 below). All non-tribal grantees included state, regional, and/or county child welfare agencies as a key partner.²³

Table 2: Breadth of the Regional Partnerships and their Interagency Relationships	
Child Welfare, Substance Abuse, and Mental Health	
<ul style="list-style-type: none"> • All 53 regional partnerships (100%) included representatives from the state, regional, county, or tribal child welfare agency • 86.8% included substance abuse treatment providers • 75.5% included mental health agencies or service providers • 67.9% included representatives from the state, regional, county, or tribal substance abuse treatment agency • 37.7% included child welfare services providers 	
Courts and Criminal Justice System	
<ul style="list-style-type: none"> • 77.4% of the partnerships included family drug courts, adult drug courts, other dependency courts, or tribal courts • 66.0% involved criminal justice and legal systems partners • 43.4% involved other court-related agencies (e.g., Court Appointed Special Advocates) 	
Other Community and Supportive Services	
<ul style="list-style-type: none"> • 73.6% of the partnerships included other community-based child and family direct service providers • 60.4% involved child and/or adult health services agencies or providers • 52.8% included parenting/early childhood education or service providers or early childhood coalitions or councils • 43.4% included state or local employment agencies or employment/vocational service providers • 37.7% engaged housing agencies or services providers • 34.0% involved state departments of education, schools or school districts, and colleges or universities 	
Other Partners	
<ul style="list-style-type: none"> • 83.0% of partnerships included their evaluator as major partner • 28.3% involved tribes, foundations, or other community stakeholder or advisory groups, committees, or boards • 30.2% included other types of partners* 	

* Other partners included consultants, training and technical assistance providers, or other state, county, or community entities not otherwise specified.

Since RPG Program implementation, grantees continually expanded their collaborative relationships. By the end of the grant period, approximately three-fourths (75.5 percent) of the regional partnerships consisted of 10 or more member agencies, organizations, and/or providers. The partnerships expanded and matured as families’ needs and the environment in which the

²³ The legislation defined “regional partnerships” as two or more partners, one of which must be the state child welfare agency responsible for administration of the state plan under title IV-B or IV-E of the Social Security Act. Tribes were exempt from this requirement, but had to include at least one non-tribal partner.

grantees operated continued to shift and evolve. Further, with certain types of member organizations or providers, grantees may have worked with multiple partners. For example, grantees serving larger geographic regions may have established partnerships with several different substance abuse treatment providers. One grantee found that as their program evolved, they needed to reach beyond traditional substance abuse treatment providers to engage Medication-Assisted Treatment (MAT) providers.²⁴

Grantees went beyond their original core partners to engage other vital services systems (e.g., health, mental health, housing, employment) and community organizations to respond to clients' complex, multifaceted needs. Growing the partnerships also was critical to leveraging existing resources and sustainability planning (see also Chapter III, Lessons 1, 6, and 10). Specifically, 39 grantees reported the addition of approximately 438 new partners over the course of the grant. Several grantees continued to expand their partnerships during program year five and at the end of the grant.

Target Population

Grantees targeted services to families with children who had been removed from their homes and placed in out-of-home care and those who were at risk of removal, but still in the custody of their parent or caregiver (i.e., in-home cases). Many partnerships expanded their target populations over the course of the grant. Overall, nearly three-fourths (72 percent) of grantees provided services to both groups of families, while 15 percent focused primarily on in-home cases and 13 percent concentrated on out-of-home cases. Within these groups, some grantees emphasized a specific subpopulation, such as pregnant and parenting women, parents and their young children (0 to 5 years), substance-exposed newborns, or families involved with the criminal justice system. More than one-third (37.7 percent) of grantees served voluntary child welfare cases, pre-filing cases, or differential/alternative response cases in which participants enter and/or exit the grantee's program voluntarily and do not have open family court cases.²⁵

Focus on Methamphetamine

Nearly all grantees included interventions to address the effect of methamphetamine use on child welfare involvement, per the authorizing legislation. However, most grantees did not limit their focus to methamphetamine, given the predominance of polysubstance use among most clients and varying drug use patterns across the country. Further, 45.3 percent of grantees mentioned that during the grant, substance use or treatment admission patterns or trends in their communities changed. For example, during the latter half of the grant period in particular,

²⁴ MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.

²⁵ Voluntary child welfare cases are those referred to community-based or voluntary in-home child protective services; pre-filing cases include those where a dependency petition has been held in abeyance pending successful completion of voluntary services or the case has been diverted from court jurisdiction in lieu of filing a dependency petition; and differential or alternative response cases include the provision of voluntary services for families, which may include closed child welfare cases.

several grantees noted an increase in the number of program participants with prescription drug abuse problems, which is consistent with recent national trends.²⁶

As previously noted, national treatment admissions for methamphetamine have declined since peaking at 9.1 percent in 2005. However, among the grantees, methamphetamine as the primary substance problem remained pervasive. The percentage of participating adults with methamphetamine as their primary substance problem at treatment admission remained relatively stable over the grant period at approximately one-third.²⁷ For 15 grantees, the percentage of all treatment admissions for methamphetamine was more than 45 percent. Among RPG admissions for methamphetamine, 45.1 percent reported marijuana as their secondary substance problem at admission, while approximately one-third (32.9 percent) indicated alcohol as a secondary problem. It is common for persons with substance use disorders to report the use of multiple substances.²⁸

Services and Activities

The 53 regional partnerships implemented a wide array of integrated programs and services responsive to the needs outlined in the legislation. These program activities addressed important gaps in current service delivery systems for children and families involved with the child welfare system who need substance abuse treatment and other health and social services. Chapter II briefly describes grantees' major program activities.²⁹

PURPOSE AND SCOPE OF REPORT TO CONGRESS

Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Abuse: Fourth Annual Report to Congress (herein referred to as the Fourth Report to Congress) is the final in a series of reports

²⁶ Past month nonmedical use of prescription-type drugs (pain relievers, tranquilizers, stimulants, and sedatives) by persons aged 12 or older rose from 6.2 million (2.5 percent) in 2008 to 7.0 million (2.7 percent) in 2010; however, it declined to 6.1 million (2.4 percent) in 2011. The number of individuals with pain reliever dependence or abuse increased from 1.5 million in 2008 to 1.9 million in 2010, but dropped slightly to 1.8 million in 2011. Substance Abuse and Mental Health Services Administration (2012). *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*. Office of Applied Studies, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD. In addition, from 2004 to 2010, medical emergencies related to the nonmedical use of pharmaceuticals increased 119 percent. Substance Abuse and Mental Health Services Administration (2012). *Drug Abuse Warning Network, 2010: National Estimates of Drug-Related Emergency Department Visits*. HHS Publication No. (SMA) 12-4733, DAWN Series D-38. Rockville, MD.

²⁷ Among adults who enrolled in the RPG Program in year one, methamphetamine represented 33.4 percent of all treatment admissions. While the percentage decreased slightly for those admitted in program years two (29.9 percent), three (31.1 percent), and four (31.5 percent), it increased again to 33.3 percent for those who enrolled in program year five.

²⁸ See, for example, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (March 4, 2010). *The TEDS Report: Treatment Admissions Reporting Abuse of Both Alcohol and Drugs: 1997-2007*. Rockville, MD.

²⁹ Please refer to the Second Report to Congress for a more extensive and detailed description of the grantees' programs. The report can be accessed at:

http://www.cffutures.org/files/RPG_Program_Second_Report_to_Congress.pdf.

for the initial five-year grant period from HHS.³⁰ Section 437 of the Social Security Act, as amended by the Child and Family Services Improvement Act of 2006, required the annual reports to Congress to focus on three key areas of the RPG Program:

- ***Services provided and activities conducted with RPG Program funds.*** This Fourth Report to Congress encompasses the activities that both the 53 grantees and HHS engaged in for this initial five-year grant period (September 30, 2007 to September 30, 2012). Chapter II provides a brief summary of grantees' various program services and activities and highlights how grantees enhanced their program models over the course of the grant. Chapter XII describes HHS's ongoing technical assistance and training activities to support grantees' continued project implementation, performance monitoring, and local program evaluation.
- ***Progress made in addressing the needs of families.*** Chapter III reviews the progress the 53 grantees made, through their increased cross-systems collaboration, in achieving the goals of child safety, permanency, and well-being for families with methamphetamine or other substance use disorders who come to the attention of the child welfare system. It summarizes 11 key lessons regarding cross-systems collaborative practice that emerged from HHS's in-depth qualitative review of grantees' Semi-Annual and Final Progress Reports.
- ***Performance measures established under the RPG Program.*** Chapters VI to X provide the RPG performance measure analyses regarding safety, permanency, recovery, well-being, and systems collaboration. Further, Chapter XI discusses grantees' progress with their local evaluations and outlines key performance monitoring challenges the partnerships encountered during the grant.

DATA SOURCES AND RPG PERFORMANCE MEASUREMENT APPROACH

The reports to Congress draw on substantial qualitative and quantitative data sources to provide a comprehensive descriptive and analytical picture of the 53 grantees' activities and services, their collaborative progress to meet families' needs, and the overall RPG Program performance measure results. This fourth report presents:

- Grantees' final performance measure data submitted representing children, adults, and families served from September 30, 2007 through September 30, 2012, and
- Qualitative and quantitative information from all of the grantees' Semi-Annual Progress Reports submitted over the grant period (nearly 500 total reports), as well as a select number of grantees' Final Progress Reports.³¹

³⁰ The three prior reports to Congress can be accessed at: <http://www.cffutures.com/projects/rpg>. HHS will publish an evaluation report for the second round of regional partnerships grants for FYs 2012 to 2016 in December 2017.

³¹ HHS was able to review 27 Final Progress Reports for inclusion in this Fourth Report to Congress; this included reports from the 9 three-year grantees and 18 of the five-year grantees received as of June 2013. At the writing of this report, 18 grantees had no-cost extensions and planned to submit their Final Progress Reports by December 31, 2013; the remaining eight grantees will submit their Final Progress Reports at the end of their two-year continuation grants (that extend through FY 2014).

This information was supplemented by several other key sources, including summary reports for the 95 grantee site visits and 9 grantee meetings conducted over the course of the grant period. Appendix A briefly summarizes all these information sources.

To organize these data, HHS developed a comprehensive RPG Program logic model that illustrates how successful cross-systems practice and services can positively affect safety, permanency, recovery, well-being, and systems collaboration. This logic model (see Appendix B) represents the 53 RPG-funded programs and shows how programmatic components and systemic factors connect to impact critical outcomes. It also served as a framework for planning the data analyses and testing relationships between specific program services and outcomes.

CHAPTER II: PROGRAM SERVICES AND ACTIVITIES—PROFILE OF THE 53 REGIONAL PARTNERSHIPS

INTRODUCTION AND OVERVIEW

The 53 regional partnerships implemented a wide array of integrated programs and services to respond to the needs of children and families involved in child welfare due to a parent's substance use disorder. Many of these cross-systems collaboration and improvement activities did not exist in the partnership sites prior to the RPG Program. Rather, they represented new initiatives or an expansion and/or enhancement of prior collaborative practices—a direct reflection of the legislation's emphasis on developing and strengthening interagency collaboration and services integration.

Grantees' major services and activities fell into five general areas:

- Systems collaboration and improvements
- Substance abuse and mental health treatment and linkages
- Services for children and youth
- Family-strengthening services
- Other clinical and community support services for children, parents, and families

HHS developed operational definitions for more than 70 major types of services and interventions (referred to as program strategies in this report) that grantees provided to their target populations. These definitions (see Appendix C) provided a common frame of reference across all 53 grantees. Since grantees' programs continued to evolve over the course of the RPG Program, HHS asked the partnerships at three points during the grant period to indicate which of the different program strategies they had implemented. This Fourth Report to Congress reflects grantees' final program strategy update conducted at the end of program year five.³²

This chapter summarizes:

³² Grantees provided initial program strategy information during spring 2009 (early in program year two), updated information during summer 2010 (about midway through the grant period), and then again in summer 2012 (just prior to the end of the grant). The Second and Third Reports to Congress provided an extensive and detailed discussion, description, and examples of the specific services and interventions that grantees provided to their target population. These reports can be accessed at: <http://www.cffutures.com/projects/rpg>.

- The major program strategies grantees implemented for the majority of their target population(s)³³
- The extent to which these strategies represented expanded capacity to serve families by establishing new services or expanding or enhancing existing services³⁴
- The primary funding sources that supported their implementation (as grantees leveraged other resources to help maximize the impact of the RPG award)
- Whether grantees’ program strategies would be sustained after the grant period
- Key insights and lessons learned about selected program strategies

HIGHLIGHTS

These highlights briefly summarize the most frequent program strategies grantees implemented and overall capacity building, primary funding, and sustainability information. This section also features selected lessons from the six tribal grantees regarding cultural strategies they used to serve Native American families. Following these highlights are individual sections for each of the five general program areas that provide more detail on grantees’ specific services and activities.

Though grantees’ overall RPG program models and target populations were diverse, the partnerships shared two common fundamental characteristics. First, grantees provided a comprehensive set of direct treatment and support services to meet the needs of children, adults, and families. Second, as the legislation intended, grantees bolstered these services with specific activities to improve cross-systems collaboration and strengthen service integration.

At-a-Glance Snapshot—Most Universal Program Strategies

Among the extensive array of individual services each grantee may have provided, there were certain program strategies that the vast majority of all grantees implemented. Program strategies universal to three-fourths (75.0 percent) or more of grantees included:

- Basic cross-systems collaborative activities (e.g., training, regular partnership meetings) to increase understanding between the different service systems about how each operates and

³³ Grantees were asked to indicate what percentage of their target population receive a given service or intervention that was part of the grantee’s overall program model. For this report, the “majority of target population” refers to 50 percent or more. For selected interventions, a substantial number of additional grantees may have provided services to a smaller percentage of clients or on an as-needed basis; this is noted, where applicable.

³⁴ Strengthened capacity was viewed as the extent to which grantees’ programs reflected new services or an expansion and/or enhancement of existing services. Expansion was defined as an increase in the number of children, adults, or families to be served from the child welfare system, or at risk of entering the child welfare system. Enhancement was considered an improvement to the existing quality of a service by moving to a more intensive or higher level of service, changing the type or level of staff, implementing an evidence-based practice, or adopting some other practice to enhance service delivery and quality to improve child, adult, and family outcomes.

the clinical and other treatment issues facing families involved in child welfare due to a parent's substance use disorder

- More focused collaborative practice strategies (e.g., joint case staffing, intensive coordinated case management) to improve services integration and case plan management for families involved in multiple service systems
- Child welfare screening or assessment to identify immediate and potential child safety issues and determine a family's strengths and needs
- Substance abuse treatment services, including the provision of family-based substance abuse services and specialized strategies to identify, engage, and retain parents in treatment
- Services and interventions to improve parenting skills, knowledge, and capacity and strengthen family functioning
- Efforts to address parents' trauma through a trauma-informed service delivery approach or more direct trauma-specific services to facilitate a parent's trauma recovery and healing

As previously mentioned, the above snapshot touches on only the most common strategies implemented across all grantees. The other sections in this chapter expand on the many other services grantees provided.

At-a-Glance Snapshot—Building Capacity to Serve Families

The majority (81.3 percent) of program strategies grantees implemented strengthened their collective regions' capacity to serve families in two fundamental ways. They created new services to respond to families' complex and diverse needs, or they expanded and/or enhanced existing services to increase the number of families served or improve the quality and delivery of existing services (e.g., provide a more intensive or higher level of service). Specifically:

- 32.8 percent were new services created for the grantees' target populations.
- 48.5 percent represented an expansion and/or enhancement of an existing service.
- 18.7 percent encompassed continued provision of existing community services that were maintained in their current capacity, but not modified specifically as part of this grant.

There were some key differences within each general program area, as noted below and captured in Table 3:

- Systems collaboration and improvements were predominantly new services (47.5 percent), compared to the other program areas. This indicates new cross-systems collaborative capacity. It directly reflects the legislation's emphasis on developing and strengthening interagency collaboration and services integration.
- Substance abuse and mental health treatment and linkages were the most likely to represent an expansion and/or enhancement of existing services (53.8 percent). This reflects grantees'

efforts to expand substance abuse treatment slots for child-welfare involved parents, strengthen services to address trauma, and move to more family-centered care.

- A substantial percentage of children’s services were new or expanded/enhanced services. However, compared to the other program areas, children’s services had the largest proportion of existing services maintained but not substantially modified under the RPG project (28.6 percent). Grantees frequently developed partnerships to strengthen referrals and connections to existing community services for children rather than implement new direct services themselves.

Program Area	New Service	Expanded/Enhanced Existing Service	Maintained Existing Service
Systems Collaboration and Improvements	47.5%	48.0%	4.6%
Substance Abuse and Mental Health Treatment and Linkages	27.9%	53.8%	18.3%
Children’s Services	29.4%	42.1%	28.6%
Family-Strengthening	33.5%	46.7%	19.8%
Other Clinical and Community Supportive Services	36.2%	45.0%	18.8%
OVERALL – ALL PROGRAM AREAS	32.8%	48.5%	18.7%

At-a-Glance Snapshot—Primary Funding Support for Grantees’ Program Strategies

To provide the comprehensive array of services that helped families meet their multiple and complex needs, the regional partnerships leveraged other available resources to help maximize the impact of the RPG award. In general, primary funding to support given strategies shifted somewhat over the course of the project as grantees advanced their sustainability planning and the grantee match amount increased from 15 percent in year one to 25 percent for the final year.

By the final year of the grant period, across all the major service interventions and activities, on average:

- 35.3 percent of services and activities were supported primarily by RPG funding.
- 33.1 percent were supported primarily by other community funding and resources.
- 31.7 percent were supported by a combination of RPG and other community funding.

Similar to capacity building, there were some key differences regarding primary funding source by program area, which are outlined below and shown in Table 4:

- Systems collaboration and improvements were more likely than other program areas to still be supported primarily by RPG funding (50.0 percent) at the end of the grant. However, this was a substantial decrease from 64.2 percent at the program midpoint. It is likely that as collaboration became more widespread and grantees expanded their relationships, partners helped support the cost of certain collaborative activities.

- Children’s services were more likely than other types of program strategies to be supported primarily by other community resources (48.5 percent). As grantees worked to strengthen this particular component of their programs over the course of the grant, they often depended on and reached out to other community partners to support this growth, or obtained other grants specifically for direct children’s services.

Table 4: Major Funding Sources—Percentage of Services Supported by RPG Funding, Other Community Resources, or a Combination of Sources, by Program Area			
Program Area	RPG Funding	Other Community Funding	Combination of RPG and Other Community Funding
Systems Collaboration and Improvements	50.0%	18.8%	31.2%
Substance Abuse and Mental Health Treatment and Linkages	36.1%	29.2%	34.7%
Children’s Services	21.9%	48.5%	29.6%
Family-Strengthening	39.4%	36.2%	24.4%
Other Clinical and Community Supportive Services	32.8%	33.7%	33.5%
OVERALL – ALL PROGRAM AREAS	35.3%	33.1%	31.7%

At-a-Glance Snapshot—Sustainability of RPG Program Strategies

In their original grant applications, grantees were required to describe how they would sustain their programs after the grant ended. Throughout the grant period, HHS emphasized the importance of program sustainability and provided technical assistance (see Chapter XII) to help grantees implement sustainability strategies. As discussed in the next chapter (see Lesson 10), grantees who sustained their program components generally were able to institutionalize and integrate RPG practices into existing systems of care.

As the end of the initial funding period neared, grantees indicated overall (see Table 5):

- Nearly three-fourths (73.2 percent) of the major services and activities provided as part of their RPG program would be sustained after the grant. Family-strengthening services, children’s services, and substance abuse and mental health treatment and linkages were the program areas with the greatest likelihood of sustainability.
- 9.0 percent of program strategies would not be sustained.
- The sustainability status for 17.8 percent of program strategies was not yet known. Near the end of the grant, grantees were uncertain, in particular, about sustainability of clinical and community support services.

Program Area	Yes	No	Don't Know
Systems Collaboration and Improvements	66.2%	13.3%	20.5%
Substance Abuse and Mental Health Treatment and Linkages	75.5%	7.2%	17.4%
Children's Services	78.5%	8.2%	13.4%
Family-Strengthening	79.0%	7.8%	13.1%
Other Clinical and Community Supportive Services	61.7%	11.9%	26.4%
OVERALL – ALL PROGRAM AREAS	73.2%	9.0%	17.8%

At-a-Glance Snapshot—Grantee Program Modifications and Refinements

Over the course of the grant period, the partnerships continually modified and refined their programs, in consultation with and approval from their federal project officer. As one grantee concluded, “Flexibility of the program is paramount.” A strength, and some would argue a necessity, of grantees was their ability to adapt their programs and service array as needed, rather than adhere to the original service model envisioned. These refinements typically resulted from grantees having:

- Developed a deeper understanding of participating families’ needs, strengths, and characteristics
- Increased their collaborative capacity and expertise—for example, by broadening their partner base to access additional services and other skilled professionals
- Identified what strategies were most or least effective in achieving project goals and promoting positive child, parent, and family outcomes
- Had to adjust their local project priorities to align with changes and shifts in the broader systems’ goals

Among the 53 regional partnerships, over the course of the grant:

- 81.1 percent further improved their program models by adding other new services or strengthening already established RPG program components. This was typically in the areas of trauma and mental health services for children and adults, parenting and family strengthening, expanded substance abuse treatment capacity, and continuing care and recovery supports.
- 34.0 percent expanded the scope of their target population—for example, to serve a wider age range of children, incarcerated parents, fathers (custodial and non-custodial), or families receiving voluntary child welfare services.
- 28.3 percent expanded RPG services to another, new site. For example, due to the close partner collaboration developed during the grant, one grantee established a new intensive treatment program for women in another county that had limited outpatient supports for families involved with child welfare.

- 20.8 percent extended the duration of services provided—often in response to the multiple and complex needs of families and trend toward serving families longer than anticipated.

In addition to these modifications, grantees also made other types of process changes (e.g., adopted new policies and procedures, revised existing protocols, modified project staffing) to improve *how* they delivered services. These broader lessons about effective collaboration and program implementation are discussed in the next chapter (see Lesson 4).

Cultural Strategies for Native American Families—Lessons from the Tribal Grantees

As noted in Chapter I, grantee lead agencies included six tribes. In tribal communities generally, client engagement and retention is often a major challenge. Many traditional evidence-based practices do not address the broad cultural, historical, and intergenerational traumas that Native Americans have experienced. The six tribal grantees were able to address the need for more culturally responsive interventions. They adapted and tailored both practice-based and evidence-based engagement and treatment strategies to more effectively serve native families.

Cultural tailoring approaches that all of the tribal grantees incorporated included:

- Increasing family access and connection to local traditional cultural supports
- Incorporating prayer in group activities
- Educating parents on how tribal-specific historical and contemporary trauma impacts traditional tribal parenting approaches
- Using the tribal language
- Conducting culture-based ceremonial approaches to celebrate family or individual successes
- Examining cultural expectations of gender-based roles and responsibilities for both adolescents and adults

In addition to the above overarching approaches, certain tribal grantees implemented several specific practice- and evidence-based culturally adapted program strategies for their communities (highlighted below).³⁵ The grantees reported these efforts were effective in overcoming long-standing engagement and retention barriers for native families and facilitating positive outcomes.

- Four of the six tribal grantees used the Positive Indian Parenting program to help parents regain a connection with their culture. The curriculum blends the strengths of historic Indian child-rearing patterns and values with modern skills.
- One grantee used Honoring Children, Mending the Circle (HC-MC), which is a cultural adaptation of evidence-based Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for children and adolescents. HC-MC guides the therapeutic process through a combination of

³⁵ Appendix D provides a brief description of these and other common evidence-based programs that the regional partnerships implemented.

American Indian and Alaska Native traditional teachings and cognitive-behavioral methods. This grantee also provided Project Making Medicine,³⁶ a clinical training program based on the Honoring Children, Mending the Circle curriculum.

- One grantee implemented the evidence-based Wellbriety treatment model³⁷ with culturally based recovery support groups and other cultural support services including equine therapy. The grantee used their data to demonstrate to the counties, who provided the majority of substance treatment services, that tribal programs can address tribal members' outpatient treatment needs more effectively. The tribe is now able to provide a full continuum of services that are reimbursable by the state—a major policy and service delivery change.
- One grantee that focused on providing substance abuse treatment to the tribal youth used the Walking in Beauty on the Red Road (WBRR) curriculum. WBRR is a holistic cultural residential treatment model for American Indian and Alaska Native youth and their families. The model weaves indigenous cultural beliefs and teachings with westernized evidence-based approaches while providing therapeutic treatment services.
- Two grantees developed and implemented a cultural assessment tool to identify families' spiritual, mental, emotional, and physical needs and inform treatment planning. The grantees reported the cultural assessment process strengthened client engagement and retention and ensured client's received appropriate level of care. In one site, several of the tribal social services programs now use the tool.
- Other tribal grantees also provided additional unique cultural support services that included cultural- and gender-based individual and group mentoring for adolescents and adults, "sweats," talking circles, and community-based cultural knowledge-building camps for families.³⁸

The tribal grantees' experiences and insights emphasized the pivotal role that culture plays in addressing the treatment needs of high-risk Native families involved in the child welfare system. Over the course of the grant, these six partnerships implemented various interventions that began to address systematically their communities' need for culturally appropriate interventions. The tribal grantees reported that collectively, these interventions helped address families' inherent distrust and fear of participating in services, strengthened engagement and retention, and improved clients' commitment to sober and healthy lifestyles. Continued evaluation of these approaches in tribal communities is needed to further establish the efficacy of these cultural strategies in improving outcomes with the tribal child welfare population.

³⁶ Project Making Medicine is for mental health professionals from tribal, urban, Indian Health Service, and residential treatment agencies who provide child abuse prevention and treatment.

³⁷ Wellbriety is a culturally- and community-based model that incorporates the teachings of the Native American Medicine Wheel and 12 Step traditions as well as Native traditional healing practices into treatment programs. More information is available at: <http://www.whitebison.org/index.php>.

³⁸ The Native American sweat lodge or purification ritual cleans and heals the body, mind, and spirit; the specifics of the ceremony vary depending on the tribe. Talking circles serve as a forum to discuss an issue or express thoughts and feelings without judgment or condemnation.

The remainder of this chapter discusses each of the five broad program areas in more detail. It focuses on key modifications and enhancements grantees made over the course of the grant. Grantee insights regarding capacity building, funding, sustainability, or general implementation successes and challenges also are highlighted.

A Word About Evidence-Based Practices

As detailed in later sections of this chapter, the 53 grantees implemented various evidence-based practices, most frequently in the areas of trauma services and parenting or family strengthening.³⁹ Some sites capitalized on the regional partnership grant to build on their prior experience with such practices and expand their scope. Others used the grant as a strategic opportunity to fill a service void for their target population with a program that has demonstrated results.

An overarching lesson from grantees on how to implement evidence-based programs effectively was the need to provide an adequate infrastructure that includes:

- Ongoing training and technical assistance
- Support to conduct fidelity assessments during implementation and correct practice as needed
- Adequate and appropriate staffing, particularly for sites experiencing significant project staff turnover
- Resources to facilitate active family involvement and buy-in

For example, one grantee that successfully implemented the Strengthening Families Program (SFP) across the state provided the private foster care agencies that adopted SFP with extensive technical assistance. Support included six trainings over the course of the grant, monthly technical support conference calls with the program developer, and annual site visits from the program developer to assess program fidelity and to provide individual support to each of the sites.

SYSTEMS COLLABORATION AND IMPROVEMENTS

As Table 6 below shows, all or nearly all (87 to 100 percent) of the 53 partnerships engaged in cross-systems trainings, meetings, communications, and information-sharing designed to improve—on a larger scale—how the various service systems work together on behalf of the families they jointly serve. The majority of grantees also implemented front-line collaborative practice activities to increase the effectiveness of direct service delivery.

³⁹ Appendix D provides a brief description of some of the evidence-based practices that grantees implemented.

Table 6: Systems Collaboration and Improvements—Grantees’ Major Program Strategies and Activities

- 100% conducted **cross-systems training** on clinical treatment as well as program and policy issues
- 98.1% convened regular regional **partnership meetings** to discuss programmatic issues and collaborative management and administration
- 94.3% held regular **joint case staffing** meetings to discuss families’ case plans or other treatment issues
- 92.5% implemented improvements in **cross-systems information sharing** and data collection
- 86.8% developed formalized **cross-systems policies and procedures** to improve communication, identification, referrals, and service delivery
- 62.3% **co-located staff** to assist with screening, assessment, referral, and/or provision of services
- 58.5% used a formal **multidisciplinary team decision-making** process (e.g., Family Group Decision Making)

The Importance of Cross-Systems Training

Grantees credit comprehensive, ongoing cross-systems training, in particular, with enhancing collaboration to:

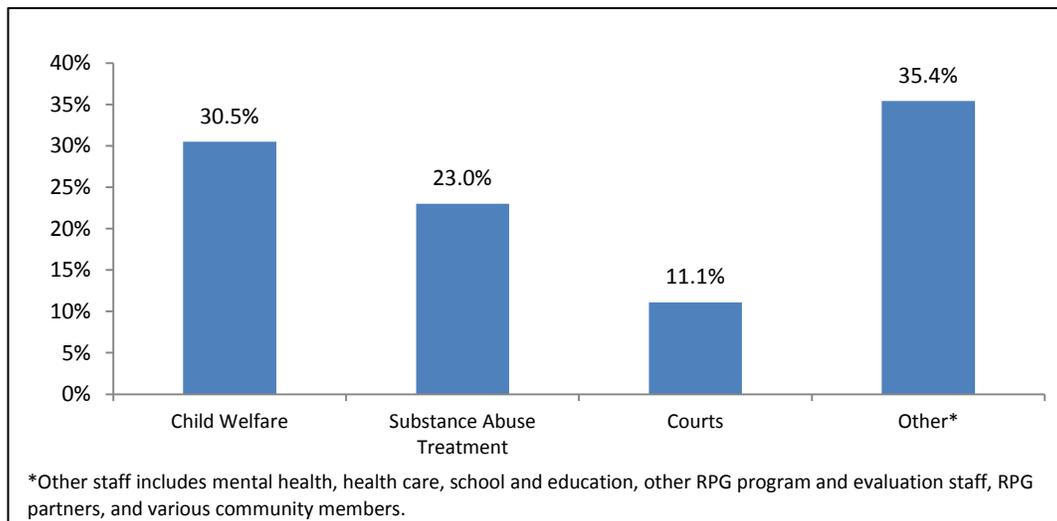
- Educate project staff and the larger community about the clinical treatment and supportive service needs of families
- Provide more coordinated services
- Increase appropriate referrals
- Implement evidence-based practices with fidelity
- Create shared values and goals
- Build local capacity to address those needs
- Achieve larger systems change

One grantee, for example, reported that after training, 76 percent of the child welfare caseworkers demonstrated improved knowledge on identification of substance exposure and referral of children for in-depth, comprehensive assessment. As workers’ knowledge increased, so did referrals for children’s assessments and services.

Over the course of the five-year grant period, the 53 grantees provided or participated in more than 6,100 training events involving more than 86,400 project staff and community partners representing child welfare, substance abuse treatment, the courts, other service systems and providers, and their larger communities. In the last two years of the grant, there was a marked shift in individuals beyond the child welfare and substance abuse treatment systems who participated in trainings. This reflects grantees’ continued expansion of project partners to improve access to other community services and supports (see Chapter I).

Overall, other types of partners, providers, and stakeholders (e.g., mental health, schools and education, health care, various community members) who participated in trainings was 35.4 percent. Child welfare staff comprised the next largest proportion of professional trained (30.5 percent), while nearly one-fourth (23.0 percent) were substance abuse treatment professionals. The remaining 11.1 percent of individuals trained represented the court system (see Figure 2).

Figure 2: Total Project Staff and Partners Trained, Percentage by Professional Area (N=86,477)



Training topics over the course of the grant covered a wide range of clinical treatment issues, as well as program policies, procedures, and operations. (This does not include additional training HHS provided to grantees through the RPG grantee meetings, which Chapter XII discusses.)

For example, nearly all of the 53 grantees indicated they provided or engaged in trainings on:

- Substance abuse and treatment-related issues (e.g., understanding addiction, treatment principles and approaches) (96.2 percent)
- Recovery for families affected by substance abuse (94.3 percent)
- Cross-systems collaboration (92.5 percent)
- The effects of parental substance use on children (90.6 percent)
- Program evaluation and information or data sharing (90.6 percent)

Nearly all grantees (96.2 percent) also provided or participated in trainings that addressed a variety of other topics, the most prevalent of which included:

- Mental health, trauma, and domestic violence issues affecting adults or children (71.7 percent)
- Child maltreatment and larger child welfare system issues (62.3 percent)

- Various other staff development issues, such as leadership training or personal safety (52.8 percent)
- Parenting and family strengthening (49.1 percent)
- Other children’s issues, such as child development, socio-emotional/behavioral issues, or adolescent substance use (47.2 percent)
- Various RPG program operations and management issues (45.3 percent)
- Client outreach, engagement, and retention strategies, such as Motivational Interviewing (39.6 percent)
- Topics related to family drug courts (35.8 percent)

A smaller percentage of grantees (30 percent or less) also addressed other issues important to their region, workforce, target population, and/or service delivery model. These topics included cultural issues and services, health issues (e.g., infectious diseases), funding and related sustainability issues, screening and assessment, drug testing, health care reform, housing and homelessness, and specific case management and treatment planning issues.

During early program implementation, training was critical to address how individuals in different agencies and organizations could work together and to educate partners about the program goals and available services. These initial trainings ensured everyone had common language, knowledge, and information related to the program model and the challenges facing families involved in multiple systems. As one grantee remarked, “Cross-training on individual program missions, policies, and protocols is as important as cross-training on substance abuse, mental health, and resource development issues.”

After initial start-up, partnerships placed a high priority on continued cross-systems training. Regular trainings over the course of the grant helped ensure new child welfare workers and other partnering project staff understood the program and target population (see Lesson 9). As the programs evolved, trainings tended to focus more on specific interventions (e.g., parenting, trauma) and emerging contextual issues (e.g., rise in prescription drug use and the use of medication-assisted treatment). During the grant, more than one-fourth of grantees (28.3 percent) increased, enhanced, or added new trainings for project staff, providers, or partners.

Value of Joint Case Staffing, Cross-Systems Case Planning, and Co-Location

In addition to formal cross-systems training, grantees cited the value of co-located staff, joint case staffing meetings, cross-systems case planning, and multidisciplinary team decision-making when serving families involved in multiple systems.

Co-located staff can take various forms:

- Substance abuse treatment staff at child welfare offices, courts, or other service systems (e.g., jails) in which at-risk parents or caregivers are involved

- Peer recovery support specialists at child welfare offices and other community-based service organizations
- Child welfare staff at the substance abuse treatment providers' facilities
- Children's clinical treatment providers at child welfare agencies, substance abuse treatment facilities, or other service settings (e.g., hospitals and health care centers)

One site, for example, co-located child welfare staff at the substance abuse treatment program and in their children's learning center. This enabled child welfare staff to see parents' progress and interactions with their children during visitations and parenting sessions. It also allowed prompt attention to child safety or other immediate needs. Another grantee echoed this sentiment: co-locating the parenting classes at the child welfare office provided the child welfare caseworkers a unique opportunity to see the family in a more natural context.

Grantees found co-location and related cross-systems program strategies facilitated clients' timely access to services and increased their treatment engagement and retention. These strategies also enhanced sharing of information, technical assistance, treatment resources, and clinical expertise among partners. All of this expanded capacity to address families' needs effectively and efficiently. As one grantee observed, clients were more at ease and more likely to engage in and complete services when they saw all of the partnering agencies on the same page. (See also Lesson 3 in the next chapter.)

As one grantee noted, Family Group Conferences played a key role in gathering together all providers and family members in one place to discuss the progress of the case and make any necessary adjustments in services, and to clarify the expectations for the family. These conferences were often turning points in a case, in that a family could get the support needed to get back on track with their treatment plan following the discussion that took place. To sustain the program past the grant period, this grantee incentivized Family Group Conferences into program billing structures. Conferences were written into contracts with substance abuse treatment agencies (who still employ the Family Therapists) as a billable expense.

SUBSTANCE ABUSE AND MENTAL HEALTH TREATMENT AND LINKAGES

As Table 7 shows, grantees implemented a range of services and activities to expedite substance abuse assessments and improve access to and effectiveness of substance abuse treatment services for parents. They also implemented services to address co-occurring trauma and mental health issues.

Table 7: Substance Abuse and Mental Health Treatment and Linkages—Grantees’ Major Program Strategies and Activities

- 96.2% implemented **specialized outreach, engagement, and retention** strategies
 - 69.8% used an evidence-based practice that included Motivational Interviewing, Cognitive Behavioral Therapy, or Moral Reconciliation Therapy
- 92.5% conducted **substance abuse screening or assessments** (for adults)
- 73.6% conducted other **specialized screening or assessments** to identify needed services for adults, including:
 - 52.8% screened or assessed for mental health/co-occurring disorders, trauma, or domestic violence
- 72.5% provided **outpatient** substance abuse treatment services (intensive, non-intensive, and/or partial hospitalization)
 - 26 (or 70.3%) of the 37 grantees providing intensive outpatient treatment used the Matrix Model⁴⁰
- 39.2% provided **residential** substance abuse treatment^a
- 71.7% engaged in one or more **substance abuse prevention** activities
- 81.1% provided some level of **trauma** services for adults*
 - 77.4% implemented trauma-informed services (in which knowledge about trauma is incorporated into all aspects of service delivery)
 - 50.9% provided trauma-specific services (that specifically address the impact and consequences of trauma on an individual and facilitate the person’s recovery)
- 78.4% provided some level of **family-based** substance abuse treatment services^{41*}
 - 54.0% offered family-involved treatment (services and treatment plans are focused on the parent; there is some family involvement or children may attend treatment with their parent, but they do not receive any therapeutic services)
 - 43.1% implemented more comprehensive family-centered treatment (that directly addresses children’s service needs, provides some services to other family members, or may include case plans and individualized services to all family members)
- 64.2% provided **mental health** services and/or psychiatric care
- 34.0% of grantees developed a new **family drug court** (FDC) and/or expanded or enhanced an existing FDC
 - These 18 grantees established a total of 30 FDCs, as some grantees operated multiple courts

* Percentages for the different service levels do not add to total as some grantees may have provided both levels indicated.

^a An additional 26.4% of grantees provided residential treatment to a smaller percentage (i.e., less than half) of adults served.

⁴⁰ The evidence-based Matrix Model specifically targets the engagement and treatment of individuals who abuse stimulants, including methamphetamine. See Appendix D for more information.

⁴¹ Since there is no current universally accepted definition of family-centered treatment, grantees were asked to classify the type of services they are providing based on the five-level continuum of family-based services outlined in Werner, D., Young, N.K., Dennis, K. & Amatetti, S. (2007). *Family-Centered Treatment for Women with Substance Use Disorders – History, Key Elements and Challenges*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

As discussed in the earlier highlights section, this overall program area represented primarily an expansion or enhancement of existing services (55.2 percent). Yet, some specific strategies were more likely to represent new services for grantees' target populations:

- Specialized outreach, engagement, and retention strategies
- More comprehensive family-centered substance abuse treatment
- Specialized screening and assessments to identify caregivers' other related needs
- Substance abuse prevention and education
- Trauma-specific services for parents and caregivers

Further, some specific strategies for which grantees were more apt to leverage other community resources (in whole or in part) included intensive outpatient substance abuse treatment and mental health services or psychiatric care. Grantees also indicated that virtually all (90 to 92 percent) of residential, intensive outpatient, and non-intensive outpatient substance abuse treatment would be sustained. Family drug courts and trauma-informed and trauma-specific services also were highly likely to be sustained.

Over the course of the grant, many grantees modified their program models to expand treatment capacity for child welfare-involved families (e.g., adding treatment slots, establishing new treatment programs or facilities) and further enhance treatment effectiveness (e.g., developing or revising incentive and sanction programs, increasing treatment hours). They often did this by working with other community partners and related initiatives. The following sections highlight changes and improvements grantees made to their substance abuse and mental health treatment services for adults.

Screening and Assessment of Substance Use Disorders

Grantees noted that prior to program implementation, their regions (and the child welfare system in particular) did not have sufficient capacity, knowledge, or skills to screen or assess parents for substance use disorders. The grantees effectively established a substance abuse screening and assessment infrastructure.

For example, one grantee permanently embedded the UNCOPE substance abuse screen into the state's larger family functioning assessment that is administered to all child welfare clients. Training on the tool is being added to new child welfare workers' orientation and the UNCOPE will be incorporated into the state's data system. One of the tribal grantees developed a unified intake and assessment process that fundamentally changed their system. Clients are assessed for substance abuse, mental health, and a range of other related needs at any point of system entry. Clinicians and physicians can access the information in the tribal information system to facilitate cross-systems treatment planning.

Outreach, Engagement, and Retention in Treatment

As Table 7 above also shows, nearly all grantees (96.2 percent) implemented specialized outreach, engagement, and retention activities to reduce barriers, increase timely access to treatment and supportive services, and facilitate a parent's treatment engagement and retention. These specialized activities stress the importance of developing long-term client-staff relationships. Research indicates if time to treatment can be expedited, more favorable outcomes can be achieved.⁴²

Most grantees employed a multi-faceted approach and used behavioral or other therapeutic type interventions in conjunction with certain organizational or staffing practices. For example, by the end of the grant, more than two-thirds of grantees (69.8 percent) were using evidence-based practices that included Motivational Interviewing, Cognitive Behavioral Therapy (CBT), or Moral Reconciliation Therapy.⁴³ This was an increase from 60.4 percent during early grant implementation. The number of grantees that established co-located or out-stationed staff also increased over the course of the grant, from approximately one-third (34.0 percent) of grantees to more than half (52.8 percent).

During the course of the grant, sites also expanded the use of peer/parent mentors, recovery coaches, or other substance abuse specialists. This report refers to these types of individuals as peer recovery support specialists.⁴⁴ In the RPG sites, peer recovery support specialists may be co-located in child welfare, court, or other agency- or community-based settings. Some grantees adopted peer recovery support specialists as a new strategy specifically to respond to client retention challenges. In other cases, grantees enhanced their existing efforts to respond to an increased need for such services.

⁴² National Institute on Drug Abuse (December 2012). *Principles of Drug Addiction Treatment. A Research-Based Guide*. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health.

⁴³ Motivational interviewing is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. CBT is a frequently used psychotherapeutic orientation that integrates the rationale and techniques from both cognitive therapy and behavioral therapy. MRT is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. See Appendix D for more information.

⁴⁴ Peer/parent mentors and recovery coaches are individuals who share their own lived experiences and successful recovery stories to guide and support others in their pathway to recovery. Substance abuse specialists may be in recovery, but they are often certified or licensed professionals (e.g., a licensed clinical social worker, a certified addiction professional). For more information on the roles and responsibilities of these individuals, see, for example: Substance Abuse and Mental Health Services Administration (2010). *Substance Abuse Specialists in Child Welfare Agencies and Dependency Courts Considerations for Program Designers and Evaluators*. HHS Pub. No. (SMA) 10-4557. Rockville, MD: Author; and Kaplan, L. (2008). *The Role of Recovery Support Services in Recovery-Oriented Systems of Care*. HHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

One grantee added a recovery support specialist program after their data indicated lower-than-anticipated completion rates. The recovery support program began at the point of the substance abuse assessment and continued through all phases of treatment, including a 90-day post-treatment component. Interventions included face-to-face support and a unique telephone support component as parents stepped down in their treatment. The program was integrated into the contract provider's service delivery package, ensuring its sustainability after the grant period.

The number of grantees using peer recovery support specialists increased from 30.2 percent in early implementation to 39.6 percent by the end of the grant. This is consistent with recent national trends in which peer recovery support specialists comprise a rapidly growing segment of the addiction recovery workforce. Grantees that implemented this approach frequently cited it as one of the more effective strategies to improve parents' treatment engagement and retention, facilitate reunification, identify unmet client needs, and help transition clients from a more structured RPG treatment setting back to the community. As one RPG provider noted, "The recovery coach reminds us that recovery should not be a barrier to success."

Grantees cited peer recovery support specialists' ability to establish supportive, trusting relationships with parents as key. They say these specialists understand the needs of families in recovery first-hand; clients trust and respect them. As one grantee emphasized, "The benefit of peers who have been there and are not viewed as judgmental or as having the authority to remove children cannot be overstated. . . . Peer recovery mentors are essential members of our treatment team and an invaluable resource to our families."

Sustainability of Peer Recovery Support Specialists—An Example of One Grantee's Success

At the end of their grant, one site successfully sustained—and even expanded—their recovery support specialist program using a multi-pronged approach:

- The grantee's community-based behavioral health organization that provided substance abuse treatment created 10 additional peer support positions within its agency to supplement the 4 original positions established through the grant.
- Another community substance abuse, prevention, and treatment program in another county adopted the peer recovery support model into their service integration.
- At the state level, the child welfare agency's family preservation in-home scope of work now includes the peer mentor component; in addition, the program model was incorporated into the statewide substance abuse program scope of work.

Adult Mental Health and Trauma Services

During the latter half of the grant period, on a broader contextual level, there was increased focus to address trauma and its impact on individuals and families. At the federal, state, and local levels, larger systems changes were underway to provide evidence-based trauma services. In keeping with these developments, the regional partnerships, too, worked to strengthen services in this area, with technical assistance and support from HHS (see Chapter XII).

In general, addressing trauma and other mental health issues was not a specific program strategy during early implementation. However, grantees quickly realized it was a significant need of their target populations and critical to stabilizing families. Grantees learned sustained recovery would be difficult for parents to achieve if their mental health issues were not addressed in conjunction with their substance use disorder. Thus, the provision of adult mental health and trauma services proved to be an essential service component. (Trauma services for children are discussed in the Children’s Services section below.)

Families’ complexity of needs and depth of trauma required substantial changes to their original program models and significant collaborative efforts to increase services to meet those needs. Grantees’ services during the course of the grant increased in scope and availability and became more trauma-informed and holistic in meeting family needs.

Some grantees focused on the more fundamental task of strengthening identification of and outreach to parents with trauma and mental health needs. As Table 7 above showed, 28 grantees (52.9 percent) conducted specialized screening/assessment on adults for mental health disorders, trauma, or domestic violence issues.

Other grantees worked to ensure that every part of the program’s organization, management, and service delivery system incorporated a basic understanding of how trauma affects the parents and families they serve. (See box below, “What Does Trauma-Informed Look Like?”) The percentage of grantees that implemented trauma-informed services increased from less than two-thirds (64.1 percent) during early program implementation to more than three-fourths (77.4 percent) by the end of the grant.

Still others grantees added or expanded the use of evidence-based trauma services and programs. Over the course of the grant, the percentage that implemented direct trauma-specific services increased from 43.4 percent to 50.9 percent. Of the 27 grantees providing trauma-specific services, the majority (20 grantees) used Seeking Safety,⁴⁵ while 7 grantees used one of Covington’s models.⁴⁶ Eight grantees implemented some other type of trauma-specific program; these included the Trauma Recovery and Empowerment Model (TREM), Addictions and Trauma Recovery Integrated Model (ATRIUM), WBRR, and others. (Appendix D provides a brief description of these various evidence-based programs.)

The RPG experience provided the foundation for the regional partnerships to move forward in this area. Yet grantees noted how to best work with clients with co-occurring mental health and trauma disorder remains a challenge. The partnerships indicated a need for further collaborative work and additional training on trauma-informed care and trauma-specific interventions to sustain change in working with these families.

⁴⁵ Seeking Safety is a present-focused therapy to help people attain safety from trauma/post-traumatic stress disorder (PTSD) and substance abuse. The curriculum has undergone numerous empirical studies that show positive outcomes across multiple domains.

⁴⁶ These include the Helping Women Recover program and the *Beyond Trauma: A Healing Journey for Women* manualized curriculum. Both programs are evidence-based and can be used in a variety of settings (e.g., residential and outpatient treatment settings, domestic violence programs, mental health clinics, criminal justice settings).

What Does Trauma-Informed Look Like?

Over the course of the grant period, grantees recognized that all program staff (not just therapists) needed to infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. The following grantees provided examples of what it means to be trauma-informed.

- To paraphrase the judge in one family drug court site: We create the illusion of time. Even if we know that we are quickly losing time on our court calendar, we try not to rush a parent through the court review. We reduce extraneous activities and noise in the courtroom so that everyone on the multidisciplinary team is singularly focused on the parent. We try to have the courtroom be uncluttered, light, clean, and quiet. Each parent is seen individually; other parents, family members, friends, or others are not allowed in the courtroom to provide the parent with a safe environment to discuss their concerns and history. We use strength-based, positive language even while staying reality-based. We consistently come from a place of hope and non-judgment. We explicitly assure the parents there is no negative judgment. We communicate that honesty authentically and with respect. We explain our expectations and processes to achieve transparency as much as we can. We honor the parent through praise, rewards, incentives, and a fair and timely imposition of sanctions. We rave about the parents' children. We provide tangible supports.

As one parent said, "I felt the friendliness right when I walked into the court room. In other courts, I felt like they were trying to take my kid away. I felt like I was not a good parent, that I was being punished, or judged. . . . With [this court], I'd leave the courtroom feeling like I had a fighting chance to reunify with my daughter."

- In another site, one of the recovery specialists noted: "I now look at a client through trauma lenses. I have become more trauma-sensitive when meeting with my clients when they exit their treatment group. I am now allowing clients to take a breather before testing and talking with me as I now realize that during group they are working on very sensitive and painful matters. It is sometimes easy to forget what traumatic situations they are addressing because clients tend to hide their pain with anger or laughter."
- Another partnership commented how trauma-informed care provides a new perspective—one in which those providing support and services shift from asking, "What is wrong with you?" to "What has happened to you?" The grantee explained this subtle change reduces the blame and shame that some people experience when being assessed for substance use or mental health issues. It also builds an understanding of how the past impacts the present, which effectively makes the connections that progress toward healing and recovery. The approach has helped build a rapport with clients and retain them in services.
- Still another site worked to create a trauma-sensitive office space. They made changes to the facility interior and exterior to make the space more inviting to families (e.g., landscaping, paintings and artwork, addition of quiet areas and therapeutic relaxation rooms). The program also increased their use of complementary therapies (e.g., art, music, dance, yoga). Staff noted the facility's entire feeling was dramatically different; it was more engaging and welcoming to families.

CHILDREN'S SERVICES

Children served by grantees' projects benefitted indirectly from the services provided to their parents and primary caregivers. However, grantees' awareness of and focus on children's direct needs steadily increased over the course of the grant period. Grantees recognized that provision and coordination of children's services was a major gap in their service array. They worked to

bridge that gap, while maintaining fidelity to their existing program models. This shift was in keeping with the increased emphasis that Congress and ACYF have placed on child well-being.⁴⁷

Table 8: Services to Children and Youth—Grantees’ Major Program Strategies and Activities

- 92.5% of grantees conducted **child welfare** screening or assessments
 - 71.1% of those doing in-depth child welfare assessments used an evidence-based protocol (most frequently Structured Decision Making⁴⁸)
- 34.9% screened or assessed children for **trauma** issues
- 75.5% conducted **other specialized** child screenings and assessments, including:
 - 52.8% for developmental issues
 - 49.1% for behavioral and socio-emotional issues
 - 30.2% for mental health issues
- 52.8% provided **early intervention and/or developmental** services
- 45.3% provided **mental health** counseling or **therapeutic services** and interventions^a
- 34.0% implemented **trauma services** for children^b
 - 10 of these 18 grantees are using evidence-based approaches that include Parent-Child Interaction Therapy/Parent-Child Attunement Therapy (PCIT/PCAT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT), or Child-Parent Psychotherapy (CPP)
- 18.9% provided **remedial or academic supports** to school-aged children
- 5.8% provided **substance abuse treatment** for youth who have substance use disorders^c

^aAn additional 26.4% of grantees provided mental health or therapeutic services to a smaller percentage (i.e., less than half) of children served.

^bAn additional 20.7% of grantees provided trauma services to a smaller percentage (i.e., less than half) of children served; the majority of these grantees also use TF-CBT or PCIT/PCAT.

^cAn additional 18.9% of grantees provided substance abuse treatment to a smaller percentage (i.e., less than half) of youth served.

As discussed in Chapter III (Lesson 5), during the initial stages of the RPG Program, grantee services tended to focus first on addressing a parent’s substance use disorder. Because the addition of direct children’s services often reflected a significant evolution of a grantee’s original RPG program model (as discussed above), grantees leveraged other resources or integrated their efforts with related initiatives to provide such services.

⁴⁷ The 2011 Child and Family Services Improvement and Innovation Act (P.L. 112-34) requires states to describe their activities to meet the developmental needs of children four years of age or younger and outline how they will respond to emotional trauma that is experienced by children in foster care as a result of child maltreatment and/or removal from their home. The April 2012 ACYF Information Memorandum (ACYF-CB-IM-12-04) outlined the agency’s priority to promote and strengthen children’s social and emotional well-being, noting that ensuring safety and achieving permanency are necessary but not sufficient to improving well-being.

⁴⁸ Fifteen grantees used Structured Decision Making (SDM). SDM uses clearly defined and consistently applied decision-making criteria for screening for investigation, determining response priority, identifying immediate threatened harm, and estimating risk of future maltreatment.

As previously mentioned, children's services overall were predominantly an expansion or enhancement of existing services in the community. Further, this program area had the highest percentage of maintained services, as grantees focused on strengthening referrals and connections to existing community services rather than implementing direct services themselves. Grantees were able to leverage other community resources (in whole or in part) to support, in particular, trauma screening and assessments and mental health counseling or other therapeutic interventions.

For example, one grantee provided the substance abuse and mental health services at the RPG program. Then children needing medical services were referred to the tribe's clinic, while those needing educational services were referred to school counselor, and those needing developmental services were referred to the health department. The grantee stated RPG staff were then vigilant about following up with each referral and providing transportation to ensure families received these services.

One grantee developed a number of community partnerships and leveraged other grants to sustain the provision of CPP. The grantee integrated this evidence-based practice into:

- The county child welfare agency's preventive services unit
- A specialized pediatric clinic for children in foster care
- A new county visitation center
- An evidence-based home visiting program for young mothers under 21 years of age
- A Substance Abuse and Mental Health Services Administration (SAMHSA) National Child Traumatic Stress Network (NCTSN) grant
- A Centers for Disease Control and Prevention grant

The more specialized child screening and assessments for trauma and other issues, as well as remedial and academic supports for school-aged children tended to be new services implemented by grantees. However, grantees reported the most difficulty in sustaining these services.

One Grantee's Program Improvements Over Time to Meet Children's Needs

Prior to the RPG grant, one site's family drug court program relied primarily on the existing efforts of child protective services to meet children's needs. During the course of the RPG program, they received and integrated another grant into their RPG program structure to:

- Add a full-time child therapist to provide comprehensive developmental screenings and additional assessments and evaluations, and connect children to various forms of therapy such as play, art, music, speech and occupational. The therapist follows children and families for up to six months to ensure children receive recommended services
- Add a full-time social services assistant to provide transportation for children's services such as medical appointments, therapies, and other services. The social services assistant also supervises parent-child visitations to increase the number of visits for each parent to at least two per week.
- Partially fund the Court Appointed Special Advocates (CASA) supervisor's salary to ensure their participation on the family drug court team.

This grantee will use their two-year RPG continuation grant to add a second full-time child therapist to expand the population served.

Grantees began to work more with other community agencies to address the substance abuse prevention and intervention needs of children and youth more directly. The partnerships paid particular attention to the following areas:

- Expanded capacity to provide trauma, mental health, and other therapeutic services. For example, grantees added project staff with an expertise in children's trauma or mental health treatment. They used curricula, technical assistance, and other resources from the National Child Traumatic Stress Network (NCTSN)⁴⁹ and engaged in clinical training to increase staff understanding about the impact of trauma on children and effective trauma services. Further, they extended trauma practices to other sites.

⁴⁹ Congress established the NCTSN in 2000 to improve access to care, treatment, and services for children and adolescents exposed to traumatic events. More information is available at: <http://www.nctsnet.org>.

Strengthening Children's Trauma Services

One site is engaged in a multi-faceted initiative to strengthen the region's capacity to address trauma in children. The state piloted the project in two regions and repurposed funding to expand it to three other regions. The initiative includes following components:

- Addition of new screening and assessment tools for children's trauma using the Child and Adolescent Needs and Strength (CANS), the UCLA Post-traumatic Stress Disorder (PTSD) Reaction Index, and the Trauma Symptom Checklist. Both child welfare and mental health are using the instruments. The child welfare agency's website houses a dashboard of the CANS assessments. This allows for analysis of statewide, regional, or county data to assess and meet the needs of children identified with the CANS. The tool will help identify the impact of multiple stressors on children and families.
- Implementation of a TF-CBT Learning Collaborative. Mental health clinicians integrate this evidence-based children's intervention and monitor their fidelity to TF-CBT by using a fidelity checklist. Therapists are provided with 45 hours of training and 18 hours of consultation in addition to the group and individual consultation given biweekly in the individual agencies. Currently 21 therapists are implementing TF-CBT with children aged 5 to 18 years. The state chose the Learning Collaborative approach⁵⁰ based on its effectiveness to translate new skills into sustained practice.
- Discipline-specific trauma skills training for education, law enforcement, the courts, child welfare, and substance abuse and mental health. The training also includes a component on secondary trauma and its effects on the workforce.

- More consistent, comprehensive screening and assessment to identify children's developmental, behavioral, trauma, and other specialized needs. Many grantees noted that before RPG program implementation, children were not consistently screened for developmental, behavioral, social-emotional, or other issues. Now there are dedicated positions (e.g., public health nurses, social workers, clinical psychologists) to conduct children's screenings and assessments, improve linkages to early intervention and developmental services, and coordinate overall service delivery.

⁵⁰ The Learning Collaborative process, which originated in the health care field, focuses on spreading, adopting, and adapting best practices across multiple settings and creating organizational change that promotes the delivery of effective services and interventions.

Successes in Children’s Specialized Screening and Assessment—Selected Grantee Examples

The Third Report to Congress highlighted in detail one grantee’s success in integrating children’s screening tools into the substance abuse treatment settings. Through their mentoring project, a social worker from the partnering children’s services agency was co-located at a substance abuse treatment program for approximately six months. At the end of the grant, the site reported that among the four treatment agencies who participated in the mentoring program, there was a nearly 300 percent increase in the number of assessments completed.

At the beginning of year five, another grantee reported they had expanded developmental screening for all children in out-of-home care or at home with their families to six other women’s intensive treatment programs and drug courts in the four target counties.

Still another site integrated common assessment tools used for children’ behavioral and developmental assessments into the county’s documentation, registration, and billing software system. The mental health department, substance abuse treatment agency, and health and hospital system all use this information system.

- Expanded substance abuse education, prevention, and related support services (e.g., tutoring) for older school-aged children. During the latter part of the grant, several partnerships paid increased attention to school attendance and related academic issues; they sought to strengthen services to increase students’ educational outcomes.

FAMILY-STRENGTHENING SERVICES

As RPG Program implementation progressed and efforts to address parents’ substance abuse treatment needs stabilized, grantees turned to building capacity to identify and address children’s specific needs (as described above). During the last two years the grant, the partnerships evolved further to integrate adult and child services more completely and provide a comprehensive family-centered continuum of care (see also Chapter III, Lesson 5). As Table 9 shows, most grantees concentrated their efforts on parenting training and family therapy.

Table 9: Parenting and Family-Strengthening—Grantees’ Major Program Strategies and Activities

- 86.8% provided some level of **parenting training and education***
 - 60.4% provided standard or enhanced parenting training and education
 - 64.2% implemented a manualized parenting curriculum or evidence-based parenting or family-strengthening program (designed or adapted to address the unique needs of families with high-risk behaviors, including substance use)
- 56.6% provided **family therapy or counseling**
- 43.4% conducted **screening or assessments** for parenting or family functioning issues
- 37.2% provided some level of **visitation services***
 - 25.6% provided traditional supervised visitation
 - 27.9% implemented supportive or therapeutic supervised visitations that include activities to promote behavioral change in the parent-child relationship
- 34.0% conducted targeted outreach of **fathers** and/or provided a specialized program or services for fathers

* Percentages for different service levels do not add to total as some grantees may have provided both levels indicated.

As previously noted, this overall program area was predominantly an expansion or enhancement of existing services in the community (46.7 percent) or new services for the target populations (33.5 percent). A closer look at individual services shows that under the RPG Program, grantees implemented more intensive services or higher levels of care, specifically:

- Nearly all manualized or evidence-based parenting programs were a new (50.0 percent) or expanded/enhanced service (47.5 percent).
- The few grantees (n=6) that implemented specialized programs for fathers were nearly all new services (83.3 percent).
- More intensive supportive or therapeutic visitation services also tended to be new or expanded/enhanced services (42.9 percent and 39.3 percent, respectively).

Not surprisingly, RPG funding primarily supported some of the more intensive services that were new—in particular, manualized or evidence-based parenting and specialized programs for fathers. However, grantees seemed to be able to leverage other community resources (in whole or in part) to provide supportive or therapeutic visitation.

Recognizing the Value of Keeping Mother and Child Together During Treatment

To strengthen the family, grantees noted the benefit of parents being able to have their children accompany them when they enter substance abuse treatment. Grantees stated allowing families to stay together in a structured, observed, safe environment while their treatment needs are met was especially important for evaluating parenting skills and child safety. Further, parents were able to put their new skills and knowledge into action. Grantees said this hands-on learning experience was invaluable to increasing clients’ parenting skills.

For example, in one grantee's program, children were placed with their mothers in transitional housing and received corresponding supportive services. The grantee reported that children showed improvements in various areas of socio-emotional, behavioral, developmental, and cognitive functioning.

One family drug court grantee described how they provided a true family-centered experience:

- An early childhood family specialist is a key member of the court team. During review hearings, the family specialists regularly share information with parents about their child's developmental needs.
- Parents receive support from home visitors, public health nurses, and mental health therapists. This includes dyadic and parent-child interactive therapies.
- Rather than focus only on the parent's substance abuse recovery, the court regularly discusses the child. These broader considerations reinforce the parent-child relationship. The court uses that relationship to motivate the parent in his or her recovery work.
- A children's mental health and development specialist is now an in-kind position and member of the family drug court Team.
- The courtroom's physical environment is designed for the child's comfort.

In short, over the course of the grant, the partnerships' programs evolved and their collaborative relationships matured. This enabled them to develop new areas of practice to overcome identified barriers to family-centered care. Three particular areas are discussed below: parenting, visitation services, and father involvement.

Parenting Training and Education

Grantees stated it became quickly apparent that parents enrolled in the RPG programs had very complex individual and family needs. Substance abuse was rarely the only problem parents faced. Grantees' experiences highlight the need for substance abuse treatment and concurrent parent education to support parents in their recovery and ability to provide a nurturing parenting environment.

As Table 9 above shows, the vast majority (86.8 percent) of grantees implemented some level of parenting training and education. Most grantees provided more than standard parenting education to teach the basics of parenting and child development (e.g., appropriate discipline techniques, appropriate behavioral expectations of children). By the end of the grant period, nearly two-thirds (64.2 percent) had implemented a more intensive manualized parenting curriculum or evidence-based parenting or family-strengthening program specifically designed to address the unique needs of families with high-risk behaviors, including substance use. This was a substantial increase from 45.3 percent during early grant implementation.

The most frequently used evidence-based programs included:

- Nurturing Parenting Programs or an adaptation of NPP⁵¹ (12 grantees)

⁵¹ Adaptations include Nurturing Program for Families in Substance Abuse Treatment and Nurturing Fathers Program. See Appendix D for more information about these evidence-based programs.

- Strengthening Families Program (6 grantees)
- Celebrating Families (6 grantees)
- Positive Indian Parenting (4 grantees)
- Triple P – Positive Parenting Program (3 grantees)

At least two grantees noted that home-based practice assignments or one-on-one work helped reinforce what parents learned in the group sessions. For example, one grantee that provided NPP to women in residential and intensive outpatient substance abuse treatment reinforced the parenting lessons in the home following treatment discharge and subsequent reunification. The in-home component allowed mothers to practice the new skills gained and served to engage fathers and other caregivers in the parenting of the children following reunification.

Implementation of the Strengthening Families Program—One Grantee’s Experience

One grantee’s project centered on statewide implementation of the Strengthening Families Program (SFP) to families affected by parental substance use who have a child aged 3 to 11 years in foster care. Six different agencies established the SFP with fidelity. The grantee reported several outcomes of note:

- An overall SFP completion rate of 84.9 percent; the rate increased from 56.9 percent in the year one to 94.0 percent in year five.
- More timely reunification. The typical SFP child spent 190 fewer days in out-of-home care compared to a propensity score matched comparison group of children in out-of-home care receiving treatment as usual.
- Statistically significant improvements from baseline to follow-up in 19 of the 21 parent, child, and family well-being outcomes.
- Cost savings. At an average out-of-home care rate of \$86 per child per day in their state, the SFP program saves approximately \$16,340 in out-of-home care costs per child. Every \$1.00 invested in the SFP program yields an average savings of \$9.83.
- All contracted child welfare service providers in the state are now required to provide SFP.

In general, the grantee learned the key ways to increase completion rates were to remove barriers to attendance, increase program appeal, and offer incentives. The grantee also provided these other lessons and recommendations:

- A SFP curriculum needs to be developed for children aged 0 to 3 years, as this population represents a critical window of child development.
- If needed, sites can modify SFP from a 14-week program to a 7-week program that meets twice weekly.
- SFP for families with children in out-of-home placement should include some type of incentive for the foster parent who may have to travel to bring the child to SFP group.
- The mealtime portion of SFP should not be cut as a cost-saving measure.
- The intervention requires a sustained commitment (e.g., training, fidelity), in particular given the continually changing nature of the child welfare system (e.g., new policies, new staff).
- If SFP can substitute for standard parenting training as a reunification case plan activity, it provides an incentive for parents to attend.
- Foster parents and child welfare workers play an important role in the program. The grantee stated they helped ensure parents whose children were in out-of-home care during their SFP participation were able to complete the home practice assignments and apply their newly learned behaviors.

Visitation Services

Grantees increasingly cited the value of supportive or therapeutic supervised visitation for children separated from their parent, to stimulate positive parent and child interaction. These approaches move beyond traditional monitored visits to include activities that promote behavioral change in the parent-child relationship. Grantees often provided transportation (a major client barrier) to enhance families’ access to visitation services.

Highlighted below are specific examples of how grantees fostered parent-child relationships and tailored their efforts to respond to their community needs:

- One grantee, a comprehensive treatment center and family support agency, implemented a supervised visitation component and added a children’s clinician and family educator to supervise visitation. This model of supervised visitation for child welfare parents provided a child-centered environment for families to visit, learn, and spend time together while being supervised and evaluated in a non-threatening, less intrusive way. The grantee stated the family educator’s immediate and direct feedback to parents on their parenting skills and goals was a key benefit.
- In another site, key components of supervised therapeutic visits included role-modeling, engaging parents in hands-on implementation of NPP skills learned, and educating parents about child development and appropriate discipline and expectations. Other partners recognized the value of the therapeutic visits. Child welfare found the visits facilitated unsupervised visitation and/or reunification, and the child protective services provider incorporated the visits into families’ reunification plans. The court and guardians ad litem also saw the benefits to families and the court began ordering these visits regularly.
- During year five, another grantee added court-ordered supervised visits for children in out-of-home care; this included children temporarily removed during the child welfare investigation and awaiting their case disposition. The child supervised visitation center was located onsite at the substance abuse treatment facility. This allowed parents access to structured, supervised visits. Yet it also proved successful in engaging parents in substance abuse treatment and parenting programs. This facilitated quicker case resolution and resulted in more timely reunifications.

Father Involvement

While overall, men comprised 27.8 percent of all participating adults in the RPG Program, 13 grantees served a population that was 35 percent or more males. For example, one grantee noted that the percentage of male caregivers participating in the Strengthening Families Program increased from 27.5 percent in year one to 39.0 percent in year five. Another grantee reported that by the beginning of year five, 47 percent of families in their family drug court involved both the mother and father; another 7 percent involved only the father.

In keeping with broader national and state policy and practice shifts to promote father involvement in child welfare case planning, grantees increased their capacity to respond to fathers’ unique issues and concerns. A substantial number of grantees implemented new or expanded existing services to improve outreach, engagement, and retention of fathers. Such initiatives included but were not limited to implementing fathers’ support groups, hiring male peer/parent mentors, adding gender-specific substance abuse treatment and parenting programs, and collaborating with statewide or local fatherhood engagement or training efforts.

OTHER CLINICAL AND COMMUNITY SUPPORT SERVICES

To enable families’ full participation in RPG services, most grantees extended their efforts beyond providing therapeutic treatment services to children and parents to address some basic, yet challenging family support needs (e.g., housing, transportation, child care, health care). During the course of the grant period, the role of ancillary services in facilitating and sustaining

positive child, adult, and family outcomes increased. (See Chapter VIII for additional information on the RPG performance measure, adults connected to supportive services.)

Grantees stated linking families to other community supports enhanced the continuum of care and promoted families' sustained recovery and self-sufficiency (see also Chapter III, Lesson 6). As Table 10 shows, the vast majority (87 percent) of grantees provided intensive case management to help families access and coordinate various support services. These grantees indicated this level of assistance did not previously exist in their regions: intensive case management was a new (50.9 percent) or expanded/enhanced (49.1 percent) service for them.

Table 10: Other Clinical and Community Supportive Services—Grantees' Major Program Strategies and Activities

- 86.8% provided intensive/coordinated **case management**
- 67.9% provided **in-home services***
 - 49.1% implemented wraparound/intensive in-home comprehensive services to keep families together and children stabilized
 - 22.6% provided more traditional individual in-home services (that do not involve a multi-agency collaborative approach)
- 64.2% provided **aftercare or continuing care**
- 63.5% provided some level of **housing services**^a**
 - 62.3% provided housing support services or assistance
 - 26.9% implemented transitional, interim, emergency, or temporary short-term housing
 - 11.5% provided permanent or permanent supportive housing

* Percentages for different service levels do not add to total as some grantees may have provided both levels indicated.

^a A substantial proportion of additional grantees provided housing services to a smaller percentage (i.e., less than half) of their families served: housing support/assistance (20.7 percent), transitional/interim/short-term housing (28.3 percent), and permanent/permanent supportive housing (18.9 percent).

Wraparound and intensive in-home comprehensive services, which nearly half of grantees provided to their target populations, also did not exist previously in most regions. Several grantees' identified these types of services as among the most important and effective, particularly as clients complete substance abuse treatment.

In one site, a marriage and family therapist (MFT) provided weekly in-home services for the client's total treatment period (5 to 7 months). The grantee noted that as a clinical mental health professional, the MFT was able to address a wide range of issues within the context of the family or home system. Clients who needed to enter residential treatment continued to receive the "in-home" counseling services onsite at the treatment facility. This facilitated their continuum of care and continued to build rapport throughout the treatment process. The grantee said adding this continuity of services in the third year increased the effectiveness of joint case staffing with residential treatment staff and reduced client dropout rates.

Discussed below are other selected supportive services.

Housing

Nearly two-thirds of grantees (64 percent) provided some level of housing services, most often basic housing supports (e.g., assistance in obtaining safe, affordable, permanent housing, developing needed life skills to maintain housing) and assistance (e.g., accessing housing funds, completing housing applications, working with property owners or assistance programs). Over the course of the grant, partnerships that originally implemented more intensive housing components, continued to expand and enhance those existing services. Others branched out to implement new housing services or programs for both community-based clients as well as residential clients going into aftercare.

As one grantee concluded, “There has been a growing awareness of the essential nature of a housing continuum from emergency housing through permanent housing in the transformation of child welfare services.” Grantees noted families may be forced to leave the area when discharged due to lack of transitional and permanent safe and affordable housing. This makes it even more difficult to keep families connected to aftercare and other community supports.

Transportation

The partnerships also reiterated the importance of transportation to increase access to and full participation in core services (e.g., substance abuse treatment, parenting training and education, supervised visitations) and improve clients’ ability to achieve their recommended service goals. Transportation challenges emerged early in the RPG Program and persisted throughout the grant period. They affected grantees and their clients in rural areas, in particular, but also extended to clients in other community-based or residential treatment settings. Overall, 84.5 percent of adults were identified as needing transportation services (see Chapter VIII).

“One of my case plan recommendations was to participate in intensive outpatient counseling. That means I need to find a ride to [one county], which takes 35 minutes to get there one-way, three times a week. My kids are in foster care in another county, which is 60 minutes away in the opposite direction. I am unemployed, have no driver’s license, and owe more than \$5,000 in fines to get it back. I am grateful for my Parent Partner who has helped me find solutions when I feel hopeless.”

RPG Program Participant

To address these barriers, grantees provided transportation directly (e.g., case managers would drive clients) or worked with community partners for other viable solutions. For example, one grantee collaborated with the area’s major public transportation source to obtain negotiated transportation rates to treatment services and other essential appointments. The program also purchased gas coupons for clients not eligible for the public transportation negotiated rates or for whom other modes of transportation were not an option. Another grantee concluded it would have been helpful to include a transportation component for the case manager in their original program model.

Child Care/Early Childhood Education

Like transportation, grantees identified child care as an important and ongoing need for parents in recovery (in both residential and outpatient settings) and a supportive service that should be included in the original program design. Grantees noted the benefits of onsite child care, in particular. For example, one grantee purchased and remodeled a facility in which mothers can participate in their treatment groups while children are onsite in day care. This grantee continued to enhance and expand these onsite services over time, adding a parent-child music class and library. In the last year of the grant, another site worked toward sustaining their child care program by becoming a licensed provider of therapeutic child care in which individual and group therapy are provided onsite and reimbursable through third-party billing.

Aftercare/Continuing Care

As part of a comprehensive approach to recovery, clients not only need support during treatment, they also need an aftercare phase to establish an adequate support system. After attaining reunification, families often find themselves immediately disconnected from formal support systems (e.g., child welfare), without adequate skills to solve everyday problems or tap into informal supports.

Aftercare and relapse prevention services strengthen personal and community relationships as well as the natural support networks that help clients sustain successful recovery and provide a safe, secure, and healthy environment for their children. As Table 10 above shows, nearly two-thirds of grantees (64.2 percent) provided aftercare or continuing care to participating families upon treatment discharge.

In one site, families are able to remain in the program's apartments for a transitional period of up to one year after they complete substance abuse treatment. This allows adequate time to develop vocational, educational, and other supportive systems needed for ongoing recovery and family maintenance. The program offers all graduates lifetime aftercare services that include counseling, case management, support groups, job placement, and housing services. Relapse prevention and aftercare services are crucial program elements that increase a clients' likelihood of long-term recovery.

Basic Financial Assistance

In addition to the services outlined above, grantees also noted the importance of financial assistance to help address some families' more basic and immediate needs. Without such assistance, the recovery process can become increasingly difficult for families. For example, one grantee stated that prior to the RPG program, the permanent housing placement process was nearly impossible for low-income families with outstanding utility bills. The ability to address debt repair through a specific budget line item was very effective in helping clients get a new start. This grantee provided debt repair to approximately 375 families. Without these dollars, they stated, these families probably would not have obtained housing. The grantee added that this budget line item was unique, as no other social services program in the area provided this type of service.

Ongoing Supportive Relationships

As described above, children, parents, and families need a range of support services, which many different organizations often provide. Further, intensive case management to coordinate and integrate these various services is particularly important. However, grantees noted that in addition to the actual services, one of the most valuable interventions for families is a healthy and trusting relationship with a helping professional. Effective case management is in essence, built on solid relationships.

One grantee reported that in focus groups, clients emphasized the importance of their relationship with their case manager in resolving problems and sustaining recovery. Many participants contrasted the supportive approach they received from RPG caseworkers with their prior case management experiences, in which staff tended to be more perfunctory. Both program staff and participants reported that intensive case management services reduced the likelihood of out-of-home placement and had positive effects on child and family functioning.

The Importance of Stable, Consistent Relationships

At the end of their grant, one partnership concluded the implementation of Dependency System Navigators (DSNs) was their key programmatic success. The master's level DSN clinicians worked with the family from the time of referral throughout the course of their child welfare involvement, including post-reunification. The DSNs established a therapeutic relationship with the family. They provided individual, couples, and/or family counseling, coordinated adjunct services, and advocated on their clients' behalf with the various service systems. The DSNs developed a "brand name" in case staffings and other partners viewed them as experts in identifying families' service needs.

The grantee reported the other core partners quickly became accustomed to having one person who worked with families. This consistency helped child welfare meet their goals. It facilitated clients' access to other community-based programs, as providers valued the additional RPG resources and supports available to participants. Families also appreciated having the same person through each phase of their treatment.

The grantee's key recommendation for future programming: Continue this specialized and expanded system navigator role. They suggested local child welfare systems explore converting existing case management positions into this type of specialty function.

SUMMARY AND NEXT STEPS

This chapter's descriptive profile of grantees' programs and continued service enhancements over the course of the grant is instructive of the wide range of services families need. It also is clear that collaboration with others is essential to adapt services as needed and sustain these efforts. Future efforts should seek to expand this knowledge base by identifying how groupings of similar service arrays implemented by multiple grantees impact selected outcomes.

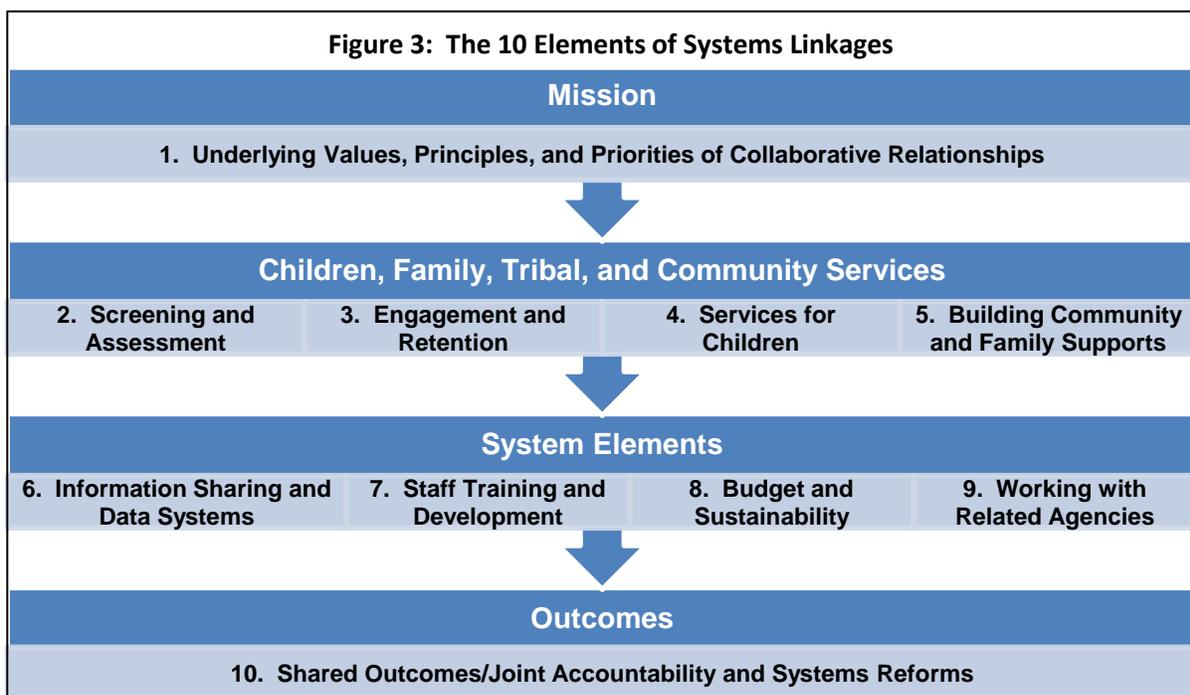
While grantees continually enhanced the type of services provided, they also made other types of systems-level changes to improve overall service delivery. For example, grantees adopted new policies and procedures or revised existing protocols, or they modified project staffing. The next chapter discusses these broader lessons about effective collaboration.

CHAPTER III: PROGRESS IN ADVANCING COLLABORATIVE EFFORTS TO MEET THE NEEDS OF FAMILIES AND ACHIEVE GOALS OF SAFETY, PERMANENCE, AND WELL-BEING

INTRODUCTION AND OVERVIEW

Twice a year, the RPGs submitted a required Semi-Annual Progress Report to the Children’s Bureau. These reports provided valuable information on the partnerships’ major activities and accomplishments, progress towards program goals, program and evaluation challenges faced and solutions to overcome them, and contextual events or community changes that affected the collaborative partnership and services provided to families.

HHS conducted an in-depth qualitative review and content analysis of grantees’ Semi-Annual Progress Reports. A 10-element collaborative framework (see Figure 3) developed by the National Center on Substance Abuse and Child Welfare (NCSACW)⁵² was used as the organizing framework for the qualitative reviews. HHS systematically assessed grantees’ progress in strengthening cross-systems collaboration to serve families and measuring their partnerships’ impact. The qualitative reviews also identified key lessons learned.



⁵² NCSACW provides information, expert consultation, training, and technical assistance to child welfare, dependency court, and substance abuse treatment professionals to improve the safety, permanency, well-being, and recovery outcomes for children, parents, and families. More information is available at: <http://www.ncsacw.samhsa.gov>.

From the qualitative analysis, HHS identified 11 key program implementation lessons (see Table 11 below). These lessons emphasize the complexity of cross-systems collaboration. They convey important insights about how grantees' collaborative experiences improved over the course of the grant and enhanced their ability to meet families' multiple needs.

The 11 lessons were first presented in the Second Report to Congress and updated in the Third Report to Congress. This Fourth Report to Congress continues to build on grantees' earlier experiences and further expands the lessons with additional information from grantees' latest Semi-Annual Progress Reports and a select number of grantees' Final Progress Reports.⁵³ The lessons thus reflect a culmination of the regional partnerships' experiences over the course of the five-year grant period.

In addition, Chapter XI highlights a corresponding set of lessons that reflect the partnerships' collective experiences specifically with the RPG Program performance monitoring and their own local program evaluations. These evaluation implementation lessons parallel the majority of collaborative program implementation lessons discussed here.

⁵³ Over the course of the project, HHS reviewed approximately 500 Semi-Annual Progress Reports. In addition, HHS reviewed and included 27 Final Progress Reports in this Fourth Report to Congress; this included reports from the 9 three-year grantees and 18 of the five-year grantees received as of June 2013. At the writing of this report, 18 grantees had no-cost extensions and planned to submit their Final Progress Reports by December 31, 2013; the remaining eight grantees submit their Final Progress Reports at the end of their two-year continuation grants (that extend through FY 2014).

**Table 11: Highlights of the Partnerships’ Collaborative Efforts—Key Implementation Lessons
(From In-Depth Qualitative Review of Grantees’ Semi-Annual Progress Reports and Selected Final Progress Reports)**

1. Collaboration is essential to address the complex and multiple needs of families and sustain integrated service delivery.
2. Collaboration to establish cross-systems linkages and effective sustainability planning takes time and is developmental and iterative in nature.
3. Intensive multi-faceted outreach is needed at the client, partner, agency, and community levels.
4. The collaborative must continually assess its progress and adapt its program and services to meet families’ unmet and emerging needs and facilitate client engagement and retention.
5. A comprehensive family-centered approach is needed to break the intergenerational cycle of substance abuse and child maltreatment and effectively address a family’s complex, underlying issues.
6. Broadening the partnership beyond child welfare and substance abuse treatment to work with other community agencies is critical to securing important core treatment and supportive services.
7. Clear roles, responsibilities, and expectations are required of partners, providers, and families to promote both individual and shared accountability.
8. Ongoing communication, information sharing, monitoring, and supervision are crucial at both the systems and direct service levels.
9. Staff training and development is an essential component of effective program implementation and sustainability planning.
10. The partnership and program need to be integrated into other existing systems’ efforts and infrastructures and leverage all available resources to facilitate sustainability.
11. The larger economic and fiscal environment has a notable impact on collaborative service delivery and sustainability planning efforts.

Lesson 1: Collaboration is Essential to Address the Complex and Multiple Needs of Families and Sustain Integrated Service Delivery

Families who are involved in the child welfare system and affected by a parent’s substance use disorder have complex and multiple needs that cannot be adequately addressed by one provider or service system alone. At its core, the RPG Program recognizes effective service coordination and timely access to treatment and related community support services are needed to address the full spectrum of challenges these families face. Grantees said these challenges included:

- Significant co-occurring mental health disorders (including trauma and domestic violence)
- Long-standing substance dependence disorders and/or multiple prior treatment episodes

- Multiple risk factors (e.g., low literacy, poverty, unemployment, homelessness, criminal justice history, lack of family or social connection) that have compounded over time
- Prior and often extensive history of child welfare system involvement (that predated and was not associated with RPG enrollment)

Extensive and well-established collaborative relationships and networking are needed for a program of this scale to:

- Implement a comprehensive screening and assessment process that identifies the intensity, duration, and range of service needs for the family as a whole as well as an individual parent and child
- Conduct effective and timely follow-up with families to engage and retain them in clinical treatment and core supportive services that address their identified needs (see also Lesson 6)
- Ensure families receive adequate continuing care and recovery support to successfully transition from treatment to the community and sustain family stability and recovery
- Provide extensive cross-systems staff training and development that helps staff identify families' needs and develop the expertise to implement evidence-based and other promising practices to address those needs (see also Lesson 9)
- Leverage all available funding and existing community resources to support and maintain the broad array of services families need (see also Lesson 10)
- Build and sustain a permanent infrastructure to provide families with a comprehensive continuum of care
- Expand on a region's capacity to achieve positive outcomes for families, particularly in the face of adverse contextual events, such as budget cuts, workforce reductions, and leadership changes (see also Lesson 11)
- Measure and achieve shared outcomes and systems reforms

Historically, the various systems have operated independently, despite serving many of the same families and accessing some of the same resources. By and large, the systems have worked vertically within their own programmatic, data, and funding boundaries. This tends to emphasize an individual child- or parent-focused approach. However, the regional partnership grant charged grantees with working horizontally, as true partners, across these system boundaries to serve the whole family.

As envisioned in the authorizing legislation, the active engagement of core partners from the child welfare, substance abuse treatment, and court systems was critical to the partnership's overall success and ensuring positive family outcomes. The grantees indicated that child welfare involvement and buy-in, in particular, was imperative. Further, that involvement needed to

extend to all levels: from front-line caseworkers, to supervisors and managers, and on up to child welfare agency directors.

Grantees also learned the active involvement of other partners beyond the three core systems was essential (see also Lesson 6). The partners who comprised a grantee's "core" team varied by site. For example, one substance abuse treatment lead agency explained the vital role of the county sheriff's department. Without them as a key partner, the grantee would not have been able to reach incarcerated women whose children were in the child welfare system, assess them inside the jail, arrange for the release of pregnant and parenting inmates into needed residential treatment, and coordinate discharge planning and family reunification services with child welfare.

Active Efforts are Needed to Foster Partnerships

As part of their funding applications, grantees had to demonstrate a record of successful collaboration among family-serving agencies, which included but were not limited to child welfare, substance abuse treatment, and the courts. Over the course of the grant period, grantees continued to emphasize that partners' active involvement, which they clearly differentiated from basic project support, was key to their success. While certain partners may have helped develop the original application and program design, provided letters of support, or agreed to serve as a primary referral source, they sometimes had difficulty truly embracing the changes required by the RPG project. As one grantee explained, partners had to "get past the thought that speaking at the monthly meeting meant we were communicating. True collaboration is a much larger endeavor than networking, coordinating, and cooperating."

Grantees said that to move personal *relationships* into more meaningful and formalized *partnerships* that meet the unique needs of families requires the following conditions:

- The individuals involved must be truly invested in the families, the community, and the actual partnership. They must be ready for change and willing, as one grantee said, to "think outside of the box" to accomplish program goals together as a system. It is this level of investment that enables partners to better serve families and share financial and other resources, which are critical for program sustainability (as discussed further below).
- Collaboration must be intentional. Grantees must place as much emphasis on engaging and retaining partners as they do on engaging and retaining program participants. Each partner needs to understand how its agency and clients will benefit from and contribute to the collaboration. The collaborative needs to articulate, pay attention to, and support partners' combined goals and visions.
- Partners should be involved as early as possible as the collaborative makes key decisions and agreements about project goals, objectives, and outcomes. As one grantee explained, partners need to plan *with* each other, not *around* each other.
- The collaborative must have steadfast leadership that involves skilled change agents. In several sites, such leadership came from a dependency or family drug court judge who championed the RPG program model and convened other stakeholders in the process. For

grantees operating in multiple counties or regions, this leadership sometimes came from the state agencies, who served as effective role models for collaboration, accountability, and data sharing at the local agency and provider level. In still other sites, the community-based treatment providers were leaders in changing the approach to working with families.

“While each agency was unique in the services provided and areas of specialty, the common thread between [the core partners] was the shared mission of achieving safe and stable environments for the children while seeking to support the parents and families in recovery. This centralized mission served as a unifying force for agencies to come together, accept joint accountability for families’ well-being, and resolve issues in the best interest of the parents and children.”

Regional Partnership Grantee

Strengthening Collaboration to Institutionalize Innovations

Toward the end of the grant period, grantees increasingly realized the importance of collaboration and full partner buy-in to sustain integrated services and a full continuum of care for families. They found that the relationships between departments and staff that grew and expanded into partnerships were most effective in helping sustain the program after the grant ended. In one site, all partners solidified their commitment by signing a Memorandum of Understanding to sustain their collaborative work.

While the majority (83.0 percent) of grantees had engaged key stakeholders in sustainability discussions, many faced challenges in channeling those discussions into active sustainability support. For example, during program years four and five, a lack of collaborative relationships, credibility, or connections at the local community or larger state level, and/or political or leadership will was identified as a major sustainability barrier for an average of 37.7 percent of grantees. This was a substantial increase from 11.3 percent in year two and 15.1 percent in year three. The ability to identify and engage key leadership and stakeholders in sustainability conversations grounded in specifics (e.g., results, costs) was instrumental in grantees’ ability to sustain their program models.

By the end of the grant, key partners and stakeholders said they had gained a much better understanding of what it really means to collaborate and the positive impact it has on child welfare families. In fact, many grantees stated the collaboration they developed and strengthened over the course of the grant was one of the most important contributing factors to their overall success. It established a foundation on which to build current and future community projects to serve families with complex needs and involved in multiple systems.

The words of these two grantees capture these lessons of the larger RPG Program:

“While there is much more work to be done, the outcomes from [the RPG program] over the last five years provide a glimpse to the many possibilities and successes for families when agencies are able to collaborate to achieve a common goal.”

“Collaboration has a powerful impact on families’ lives. Together we can put the complex pieces of the puzzle together . . . and do right by the whole family.”

Lesson 2: Collaboration to Establish Cross-System Linkages and Effective Sustainability Planning Takes Time and is Developmental and Iterative in Nature

Collaboration is developmental and iterative in nature and can become increasingly challenging as partners move beyond the beginning stages of collaboration (sharing basic information about each other's systems, convening partnership meetings) to more advanced levels (implementing practice, policy, and systems changes). Agencies develop and acquire collaborative capacity through experience and by applying lessons learned.

An important lesson and recommendation from both the three- and five-year grantees is that adequate time is needed given the broad scope of the project goals and objectives. As one grantee noted, "It is a complex program with many components, many committees, many personalities, and many experiences." Another grantee added, "We cannot overwhelm or inundate our client, our agencies, or our systems, expecting grand change without respecting the process of change."

The need for ample time was particularly true for programs starting from scratch. Yet even those with a prior history of collaboration agreed that a minimum of five years was needed to work collaboratively with a diverse set of partners to achieve the far-reaching RPG Program goals to:

- Build and nurture trusting collaborative relationships that address underlying values and beliefs, identify shared outcomes, and instill joint accountability for those outcomes
- Design and implement a program that meets the various needs of the target population, key stakeholders, and larger community
- Provide the needed breadth and depth of cross-systems staff training on clinical treatment and collaborative practice issues
- Carry out a comprehensive local evaluation that captures all needed short- and long-term outcomes and process evaluation data
- Step back to assess what is and is not working, identify gaps in services, and modify the program as needed
- Document and aggressively disseminate the program's successes to collaborative partners, the larger community, and other key stakeholders
- Create a comprehensive sustainability strategy that institutionalizes collaborative practices and secures continued funding before the grant ended
- Effect larger systems change

Collaboration is a Process, Not an Event

Grantees all agreed that cross-systems collaboration is difficult and time intensive (especially at first). It requires work and ongoing maintenance. As one grantee remarked, "Partnering, we

have learned, is far easier said than done. It requires a unique set of tools and a unique style of leadership to gather the type of resources needed for successful collaboration.”

Grantees found that the collaborative process ebbs and flows, partnerships evolve and sometimes devolve, and relationships must be cultivated and recultivated with new and existing partners. The need for continued nurturing of the collaborative, at both front-line and management levels, became even more important in an environment of budget cuts, leadership and project and partner staff changes, and as grantees sought to sustain their programs.

Over the course of the grant, sites had to work through and adapt to new challenges. In fact, more than three-fourths (79.2 percent) of grantees experienced moderate to significant challenges with key partners at some point during the grant period. Grantees grappled with (and typically were able to resolve) difficult issues. These included the appropriateness and role of drug testing, differing beliefs about whether children should reunify with parents with substance use disorders, how to effectively address a parent’s relapse, how to engage and retain families who are voluntary child welfare cases, and creating a shared understanding of what “systems change” means for both the larger collaborative and individual partner agencies.

Moving to Advanced Stages of Collaboration

Despite the challenges, by the end of the grant, the majority of grantees (90.6 percent) had moved beyond exchanging information about each other’s systems to more advanced stages of collaboration.⁵⁴ A substantial number (30.2 percent) of grantees had undertaken joint projects or shared grants to better meet families’ needs and help sustain RPG services. Most partnerships (43.4 percent) progressed a step further and changed the rules for how they serve children and families. For example, grantees redirected funding or implemented interagency agreements and processes for case management of shared clients. Others developed unified family-centered treatment plans rather than separate plans for the individual child or adult.

Further, several partnerships (9 grantees or 17.0 percent) achieved larger systems changes, such as institutionalizing RPG practices and services within system-wide practices that went beyond the funded project. In these sites, integrated services, coordinated case planning, improved cross-systems communication, and shared agreement on client outcomes became the preferred way of operating. Child welfare, substance abuse treatment, the courts, and other systems adopted and expanded many of the practices established through the RPG project for all parents and children involved in their system or similar programs. The end result: increased coordination and less duplication of efforts.

⁵⁴ For information on four key stages of collaboration, see Gardner, S. (1998). *Beyond Collaboration to Results: Hard Choices in the Future of Services for Children and Families*. Tucson, AZ: Arizona Prevention Research Center.

As a result of one grantee's work in their region, families now have an integrated system of care where:

- All pregnant women receiving prenatal care are screened for substance use and domestic violence issues and linked with appropriate interventions, as needed. Their care is then coordinated with the attending physician(s).
- Children who are born to mothers who used substances during pregnancy receive follow-up from the pediatrician immediately and over the next two years for developmental and other issues.
- A single case coordinator ensures coordination between the obstetrician and the pediatrician or family practitioner. The coordinator maintains a single case file with information on both the mother and the child, and the case file is routinely shared across systems. Parents and children have timely access to therapy services.
- The other partners, such as the courts, schools, child welfare, and juvenile justice, all have staff trained to ask questions and seek support for children who are affected by parental substance use disorders.
- Data and information from the grantee are guiding the development of four children's mental health systems of care in rural areas of the state. Further, the grantee was contracted to provide training and technical assistance to the selected communities as they replicate the RPG processes and strategies.

In another site, the RPG model of public-private partnership with shared responsibility for client outcomes started a trend statewide:

- The state child welfare agency is creating three private-public partnership pilot projects in other regions of the state to replicate the model.
- The state substance abuse agency has funded the RPG lead agency to provide technical assistance on collaborative practice to other agencies in the state. The grantee is serving as technical assistance advisor for the state agency's work with local community services regarding families affected by opiate addiction.
- The Department of Corrections is examining how they can apply a similar model of collaborative practice and a family-centered approach to their work with the criminal justice population.

Factors that Facilitate Advanced Levels of Collaboration

Those grantees that moved to the more advanced levels of collaboration described above shared several common characteristics:

- Consistent and dedicated program leadership who supported the project over time (85.4 percent). Such leaders were embedded in the community, had a deep understanding of families' needs, and were linked in to relevant policy and program discussions at the local, state, and national levels.
- Sustainability planning that did not rely on one agency to pick up funding; rather, various partners contributed in-kind, matching, or other resources (70.8 percent).
- Collaboration that extended well beyond child welfare, substance abuse, and the courts to include other critical stakeholders that provided necessary project support and resources (68.8 percent).
- An oversight body that prioritized and addressed collaboration regularly at partnership meetings (66.7 percent).

- A collaborative that asked partners what they needed to improve outcomes and then responded to those needs (62.5 percent).
- Regular review of any major collaboration barriers and development of practice or policy changes to address those barriers (58.3 percent).
- Use of results to make the case for policy and practice changes to implement proven strategies that will improve child, parent, and family outcomes further (56.3 percent).
- Regular review of outcomes and available resources to make the case for more or sustained resources, based on proven results (54.2 percent).

In addition to these factors, several grantees also cited the value of HHS providing substantial technical assistance and resources regarding collaboration. With such targeted support, grantees said they were increasingly able to identify, acknowledge, and work through the more difficult and underlying values-laden issues and strengthen communication and cooperation (see Chapter XII for more information about grantee technical assistance and training).

It is important to note that larger systems change was not necessarily a focus for all grantees. Such change may have been beyond the parameters of a grantee's original scope of work and project goals, or the lead agency's purview. While not the primary drivers of change, these grantees did lay the foundation for, and in some cases, paved the way to influence larger or future systems change work. These grantees succeeded in creating an essential "stepping stone" for the next stage of change. They served, in the words of one grantee, as "incubators" for change and became the springboard to focus attention on the needs of these children and families.

Integrating New Values, Beliefs, and Practice

Perhaps less measurable, but no less important in considering systems change is the impact the RPG had on the partners themselves. Grantees described two fundamental shifts that resulted from the RPG Program. The first was how partners think about the most vulnerable children and families in their communities. The RPG programs noted how people now think they can make a difference with these families. As one grantee simply put, "We share a belief system that it can work." The second was how the partners work together to ensure they meet families' needs. These two changes are inextricably intertwined.

One grantee summarized the following major philosophical shifts in thinking and client approaches that occurred and will be sustained long-term. Partners now:

- Look at child welfare process from the client’s perspective
- Set clear expectations for partners and clients
- Shift their focus from mere task completion (e.g., clients pass a class) to demonstrated skill building
- Collaborate on decisions for families
- Understand the benefits of having mothers and children together in treatment
- Make decisions about child safety and placement that take into account all contributing factors and surrounding circumstances, rather than being incident driven
- Recognize the importance of including fathers and other family members to build a client’s support system

Grantees described how the RPG projects evolved beyond being a “special project” into accepted practice models adopted as the standard way of doing business. This increased knowledge and trust has resulted in new norms for agency practices. The partnerships have established what they refer to as a culture of collaboration in serving child welfare families affected by parental substance use. As one grantee described it, “local agencies now start with collaboration as our operating principle, rather than ‘resorting’ to collaboration after all else has failed.”

For example, one grantee talked about how family-focused treatment, open access for treatment, integration of physical and behavioral health, comprehensive family needs assessment, coordinated case management, and co-located staff have all become standard practice. “These things have become values within the agencies and expectations from families and community members. They also have outlived staffing changes and still fit within any best practice models as they are presented.” The grantee added that the RPG project “was a lifesaver for all three communities and totally changed the way things were being done.”

Grantees stated increased collaboration has been the most important catalyst for improving services and shifting ideology on how best to serve these families. Grantees were successful in bringing the collaborative voice to the larger community and creating a collaborative model to inform other initiatives. They are paying it forward by expanding to other populations and settings. For example, one grantee described a “ripple effect” in their county. They noted how advanced practice in a few of the substance abuse treatment programs has reverberated through the rest of the county’s treatment programs. The screenings, assessments, and treatment for young children that they implemented in their three RPG treatment sites will be expanded and provided onsite at all nine women’s perinatal treatment centers.

The grant helped the partnerships develop their local capacity, as the various providers now commonly share information and resources, and refer back and forth to each other as needed. The relationships, increased communication, and collaborative processes put in place will continue regardless of financial sustainability of a specific program.

In the end, grantees agreed the investment in collaboration was well worth the effort, despite the challenges. As one county child welfare director said, “I was really hesitant. We were used to being in control of the case; we were not used to partnering on decisions. . . . And now, I wouldn’t want to do this work any other way.”

“I’ve been involved with criminal type cases and juvenile and dependency cases for 30 years. I was a cynic to the idea of the [RPG] to begin with. . . . Now, with this collaboration, I see different people in six months than when people came in. Their attitudes are different and their joy of life is back.”

RPG Family Drug Court Judge

Lesson 3: Intensive Multi-Faceted Outreach is Needed at the Client, Partner, Agency, and Community Levels

Intensive multi-faceted outreach at all levels impacts multiple practice and systems areas. It improves cross-systems collaboration, client engagement and retention, program sustainability, working with other community agencies, and building supports for families, among other things.

Over the course of the grant period, the regional partnerships increased the breadth and depth of their local, state, and national outreach. Grantees used a myriad of client, partner, and community outreach strategies that included:

- Development of project websites for internal and external use
- Creation of logos, brochures, newsletters, and related marketing materials
- Formal and informal presentations and trainings to partners and community members
- Active involvement on other local, state, or national advisory boards, steering committees, or workgroups
- Regular participation and networking at various local meetings and groups
- Co-sponsoring or sponsoring of community events, conferences, community forums, and town hall meetings
- Video stories and other storytelling of families’ experiences

Client Level Outreach—Key to Trusting Relationships

Targeted outreach to and consistent, regular contact with families builds the trust needed to engage families and, as one grantee stated, show them “we’re all on your team.” Systematic outreach is needed to help families navigate multiple and often conflicting systems. It provides families with clear expectations about program participation and services offered.

By the end of the grant period, one partnership had eight staff certified to go into jails and assess women for substance abuse treatment and other needs. Through what they termed extensive “inreach,” the grantee noted that families began to see the child welfare and criminal justice program partners as helping, rather than punitive entities. The staff’s onsite presence strengthened client engagement and greatly improved the reputation of these partner organizations among families and the larger community.

Grantees also described the importance of meeting clients where they are—literally and figuratively. They said program participants valued RPG project staff (e.g., recovery specialists, child welfare caseworkers, family support specialists) coming directly to their home to provide treatment and supportive services. This was especially true for clients in rural areas, who often experienced significant transportation barriers. More than two-thirds of grantees (68 percent) had implemented comprehensive wraparound or individual in-home services (see Chapter II).

Home visits and related strategies proved effective in building trust, creating open communication, and engaging other family members. Program staff were able to meet with clients in a safe, comfortable environment to provide concrete assistance (e.g., hands-on examples of parenting techniques). Home-based approaches also enabled grantees to monitor families’ progress and identify if a family needed more intensive interventions. One grantee, for example, reported that the more than 5,200 home visits conducted over the five-year grant period were essential to achieving positive client outcomes.

“At first I didn’t want to come [to treatment] and I didn’t want to stop using, but [the outreach worker] came knocking on my door every day, telling me I was going to make it to treatment no matter what. She would do whatever it took to get me involved. . . . What I got out of it was a true friend—somebody I could trust. She’s changed my whole life.”

RPG Program Participant

Partner Level Outreach—Benefits to both the Collaborative and Clients

Outreach to key partners provided continuity and coordination between systems and providers, facilitated early intervention and timely access to treatment, and helped establish the RPG program as an essential community resource. Continued partner outreach also was needed to increase and diversify referral sources. Grantees found that establishing connections with new partners was important to maintain a consistent rate of referrals, particularly as a grantee’s primary referral source(s) may have shifted due to contextual events.

Early and extensive outreach was particularly important for grantee lead agencies new to a region or largely unknown by potential community partners and stakeholders. Yet it also was important for already established agencies implementing new collaborative practices and interventions. One grantee, for example, noted their biggest challenge was in “selling” the SFP to certain partners. Judicial officials and child welfare workers unfamiliar with this parenting program were resistant to adopting it in their communities. To overcome this barrier, the grantee held informational sessions and highlighted the program’s evidence base.

One grantee acknowledged they had mistakenly assumed child welfare social workers were familiar with all aspects of their family-centered treatment program. As such, they did not adequately inform child welfare of the program's comprehensive benefits to parent, child, and family. The grantee said this became clear when a child protective services supervisor stated they did not refer mothers with co-occurring mental disorders to the RPG program because the grantee is a "substance abuse treatment agency." Through extensive outreach and education about the array of services provided for pregnant women and women with children (including mental health services for parents and therapeutic services for children), the grantee was able to significantly increase program referrals from child welfare.

One strategy grantees found to be particularly effective in strengthening partner collaboration was co-location of staff. As noted in Chapter II, 62 percent of grantees have co-located staff to assist with screening, assessment, referral, and/or service provision. Grantees emphasized the value of co-location in:

- Rapid identification of needs and timely access to treatment and other services
- Increased client engagement and retention
- Providing more coordinated services across agencies
- Building trusting relationships with families and among project staff across systems
- Facilitating larger shifts in collaborative practice

Community Level Outreach—A Vital Part of Sustainability Planning

Grantees stated the same vigor that goes into client and core partner outreach needs to extend to the broader community and potential funders. Grantees learned continued and proactive outreach at the community level is essential for several important reasons, including to:

- Ensure the voices and opinions of families in the system are heard
- Keep informed of policy and program issues that may affect the collaborative's service delivery system and target population
- Understand the needs of families, the extent and quality of available services, and any gaps in services
- Reeducate people about the RPG program goals as partners, project staff, and state or regional agency personnel change
- Enhance the program's visibility, credibility, and presence in the community
- Raise larger awareness about the benefits of a collaborative approach to serving families

Several grantees found sponsoring conferences was an excellent way to build and strengthen partnerships, promote networking and information sharing, and educate the community about

substance abuse and child welfare issues. Several partnerships played a primary role in organizing and funding “first annual” community education and related events, which were then sustained and continued by the larger community.

One grantee collaborated with partners in all nine of their RPG counties to host three annual Recovery Walks and Celebrations. As one of the partners stated, “Until we began to jointly sponsor the annual Recovery Walk and Celebration our staff, our agency, and our community did not really understand and accept that recovery is possible and that parents and families can get better. We have been doing this for three years and it gets bigger and better each year with more of the community stepping forward to support and celebrate recovery.”

During early program implementation, another grantee convened a “Building Strong Families” conference to build and strengthen their partnership and meet their community education goal. Based on the community’s widespread interest and the event’s overall positive impact, a local county anti-drug coalition assumed sponsorship of the annual conference for the next two years, with the grantee playing an advisory role. Planning for the next annual Building Strong Families conference is underway. The grantee noted community training and education will be sustained.

Data and Client Stories are Integral to Outreach

As their programs reached full implementation, grantees increasingly recognized the importance of communicating more information about their programs, partnerships, and families served to local and state policymakers, in particular. Such outreach is needed to garner key stakeholder support to sustain the RPG efforts (as discussed further below).

Grantees developed outreach plans to bring a number of impactful participant stories and program outcomes to the attention of the wider public. The partnerships continually broadened their audience and expanded the ways in which they delivered the RPG stories. They often identified local champions to tell the RPG program story.

Data were an integral and fundamental part of grantees’ information dissemination efforts. Data were vital in answering questions about program effectiveness, cost savings, and impact on the larger child welfare, substance abuse treatment, and court systems. Over the course of the grant period, grantees increasingly shared local evaluation findings with partners. Well over half (54.7 percent) of grantees actively disseminated their project outcomes. Sites used data to inform key stakeholders and community members of successes and ongoing needs of families served. (See also Lesson 4 for how grantees used data to inform program and policy development.)

In addition to disseminating program evaluation data, grantees say client stories—especially when told directly by the families—effectively engaged families and facilitated greater community awareness, interest, involvement, and support. One grantee adopted the practice of sharing a client story at each partner meeting. They noted, “Each time a client was able to convey their appreciation for sobriety, the lessons learned through the curriculum, and their ability to provide safe home environments for their children, it helped each agency know how best to serve the clients. . . . It provided a reminder of the importance of the work accomplished through the grant.”

Another grantee created approximately 40 digital stories (video vignettes) over the course of the grant. The partnership initially used the digital stories to educate and mobilize key stakeholders at the local, state, and national level. Yet the grantee explained the stories also became a powerful vehicle in families' overall recovery and healing. They used the stories in therapy sessions, as a healing tool when parental rights were terminated, and to give children a voice to help improve the child welfare system.

"Likely the greatest source of impact on and in the community has been the work of the participants themselves. . . . The [family drug courts] have become integral and critical parts of their respective communities, reuniting families and bringing hope where little or none existed previously."

Regional Partnership Grantee

Translating Lessons into Action

As the RPG Program progressed, grantees worked to transform their established relationships into active support to sustain their program. They sought to ensure the RPG lessons learned were shared, understood, and informed broader practice and collaborative efforts in their communities and regions. Grantees participated in state, regional, and federal workgroups and conferences. They attended strategic planning and budget hearings to promote positive program results that make the case for funding treatment and essential supportive services. As discussed in Lessons 2 and 10, many grantees succeeded in changing their larger systems and institutionalizing their RPG practices and partnership.

Grantees efforts to increase recognition and support paid off. Several regional partnerships received local, state, or national awards for their cross-systems collaborative efforts, leadership, management and process improvements, and/or innovative programs and services for families. Other sites were highlighted in news stories about how their projects were meeting the needs of families in the child welfare system affected by parental substance abuse.

Lesson 4: The Collaborative Must Continually Assess its Progress and Adapt its Program and Services to Meet Families' Unmet and Emerging Needs and Facilitate Client Engagement and Retention

The RPG Program authorizing legislation envisioned that families would receive a comprehensive and integrated service array to meet their needs. To fulfill this legislative intent, grantees continually assessed their overall collaborative progress and refined their program models over the course of the grant. Nearly all grantees (92.5 percent) made new program changes to serve their children, adults, and families more effectively and efficiently. For approximately three-fourths (75.5 percent) of grantees, this meant adding new services or enhancing existing interventions; these improvements are discussed in more detail in Chapter II.

Grantees also adopted new or revised protocols, procedures, or policies, or modified project staffing to improve service delivery. This discussion focuses on these and other types of process changes to strengthen collaboration and improve *how* grantees delivered services.

The Importance of Data for Program Improvement

Throughout the grant, program evaluation was integral to ongoing program development and improvement. Even grantees that did not implement formal quality improvement processes did report using program data and information to improve their programs. During the course of the grant, the partnerships increased their proactive use of both quantitative and qualitative data to:

- Better understand their client populations
- Identify gaps in services
- Document barriers to client engagement and treatment retention
- Respond to significant contextual events (e.g., changes in substance use trends, budget and staff cuts that affected availability of and access to services)
- Make needed program and practice adjustments

One partnership reported that over the course of the grant, they naturally became “a data-driven decision-making collaborative.” The project team measured everything and used the data at each partner meeting to build a story of what was going on with services. They noted that without data to drive their conversations and decisions, the partners’ discussions would have been very different: potentially more speculative, rather than grounded in data.

Grantees emphasized the value and importance of continuous quality improvement and process evaluation activities. They used multiple methods and sources to obtain data and feedback to improve program operations. Grantees received technical assistance to implement these various methods, which included:

- *Case reviews* to improve specific services and overall service delivery structure. One grantee, for example, conducted 26 formal case reviews of families currently receiving services to identify needed process improvements as well as individual worker strengths and challenges. The case review recommendations resulted in several program and policy changes to strengthen risk assessment and safety planning.
- *Agency walk-throughs* to experience service provision from the client’s perspective. Walk-throughs are particularly useful when multiple agencies are providing services to families. For example, one grantee’s walk-through involved 24 state and local agency front-line staff, administrators, and directors. The process identified 27 potential areas of improvement and action steps to strengthen client engagement and retention.
- *Drop-off analyses* to identify specific points where clients drop out of services. By examining their completion and dropout rates, grantees developed a better understanding of where to target interventions and incorporate additional services to improve client engagement or retention.
- *Client satisfaction surveys, interviews, or focus groups*. Many grantees provided opportunities for families to be meaningfully engaged in the design, delivery, and evaluation of RPG services. Grantees found that focus groups, in particular, were valuable in obtaining constructive participant feedback on the effectiveness of specific interventions, their interactions with staff from different systems, and their overall program experience.
- *Project staff and key stakeholder satisfaction surveys, interviews, or focus groups*. In addition to clients’ perspectives, grantees found staff, partner, and other stakeholder feedback to be equally valuable. Their periodic insights helped gauge the partnership’s strengths and limitations, its collaborative progress, and the program’s impact on families and their larger systems.
- Evidence-based *systems improvement processes* such as the Network for the Improvement of Addiction Treatment (NIATx) change model.⁵⁵ Grantees noted that a process like NIATx can be extremely instrumental in getting partners to identify and focus on a problem and to develop and test solutions. See discussion below.

The NIATx Process Improvement Experience—Producing Results

The NIATx training and use of change teams made a significant difference for several grantees, three of whom are highlighted below.

One site’s change team reduced client dropout rates within the first 60 days of the program from 42 percent to 20 percent. They used a small scale, rapid-cycle change process to implement and test two strategies: monthly in-person joint staffings (which include the family) and a “What to Expect” handout for families that outlined the roles and responsibilities of the three main

⁵⁵ NIATx is a national initiative, supported in part by SAMHSA, which works with substance abuse and behavioral health organizations to implement process improvement strategies to reduce wait times, reduce no-shows, increase admissions, and increase continuation in treatment. Additional information is available at: <http://www.niatx.net>.

partners (RPG clinicians, child welfare caseworkers, and substance abuse treatment staff). All of the new practices and procedures have become a permanent part of service delivery procedure for several partners.

Further, the grantee reported that the NIATx process helped more broadly to:

- Unify collaborative members
- Increase the frequency and clarity of communication
- Establish a continuum of care
- Streamline processes and recognize how each of the four partnering agency's own procedures affect clients
- Identify key areas for improvement and clearly lay out a structured plan of action

Another grantee combined resources with one of the state's primary Medicaid managed care organizations for behavioral health to help the grantee's three sites develop their own individualized NIATx change projects. All three individual projects will continue past the grant. Results were positive, as the selected examples below show:

- One county developed a rapid response process to increase substance abuse treatment referrals from child welfare. Substance abuse screening and intake occurs within 30 minutes of referral and families engage with a clinician and treatment group within 24 hours. In addition to increased referral rates, clinicians and child welfare workers reported improved cross-systems communication and increased time in joint staff meetings.
- To increase substance abuse treatment retention and group participation, another county developed a rewards incentive system that reflects a family's list of identified needs (e.g., gas cards). In the first month alone, the participation rate increased from 58 percent to 70 percent; it has since improved to 90 percent. The groups also increased in size and reached maximum capacity.

A third grantee received the 2011 State Associations of Addiction Services/NIATx innovation in behavioral health services award for their multiple change projects, which included:

- A Strengthening Reunification change team that addressed a critical Child and Family Services Review goal and reduced the out-of-home care re-entry rate in one county from 23 percent to 0 percent. Importantly, the county has sustained their success of no re-entries. The grantee also noted the process identified and improved communication and planning with the attorney and judge.
- A second change project integrated the Ages and Stages Questionnaire (ASQ), ASQ Social-Emotional, Pediatric Symptom Checklist, and UCLA PTSD Reaction Index into the parent assessment, for women in residential treatment with their children. All (100 percent) of the children in residential treatment now receive needed services. The grantee extended the

process to their intensive outpatient services for parents whose children are in out-of-home care, and to six other women's intensive treatment programs and drug courts in the region.

- A third change project sought to increase connections and communication with families by providing them with cell phones to maintain contact with their assigned workers. During a 5-month period, 100 percent of families with cell phones remained in the program, compared to 77 percent that did not receive phones.
- A fourth change team broadened its focus beyond the RPG goals to deal with a larger community issue. They implemented a mentoring program to engage students with excessive unexcused absences. As a necessary first step, the team improved the school attendance reporting and tracking system; data consistency and accuracy increased from 53 percent to 95 percent. This increased the school's average daily attendance (which the state uses to determine a school's general purpose and other funding) and provided a baseline to measure truancy reductions. The school superintendent plans to continue the project.

The NIATx experience has helped these grantees build their region's capacity. Each member agency has learned how to facilitate a process improvement project. This new skill benefits future collaboration, service delivery, and sustainability of the larger regional partnership and each participating organization.

As one grantee that recently sponsored a Change Leaders Academy for more than 40 participants from five different community partners noted, "The [RPG's] introduction of the NIATx model to community partners has been a major contribution to helping organizations approach change in an organized and measured manner."

In addition to the specific NIATx examples above, grantees also focused on process improvements to strengthen their child and adult screening and assessment practices. The nature of program improvements varied among grantees. Several sites implemented new screening and assessment tools or processes, while others expanded or modified existing practices. The grantees' collective experiences point to a series of progressive steps needed for successful screening and assessment implementation:

1. Identify the appropriate instrument.
2. Train staff to administer and use the results.
3. Pilot test the tool.
4. Use data and staff feedback to evaluate the tool.
5. Modify the screening and assessment process as needed.

A final lesson from grantees: Universal or consistent screening will likely increase treatment need. Ensure adequate treatment capacity exists or can be developed to respond to this increased need.

Understand the Customers' Needs

A pervasive theme underlying many grantees' program adaptations was the need to make treatment and services both more convenient and appealing for families. Three areas, in particular, emerged as important to consider: scheduling, employment, and location.

- *Scheduling.* To accommodate needs of both families and partners, grantees identified a need for more flexible treatment program and visitation schedules. This is particularly important for clients who are involved in multiple systems and services and may have other numerous obligations or requirements.
- *Employment.* Some grantees identified a need to adapt their approach to helping clients obtain employment and maintain self-sufficiency. Clients often experienced many competing priorities and program requirements. The adverse economic environment exacerbated these challenges. Further, grantees found that typical drug court employment requirements did not always meet the unique needs of the child welfare population. The partnerships often needed to add other resources (e.g., job coaching, transportation, child care) and provide more tailored, individualized approaches to assist participants seeking employment.
- *Location.* Several grantees' experiences also highlighted the important role that treatment location plays in client engagement and retention, particularly since many of the RPG families have limited time and resources to travel. To overcome this barrier, some sites opened new satellite offices or moved services to more convenient and accommodating locations for clients.

The lesson of ongoing program assessment and adaptation also is useful for collaboratives to remember when they are designing a single program model to implement in large regions with multiple communities, or seeking to replicate evidence-based national models. Some level of program customization may be necessary to respond to the various contextual factors that may affect program effectiveness. Such factors may include the local fiscal environment, a different client mix, and partner agencies' capacity and readiness to collaborate.

One partnership made a number of program modifications during the grant. Some improvements resulted from integrating a new grant into their existing RPG program model. Others were in response to a core partner's agency reorganization. Still other changes stemmed from close review of their data and program practices. Refinements to their FDC program included:

- Revised criteria for the different FDC phases
- Revised graduation criteria to require a minimum of six months of continuous sobriety at the time of graduation
- Revised prescription medication policy and procedures
- Revised sanctions administration for missed random drug tests and dilute sample drug tests
- Revised definition of "support group meeting" to include non 12-Step meetings under certain circumstances
- Revised community service requirements to include viewing and writing about instructional and recovery videos

Lesson 5: A Comprehensive Family-Centered Approach is Needed to Break the Intergenerational Cycle of Substance Abuse and Child Maltreatment and Effectively Address a Family's Complex, Underlying Issues

Over the course of the RPG Program, grantees experienced a major paradigm shift: They moved from individual-focused services to more comprehensive family-centered treatment. The partnerships, and the families they served, came to recognize that treating the family system—rather than an individual child or parent in isolation—is far more effective in addressing a family's underlying and complex issues. They learned that responding concurrently to the needs of the whole family:

- Increases parental engagement and retention
- Improves the likelihood of successful and sustained reunification
- Decreases the risk of relapse and recurrence of maltreatment
- Helps break the intergenerational cycle of substance use and child maltreatment

Grantees' Evolution to a Family-Centered Model of Care

During the initial stages of the RPG Program, grantee services tended to focus first on meeting the parents' substance abuse treatment needs. Though children benefitted indirectly from the services provided to their parents, grantees soon recognized that direct provision and coordination of children's services was a major gap in their program models.

Beginning in program year two and for the remainder of the grant, grantees worked to develop the direct children's services component of their programs. The partnerships paid particular attention to strengthening early intervention, developmental, mental health, and trauma services for young children. Grantees also expanded substance abuse education, prevention, and support services for school-aged and older children. (See also Chapter II.) As children's services often were not a part of grantees' initial project goals or program budgets, grantees had to develop new partnerships, leverage existing community-based services, or obtain other funding specifically for children's services.

During the last two years of the grant, grantees then advanced further to better integrate parent and child services to provide a more family-centered continuum of care. As a next stage, the partnerships also began to broaden their scope to engage and support other family members (particularly fathers). They recognized a need to address conflicts, stresses, and related problems (e.g., domestic violence) between parents/caregivers to strengthen their relationships and create an overall healthier family environment. For example, one tribal grantee was able to extend services to the non-tribal spouses of tribal members, which the grantee stated was a major success.

However, the shift from a person-centered mode to a family-centered approach was not without its challenges for grantees. For lead and partner agencies whose core "line of business" has been

providing services primarily to children or to adults, this change was often a significant and difficult adjustment.

An agency director in one site remarked that previously when the clients were “just the adults,” it was often easier to set treatment goals and expect the client to complete them within a reasonable amount of time. Now that the program focuses on “family goals,” they have had to address many more issues. The director noted that while this shift has yielded better outcomes, the process is much more complex and it takes much longer to stabilize families.

Program participants stated the substance abuse treatment counselors’ approach to “inviting” people into the program and asking about the needs of their children and families increased their willingness to seek and remain in treatment. The grantee added that just asking simple questions, such as, “How is your child’s school attendance?” and “How is your family?” had a positive impact on client engagement.

To move to family-centered treatment, the partnerships and their larger communities must be ready to do things differently. Grantees stated programs need to:

- Accommodate varied family structures and ages of children
- Involve all levels of care and partners across all systems
- Hire and retain more experienced and qualified staff (e.g., Master’s level case managers)
- Provide increased training to project staff and partners on the importance of a family-centered philosophy and effective family-based approaches
- Develop funding strategies that can support a more comprehensive family-centered approach
- Address conflicting values among partners on difficult, underlying issues, which may include safety and risk concerns about children entering treatment with their parents or deep-seated beliefs that parents with substance abuse problems cannot recover and become “good parents”

Prior reports to Congress highlighted one grantee’s success in partnering with the county Head Start program to provide onsite services to young children (aged 0 to 3 years) of parents in substance abuse treatment. The grantee recently conducted an analysis of mothers who dropped out of residential substance abuse treatment in the first 30 days. They found the majority of these women had entered the program without their children and were unsure if their children would be placed with them while in treatment.

To address this client barrier, the grantee and child welfare partners reached an agreement to place children with their mother within 30 days of the mother’s treatment entry (where appropriate). The grantee stated this meets the court’s and child welfare’s need to demonstrate that the mother is committed to remaining in treatment, while it also achieves the treatment program’s goal of strengthening mother-child attachment as early as possible. All parties have agreed to test the new policy for three months before formalizing it.

Lesson 6: Broadening the Partnership Beyond Child Welfare and Substance Abuse Treatment to Work with Other Community Agencies is Critical to Securing Important Core Treatment and Supportive Services

New relationships must be cultivated continually to establish true collaboration and increase program and partnership effectiveness. To enable families' full participation in RPG services, most grantees had to extend their efforts beyond providing therapeutic treatment services to children and parents to address some basic, yet challenging family support needs (e.g., housing, transportation, child care, health care).

Linking families to other community supports enhances the continuum of care. It fills gaps in the current systems of care, facilitates clients' engagement and retention, and promotes families' sustained recovery and self-sufficiency. Equally important, broad-based collaborative relationships helped the partnerships maximize all available resources and increase sustainability potential. They strengthened the grantee region's collective ability to influence practice and policy changes.

Reaching Out to New Community Partners

The regional partnerships continually evolved over the five-year period, with the member agencies becoming more diverse as services progressed and community awareness increased. With the addition of each partner, the reach and scope of the grantees' projects broadened; their overall capacity strengthened as they added new ideas, expertise, and services. Over the course of the program, partners may have ebbed and flowed in some sites, but in general, grantees learned to look beyond individual members to consider how their collaborative was part of a larger community system.

Several grantees continued to expand their partnerships up to and beyond the end of the grant. Over the course of the grant period, nearly three-fourths of grantees (39 grantees or 73.6 percent) reported the addition of approximately 438 new partners. While the level of involvement and responsibility of these new partners may vary, 29 of the 39 grantees reported developing Memorandums of Understanding (MOUs) or other formal written agreements with some or all of their new partners.

These new partners typically extended well beyond the core child welfare and substance abuse treatment systems. But the specific types of new partners that were needed, and why, varied by grantee, depending on their geographic location, target population, availability of other community resources, fiscal climate, local priorities, and other issues. The examples below illustrate this broad range:

- *Courts, Criminal Justice, and Legal System.* Though some grantees counted the courts among their core partners from the beginning, others developed these new partnerships over the course of the grant. Several grantees, for example, reached out to the criminal justice system to ensure incarcerated mothers receive needed services while incarcerated and to transition successfully to the community. Other grantees engaged family or adult drug courts in which their RPG participants were involved. For instance, one tribal grantee established

collaborations with the three county drug courts serving a significant population of parents in the RPG program. This was a unique relationship, as tribal communities rarely initiate relationships with neighboring county drug courts.

- *Mental Health.* As discussed in Chapter II, grantees did not always include trauma and other mental health services as a planned program strategy during early project implementation. However, grantees quickly realized they needed to modify their original models to provide these essential services. As one grantee noted, “It became evident from the onset that without mental health intervention, some families would no doubt continue in the cycle of addiction long after the end of the grant.” To meet clients’ complex co-occurring needs also required expanded collaborative efforts. It became apparent to many grantees that additional partners were critical to develop and implement such services.

In one site, the lead substance abuse treatment agency officially merged with the mental health agency during the final year of the grant. The merger allows for a more seamless approach to treating families with co-occurring disorders. Prior to the formal merger, the two agencies had begun co-facilitating groups and increased joint case planning with social workers. They also had worked on a joint response for investigations involving reported substance use and co-occurring mental disorders. More recently, a psychiatric nurse practitioner joined the team to provide increased oversight and support for medication management for children and their parents.

- *Housing and Homeless Services Providers.* During the latter part of the grant, housing shifted to the forefront of families’ needs and was an evolving program component for many grantees. The partnerships recognized its direct impact on a family’s ability to reunify in a timely manner and its critical role in families’ long-term success in the community. Grantees expanded the depth and breadth of their collaborative to address the housing needs of their clients and larger communities. Examples of their progress included: implementing comprehensive housing assessments, providing families in the RPG programs with housing vouchers, launching a broader community-wide effort to build low-rent apartments in the target geographic region, and prioritizing RPG families for transitional or subsidized housing.⁵⁶
- *Medical and Health Care.* Towards the end of the grant period, medical and health care services become a more predominant need among clients. Grantees worked to establish collaborative relationships with local community health centers, particularly Federally Qualified Health Centers (FQHCs), evidence-based home visiting programs, or other related agencies to implement or expand medical services. Cultivating these relationships became a priority as health care reform advanced.
- *Medication-Assisted Treatment Providers.* As stated in Chapter I, during the latter part of the grant, several partnerships noted an increase in the number of program participants who abused prescription drugs. In program year five, at least two grantees worked to build relationships with MAT providers (in addition to traditional substance abuse treatment providers). Another grantee began participating in a monthly prescribers group to develop

⁵⁶ Refer to the Second Report to Congress for more detailed grantee examples.

community standards for opioid prescription practices and strengthen referral relationships for alternative treatments.

- *Aftercare and Other Key Recovery Support Services.* As the grant progressed, the role of key supportive services to help parents with substance use disorders achieve sustained recovery and reunify with their children increased.⁵⁷ Connections with the many different local organizations providing needed support services became even more critical as grantees moved into the final grant-funded year and families completed RPG services and transitioned to other community-based supports. For parents in more isolated regions, where recovery supports are often even less accessible, grantees worked with providers to further identify and develop aftercare supports.

Strong Collaborative Relationships—An Essential Sustainability Component

As the grant progressed, the partnerships also increasingly realized they needed to expand their collaborative relationships to plan for and achieve sustainability. A comprehensive funding and sustainability strategy that maintains the broad array of treatment and support services families need requires extensive networking and collaboration. Grantees must establish strong collaborative relationships to:

- Provide services efficiently and effectively
- Inform state and local funding decisions
- Endure larger system budget, staffing, and leadership changes
- Leverage all available resources and expertise to secure and manage different funding streams (discussed further in Lesson 10)

Lesson 7: Clear Roles, Responsibilities, and Expectations are Required of Partners, Providers, and Families to Promote Individual and Shared Accountability

The regional partnerships are dealing with complex family situations and multiple providers and systems responsible for monitoring participants' behavior and progress. As such, clear roles, responsibilities, decision-making processes, and client and partner expectations about the respective systems are essential. Without such clarity, diffusion of responsibility can lead to conflict, fragmentation, duplication of services, ineffective collaboration, and unproductive sustainability planning.

⁵⁷ Refer to the prior two reports to Congress for further discussion regarding this issue.

The most important thing I learned is that one cannot spend too much time planning ahead and setting up a clear line (chain) of communication and accountability. When entering such a partnership, there must be an agreed outcome or goal.”

Regional Partnership Grantee

Over the course of the grant period, several partnerships found they needed to outline formal collaboration roles and decision-making protocols. In particular, agreed-upon protocols were required for key operations, such as referral processes and pathways to access services, type and length of services to be provided, eligibility and discharge criteria, case management, and data collection. Establishing clear roles and responsibilities facilitated more open communication, the importance of which is discussed in the next lesson.

Agreement on roles and responsibilities needs to extend beyond the local level partners and include state level partners. This is important for large-scale collaborative efforts—such as the RPG Program—that require active state agency programmatic and evaluation involvement and dedicated resources.

Grantees indicated a formalized interagency agreement, such as a MOU or performance-based service contract, can help institutionalize such clarity. It can facilitate issue resolution should partner conflicts or concerns arise (e.g., disagreement on when clients should be discharged) and encourage shared accountability for project goals.

As one grantee stated, the nature of collaborations involves ceding some authority and control to another agency (or agencies) and the lines of responsibility can easily become blurred. In sites where partner agencies share co-located staff or positions, clear supervisory roles must be established upfront. Similarly, in programs that use a multidisciplinary team approach, the roles and responsibilities of staff, particularly those in non-clinical positions (e.g., peer/parent mentors), need to be articulated clearly to all community partners.

Contextual changes (e.g., changes in staff positions or staff turnover) were a significant barrier to institutionalizing roles and responsibilities (see Lessons 9 and 11). Clear delineation of staff roles can help mitigate these problems and create a more fluid transition during staff changes. This ensures services to families remain as stable and consistent as possible, which grantees noted was critical to gain the trust of families.

Engaging Families in the Process

Families, too, need clarity and consistency on the various systems' roles and expectations so they understand what services will be provided and what successful program participation entails. For example, one grantee reported they had to take concrete steps to ensure parents and caregivers had a clear understanding of the comprehensive child screening and assessment process. The grantee needed to educate their various referral sources on what to say to parents about the program. Further, once parents were referred, intake workers had to provide explicit instructions to parents on what they should expect.

Rules and expectations need to be consistent from one system to another and across staff within the same system. Grantees found setting clear client expectations increased engagement, retention, and successful program completion. Further, it provided a structure of accountability and support that helped empower parents.

One grantee has an active client council that helps formulate policies related to daily client procedures and rules, as well as the program's overall cultural sensitivity and responsiveness. The major purpose of this collective body, which meets weekly, is to promote ownership and enhance accountability of client participation in the program.

The partnerships described various means for communicating program expectations to families and engaging them to be fully responsible and active in their treatment, including:

- *A Shared Treatment Plan.* Grantees emphasized the value and importance of a shared treatment plan, with parents empowered to take the lead in identifying needed services and key support persons in their recovery. As active and full partners in the decision-making and treatment planning process, participants tended to demonstrate increased personal accountability as well as greater accountability to the larger project team.
- *A Client Orientation Process.* Several grantees developed or revised participant handbooks and related client materials to clarify program and participant expectations and support treatment engagement and retention. The partnerships also implemented or modified client orientation processes.
- *An Incentive System.* Immediate sanctions and rewards are an effective way to recognize and encourage families' progress and hold parents accountable for their actions and decisions. Grantees reported that in client focus groups and interviews, participants said sanctions and incentives provided a structure that helped keep them on track and taught responsibility, discipline, and commitment. Over the course of the RPG Program, many grantees implemented a new reward and incentive program to enhance client engagement and retention; others modified and revised their existing incentive system to increase its effectiveness.

Partnership Roles in Sustainability Planning

The importance of clear roles, responsibilities, and expectations also extends to sustainability planning. Grantees that made sustainability an explicit program objective or established a designated group or structure (e.g., task force, subcommittee) to focus on sustainability seemed to have more success. Yet making sustainability a stated objective is not sufficient without dedicated staff and specified roles. Grantees' experiences also indicate the lead agency needs to assume a clear leadership role to direct and move the project forward and act on the larger partnership's sustainability plans.

Initial and sustained program implementation also requires contextual knowledge of existing services and how new or enhanced RPG services can link to and strengthen those resources. Without a clear understanding of how the partnership and overall RPG program and service

delivery approach relate to other community services or initiatives, achieving project sustainability will likely be a challenge (as discussed further in Lesson 10).

Lesson 8: Ongoing Communication, Information Sharing, Monitoring, and Supervision are Critical at both the Systems and Direct Service Levels

Ongoing and regular communication, information sharing, and monitoring of client progress and partnership activities are essential to identify and respond to both direct service and larger collaboration challenges. Formalizing both the infrastructure (e.g., oversight or steering committees) and processes for such activities, helped ensure consistent program implementation and institutionalize this “new way of working together.” It also provided accountability and leadership support for the continuous quality improvement efforts discussed in Lesson 4.

At the direct service level, ongoing communication and oversight serves to maintain and increase program referrals, address client engagement and retention barriers, provide continuity of care for families, and better follow families’ progress. At a broader level, these efforts help reduce duplication of services, identify needed program improvements, and maximize available resources. They help build trust among systems, ensure joint accountability for project goals, create stakeholder buy-in for sustaining effective practices, and translate the project’s successes into larger systems change.

An infrastructure of consistent, frequent communication and regular monitoring was especially important for partnerships as they dealt with adverse community and contextual events. Grantees reported a cross-systems communication infrastructure was critical given the ongoing budget cuts and related staffing challenges (particularly within child welfare) that impacted their programs and services. Other significant contextual events may include change of leadership, addition of new partners, policy changes, shifts in substance abuse and child welfare trends, and the emergence of divergent values or conflicts among key partners.

In recounting their most important lessons learned over the course of the grant, several grantees emphasized the essential nature of communication:

- *“The most important recommendation to creating a successful cross-system collaborative learned from the [RPG] project is to have constant communication, among all the different agencies and at all staff levels.”*
- *“The communication systems of the project should be very well established and all members of the partnership, including the evaluators, should be well aware of all collaborative practice activities.”*
- *“Regular communication among project staff is key to operating programs such as these. While this seems like a common sense statement, there were definitely times in which lack of communication between staff and partner agencies resulted in confusion and friction.”*

Effective Strategies to Facilitate Cross-Systems Communication

Grantees highlighted several ways in which they were able to promote communication:

- *Regular Partnership Meetings.* Grantees stated that regular partnerships meetings at various levels (e.g., leadership, management, front-line workers, partners, and providers), where all partners were represented, served multiple purposes and were an effective means to transmit critical information. They provided a forum to address a range of issues from client-specific matters to program operations to larger policy and systems issues. They helped increase efficiency, mutual trust, and agreement on shared goals for families. However, as one grantee noted, the partners had to move beyond “just meeting for meeting sake” and engage in the right kinds of conversations. The discussions needed to evolve from what partners are doing to how family outcomes are improving. A key facilitating factor: make sure the appropriate individuals are available to make needed decisions and move initiatives forward.
- *Multidisciplinary Case Planning Processes.* A second strategy that grantees found effective in establishing and maintaining open lines of communication was regular joint case staffings, family case conferencing, or team decision making. These and other related types of multidisciplinary case planning processes helped connect the project team and parents and enabled more immediate case planning responses. As one grantee explained, the various providers were able to address a family’s emerging issues as a collaborative unit, rather than in a fragmented way, within each agency’s narrow treatment context. This resulted in a more seamless and consistent collaborative process that ensured treatment plans progressed smoothly and stayed on track.
- *Formalized Communication Protocols.* Grantees also used formalized protocols or policies to establish more regular and effective communication. Cross-systems communication protocols specified appropriate confidentiality protections, and specific data and case information to share. Clarifying who needs to know what and when helped increase the efficiency of grantees’ information exchange. One grantee noted the communication protocols they developed with child welfare influenced information sharing with other agencies in the community.

During the last year of the grant period, one site pilot tested a best practice guide for communication between child welfare and substance abuse treatment providers. The guide outlines a protocol to improve the screening and referral process and communication about assessment and treatment. It also recommends protocols for ongoing collaboration between child welfare, substance abuse and mental health treatment providers, and early intervention, from the point of referral all the way through discharge and aftercare planning.

The site held a 6-month training for the pilot test participants so people could share their experience with the protocol and discuss challenges. A key lesson learned from the pilot test was that practice change takes time. The grantee concluded the pilot test group needed continued training and support for a minimum of 12 months to address required policy changes within each organization to support the collaborative work, a longer-term investment in training, adequate relationship building, and sufficient follow-up to assist front-line staff in practice changes.

- *Dedicated Staff Person.* Grantees’ experiences also suggest it may be helpful to have one central or dedicated person to coordinate and streamline communication. Someone who, as one grantee described serves as the information “hub” among multiple providers. Having a dedicated person to gather and disseminate relevant information to other partners in a timely manner ensures treatment barriers are addressed and needed services are provided. As one

grantee noted, within child welfare alone, there are separate departments that families often move across, each with different staff. All these layers make communication and information sharing that much more difficult.

An Effective Oversight Structure is Key

In addition to a communication infrastructure, a stable, secure, and knowledgeable supervisory structure (e.g., advisory board, oversight or steering committee) is needed to maintain effective integrated service delivery and ensure program fidelity. Such structures are particularly important if there is no prior history of collaboration among partners, as they help promote both agency and community buy-in. Grantees typically established these structures in the first year of the program. As the RPG Program progressed, grantees periodically revised the structure and purpose of selected oversight bodies to improve collaborative efforts and increase efficiency.

Strengthening Communication to Improve System Efficiencies

In general, the partners shared information with each other for two overarching purposes: effective treatment planning and project evaluation. Most grantees succeeded in sharing case-specific information, particularly at the front-line staff level, for client treatment planning. Team members discussed, for example, assessment results, treatment recommendations, and treatment progress.

A child welfare caseworker in one site expressed the value of receiving psychological reports and recommendations for each child, based on the grantee's comprehensive assessments. "I have used these reports numerous times with school professionals, mental and physical health professionals, and day care providers, as well as parents. We have team meetings quarterly and go over the reports and progress towards goals set from the recommendations."

Yet when it came to information sharing for evaluation purposes, grantees often experienced challenges. As discussed in Chapter XI, grantees sometimes encountered difficulty with getting needed outcomes data from partnering agencies, and with effective communication between program and evaluation staff. However, grantees did strengthen this area of collaborative practice over the course of the grant. Information sharing and data systems showed the second greatest amount of change over the course of the grant period (see collaborative capacity performance measure results in Chapter X).

For both types of information sharing, grantees found informal agreements were not sufficient. Grantees stressed the importance of having formal data-sharing agreements among key agencies and signed consents from families to release their information. One grantee, for example, had a data workgroup, in which data-sharing agreements among members were in place among, with annual renewals required. The grantee noted the agreement is permanent and sustainable without grant funds.

Grantees' experiences suggest the information sharing started with the RPG project has helped lay the foundation for sustained collaborative efforts that will extend beyond the grant. For instance, as a next step, one county child welfare agency requested to work with the grantee lead agency to develop a reporting tool designed to share information between child welfare and

community agencies. The intent is for the tool to become the standard for all community-based agencies working with child welfare families.

Lesson 9: Staff Training and Development is an Essential Component of Effective Program Implementation and Sustainability Planning

Within the collaborative partnerships, families were served by multiple agencies and direct service professionals from diverse educational and service backgrounds. Many of these service systems are (and have long been) prone to substantial staff turnover, particularly at the direct service level. Grantees' programs also generally provided intensive treatment services, including evidence-based programs that require highly skilled and adequately trained staff. Many grantees operated programs covering large geographic regions or rural areas, which contributed to staffing capacity challenges. These issues, taken together, required grantees to provide ongoing team-building and professional staff development and educational opportunities.

According to grantees, the importance of staffing issues cannot be underestimated. Grantees noted having experienced and consistent project leaders and direct service staff was a critical contributing factor to the partnership's success and achieving positive family outcomes. Further, many partnerships acknowledged that recruiting, training, supporting, and retaining highly skilled professionals proved to be more difficult than they anticipated. Achieving full staffing was one of the most challenging goals to achieve.

Staff turnover was pervasive throughout the grant for the majority of the partnerships:

- Nearly all (86.8 percent) of grantees reported challenges with turnover or retention in front-line or direct service staff. Turnover seemed to peak in program year three, but was also high during the first part of the final program year, most likely because of uncertainty about continued funding.
- Nearly two-thirds (62.3 percent) of grantees also experienced turnover or retention difficulties with key management or administrative positions.
- In addition, 79.2 percent of grantees also cited state, county, or other agency personnel changes or reorganizations (outside of the RPG) as an important contextual issue (and one outside their direct control) that impacted their program's operations during the grant.

Larger state and county budget and staff cuts and resulting staff layoffs further compounded staffing challenges (see Lesson 11). The clear message from grantees is that staff training and development need to be a key project component in larger implementation and sustainability plans. Collaboratives need to build in sufficient time and funding into their project plans and budgets to hire and train staff. This is even more critical given the increased emphasis in the field to provide evidence-based practices and monitor their fidelity.

Supporting Staff through Ongoing Training and Development

As outlined in Chapter II, cross-systems trainings for staff, partners, and the community on various clinical, programmatic, and evaluation issues have been and continue to be a central focus of grantees' overall efforts. Indeed, nearly three-fourths of grantees (71.6 percent) have staff training and/or community awareness and education identified as one of their major project goals or objectives. Underlying all of grantees' cross-systems staff training and development efforts was the need to maintain a fully staffed, skilled, and trained workforce with a high level of accountability.

Grantees emphasized the essential role that cross-systems training played in:

- Educating project staff on addiction as a disease, the impact of parental substance abuse children and families, and effective treatment principles and approaches
- Providing project staff with the essential clinical knowledge, skills, tools, and practice models needed to serve families more effectively
- Educating the larger community and stakeholders about families' complex needs
- Increasing project staff understanding of each service system's operating procedures and constraints
- Enhancing collaboration to increase appropriate program referrals and provide more coordinated services
- Establishing a common ground for lasting collaborative relationships
- Building overall local capacity to address families' needs

Grantees reflected that comprehensive, ongoing cross training eliminated much of the miscommunication and misperceptions that had historically plagued their cross-systems collaboration. Such efforts helped partners reach agreement on how best to serve families impacted by parental substance abuse. As one grantee concluded at the end of their grant, "We needed a lot of cross training to understand each other's roles and responsibilities and to develop patience and trust with each other."

One grantee noted that as the clinical work continued over time, child welfare staff showed a greater willingness to be educated about addiction, substance abuse treatment, and the recovery process, and how working together collaboratively (especially on complicated cases involving domestic violence and mental health issues in addition to substance abuse) is in the best interest of the family.

The partnerships placed a high priority on continued cross-systems training throughout the five-year grant period. A key lesson grantees learned was the continued need for cross-systems training on the program's mission, philosophy, and treatment modalities. Continuing education on collaboration and best practices was needed for existing as well as new team members. In fact, more than one-fourth of grantees (28.3 percent) increased, enhanced, or added new trainings for project staff, providers, or partners during the program. In addition, as described in Chapter

XII, HHS provided ongoing technical assistance and training to grantees throughout the grant period on effective collaborative practices and evidence-based and promising practices.

Through ongoing trainings, grantees were able to respond to emerging family needs (e.g., trauma and mental health issues) and broader contextual issues (e.g., rise in prescription drug use and the implementation of medication-assisted treatment). Ongoing trainings also served to maintain the program's standard of care and ensure fidelity to evidence-based practices. Further, grantees stated the extensive and ongoing trainings to project staff, partners, and the larger community changed the way service systems and others think about families with co-occurring substance use disorders and child maltreatment issues.

One grantee stated their staff were one of the program's biggest successes. "Our clients have been fortunate to have access to the same set of counselors for the past five years. Because of our counselors' willingness to continue their education and enhance their skills, our clients and their families have been offered the newest and best forms of therapies."

Efforts to Sustain and Institutionalize Cross-Systems Training

As the RPG Program progressed, grantees incorporated more experiential field training into their overall staff development efforts. This was in response to training budget reductions, but also to apply knowledge gained in formal trainings. Grantees also worked to enhance and sustain staff expertise by institutionalizing ongoing training into regular program and partnership operations, such as during joint case management meetings or cross-systems partnership meetings. To enhance their cross-systems training further, the partnerships also reached out to involve other agencies and systems and leverage additional training resources.

For example, during the grant, one site's state substance abuse agency amended their licensing regulations for treatment programs to include mandatory training guidance. Each year, providers must train staff on "the effects of substance use disorders on the family and related topics such as the role of the family in treatment and recovery." In response to the new regulations, the child welfare agency's substance abuse unit developed training for all substance abuse treatment providers to provide an understanding of child welfare, particularly as it relates to families affected by substance use disorders, and to build upon the existing collaborative efforts between child welfare, treatment providers, and families.

Turnover Impacts Larger Staff Training and Development Efforts—And More

Institutionalizing ongoing training became essential in light of continued high turnover among RPG project and partnering agency staff, particularly child welfare. Grantees noted that with such ongoing turnover comes the frequent need to repeat new staff orientation trainings on basic issues (e.g., identification and referral of clients, program eligibility criteria, communication structures). Many grantees expressed frustration and concern about the extensive amount of time and resources spent having to continuously retrain, engage, and orient new staff and partners about the program, services, and target population. While necessary, this retraining often occurred at the expense of more advanced clinical trainings (e.g., evidence-based practices) that

grantees say staff needed. Slightly less than half (45.3 percent) of grantees reported difficulties or delays with staff training and development.

Other consequences of these staffing challenges included:

- Maintaining service continuity for families. For example, turnover can impact the number of workers available to conduct evidence-based programs or groups/sessions that are part of a manualized curriculum.
- Maintaining program continuity for partners. For example, one grantee noted that with extensive turnover, partners reported not knowing who to call, who to invite to meetings, or who was responsible for essential program components.
- Ensuring the regional partnership is a priority among new partners. Changes in key leadership positions may mean changes in priorities.
- Maintaining sufficient partner commitment and a common mindset.

Need for Higher Qualified and Skilled Staff

In addition to extensive retraining, grantees identified a second challenge stemming from front-line staff turnover: new staff who were less experienced and lacked the knowledge and skills to serve the RPG target populations effectively. Even among more seasoned staff, grantees found their programs required staff with specialized skills, licensure, certification, or expertise. For example, one grantee hired a new licensed clinical social worker to provide TF-CBT. The grantee noted that although this social worker had received needed TF-CBT training, she still lacked final supervised clinical hours to be certified.

Grantees noted significant challenges in recruiting and retaining such qualified staff, particularly those partnerships operating programs in sparsely populated, remote, rural areas with long-standing shortages of licensed staff. Overall, more than one-fourth (26.4 percent) of grantees reported challenges with hiring qualified program or clinical staff. However, grantees stated placing a high priority on providing quality staff training and skill development does help retain staff and increase and sustain the community's capacity to serve children and families.

Children's services seemed to be the most challenging area to adequately staff. Grantees cited difficulty hiring and retaining qualified clinicians (e.g., clinical psychologists, developmental pediatricians) with expertise in prenatal and postnatal substance exposure, infant and young children's mental health diagnoses, and providing trauma-specific children's services.

The need for qualified staff extended beyond those in clinical positions. Grantees stressed the importance of having a strong and consistent project director with adequate leadership and management abilities to advance the collaborative. The project director must have a deep understanding of the program and families served, be able to establish trust among core partners, and garner the support of other key stakeholders. Equally important, the project director must have sufficient time to focus on the project and carry out its many tasks. Approximately one-fifth (20.8 percent) of grantees encountered issues with program management resources being insufficient to oversee the project.

In short, recruiting, training, developing, and retaining qualified staff are key ingredients for comprehensive collaborative programs. Staffing impacts all program aspects, from the effective identification and engagement of families, to the provision of evidence-based and promising clinical treatment and support services, to the development of productive and ongoing collaborative relationships. Further, as discussed in Chapter XI (see Evaluation Lessons 2 and 6), staffing is key for cross-systems data collection and performance monitoring. Identifying resources to support and institutionalize staff training and development needs to be an essential aspect of project implementation and sustainability planning.

Lesson 10: The Partnership and Program Need to be Integrated into Other Existing Systems' Efforts and Infrastructures and Leverage All Available Resources to Facilitate Sustainability

To institutionalize and sustain the RPG interventions, a grantee's overall program (encompassing both administrative systems and direct services collaboration) needs to be integrated into existing efforts rather than operate as a stand-alone model or project. This requires an understanding of how the grantee's program and partnership align with other agency goals and their role in the broader community's child welfare, substance abuse treatment, and other service systems. The lesson of integration applies not only to direct services, but also to agency-level collaboration.

The RPG Program is one of many national initiatives designed to promote the overall well-being of children and families. As such, a myriad of potential opportunities exist that the regional partnership grantees can connect with to develop the support and resources needed to sustain their programs. In the current fiscal environment, it is essential that grantees identify new community partners with whom they share clients and are able to blend and leverage resources.

While many grantees had made inroads in their sustainability efforts by the end of the grant, some partnerships faced continued challenges in this critical collaborative practice area. As discussed in Lesson 11, the fiscal environment was a primary factor that affected grantees' sustainability planning. In general, some grantees seemed to struggle with the more difficult task of institutionalizing their programs (e.g., through changes in funding, policies, line item budgets) and instead focused on another new time-limited grant to support their work. During the course of the grant, 58.5 percent of the partnerships received other grant funding to support their projects. (In addition, 62.3 percent of grantees had submitted other grant applications or proposals that were either unsuccessful or still pending when the RPG ended.)

As previously mentioned in Chapter I, eight grantees received a two-year extension grant to continue their programs (per the RPG Program reauthorizing legislation). Among the other 45 regional partnerships:

- Fifteen grantees (33.3 percent) were assessed as being able to sustain their project in its current form or model beyond their grant period. In some cases, the collaborative partnerships, the target populations, and/or the services provided were enhanced or expanded.
- Another 24 grantees (53.3 percent) were identified as having sustained specific components or a scaled down or modified version of their overall program model.

- Five grantees (11.1 percent) were not able to sustain any of their programs.
- One grantee's (2.2 percent) sustainability status was uncertain as they continued to pursue their options.

The grantees that did successfully integrate their efforts with other related program and policy initiatives and used the RPG experiences to inform broader efforts pursued various strategies. The primary ones are highlighted below.

- *Integrating with Other Child Welfare Systems Improvements.* Several grantees integrated their efforts into their state's Child and Family Services Review (CFSR), Performance Improvement Plan (PIP), or other similar child welfare systems improvement processes to sustain major RPG service components. By being responsive to key issues and closely aligning their RPG models with these larger initiatives, grantees were able to develop both the rationale and tangible support for sustaining their partnerships and services. For one tribal grantee, it also helped them establish third-party billing capacity.

In one site, the RPG program had significant influence in promoting a statewide rollout of a similar parent partner/peer mentor model and providing input on the credentialing process for family support specialists. RPG parent partner staff also were invited to participate in the statewide implementation of two other related initiatives to improve case planning (family interaction training and fatherhood joint training).

At the beginning of year five, one grantee received funding from the juvenile court for their parent mentors to facilitate clients' daily orientation. At the end of the grant, the county's commission on children and families agreed to provide continuation funding to maintain this service. Mentors are now part of the core child welfare training for all new caseworkers and social services assistants, focusing on how to engage parents with substance abuse issues.

- *Connecting with Other Related Grants or Initiatives.* A substantial number of grantees (58.5 percent) mentioned in their progress reports a new grant or related initiative in their community that positively impacted their RPG project operations at some point during the grant. Grantees sought to integrate and connect with these endeavors to leverage additional resources. Several specifically mentioned collaborating with other related federally funded grant projects designed to improve services and outcomes for families affected by substance abuse.⁵⁸
- *Incorporating RPG Efforts within their Own Agency.* Several of the regional partnership lead agencies also leveraged and integrated the RPG-specific efforts with complementary initiatives within their own larger agency or organization. For example, one grantee was able to institutionalize the RPG program's comprehensive assessment and service planning into

⁵⁸ These included Children Affected by Methamphetamine (SAMHSA), Pregnant and Postpartum Women's treatment programs (SAMHSA), Access to Recovery (SAMHSA), Abandoned Infants Assistance: Comprehensive Support Services for Families Affected by Substance Abuse and/or HIV/AIDS (ACF), Initiative to Reduce Long-term Foster Care (ACF), Trauma Informed Child Welfare Systems (SAMHSA), the Maternal, Infant, and Early Childhood Home Visiting program (HRSA), Fetal Alcohol Syndrome Disorders Training Grant (HRSA), and Family Drug Court Programs (OJJDP).

their larger agency's standard intake process and continuum of services as well as the state's child safety practice model. A few grantees had a similar unique opportunity in that many of the other services needed by RPG families existed within their larger organization's different service areas. However, this was not the case for the majority of grantees, who relied on outside partnerships to deliver comprehensive services.

- *Transitioning Services and Staff to Other Partner Organizations.* By the end of the grant period, some grantees had successfully transitioned RPG staff positions, services, and knowledge to partnering agencies that will continue to serve families beyond the grant. This integration strategy seemed to be particularly effective for some smaller community-based grantee lead agencies that determined long-term sustainability could be achieved better by moving the program to another agency with increased capacity to secure funding and affect larger systems change. Grantees often provided technical assistance, training, and mentoring of partnering agency staff as services and functions were transferred.

In one site, the RPG approach to substance abuse treatment will be fully supported by the tribal substance abuse program. They have revised their operating procedures to incorporate the evidence-based Wellbriety treatment model and other cultural support services used by the RPG into their services. One of the RPG counselors also has transitioned into an administrative management position within the tribal outpatient program.

- *Joining with Larger Health Care Reform and Care Coordination Efforts.* Nationwide, states continue to prepare for implementation of the Patient Protection and Affordable Care Act. They are involved in various delivery system changes, including managed care reforms and care coordination strategies. In fiscal year 2012, 16 states (including 8 RPG states) had reported initiatives to coordinate physical and behavioral health care. In fiscal year 2013, this increased to 28 states (including 13 RPG states).⁵⁹

It follows that in some RPG sites, sustainability planning became a natural part of the health care reform discussions and evolved into an integral component of their long-term sustainability strategy for services. These sites initiated discussions with FQHCs, managed care providers, or local primary care providers to establish a permanent medical and behavioral health care home for their RPG families.

At least two grantees encountered a potential challenge: managed care companies lack of knowledge about substance abuse treatment issues. As one of these grantees commented, the managed care companies are not accustomed to referrals coming from partners such as child welfare and probation and parole. They often do not understand the service demands and multiple areas of need of the RPG populations, and the need to leverage services offered by other human services partners. The inherent pressure to maximize outcomes at the lowest possible cost also may create service barriers for clients with multiple and complex needs.

⁵⁹ Smith, V.K., Gifford, K., Ellis, E., Rudowitz, R. & Synder, L. (2012). Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

Integration with Health Care Reforms—Selected Grantee Examples

- One grantee collaborated with one of the state’s primary Medicaid managed care organizations (MCO) to integrate physical and behavioral health care plans in the grantee’s three RPG counties. The grantee and MCO identified shared goals and combined resources for staff trainings. The way in which providers in the three counties have collaborated to engage and retain hard to reach families is having an influence on managed care planning in the larger region.
- Another grantee completed the planned integration of its children’s social, emotional, and behavioral health services and family support services into an existing FQHC. Health records are coordinated, clinicians are cross-trained, and children’s assessments are billable to Medicaid under the FQHC designation. No further grant money was used to support and sustain this work past the grant. However (as discussed further below), the grantee notes that current billing rates, even under a FQHC, do not adequately cover the cost of the comprehensive children’s assessments.
- Still another grantee lead agency became part of their region’s new Medicaid managed care system. Their involvement enabled them to integrate their family care coordinators into the broader comprehensive health services integration model. The care coordinators will continue to be housed at the state’s child welfare and family services agency and RPG sites. They will continue to serve as the primary referral point and facilitate and track referrals between partners in the region’s eight counties. The grantee called this integration of behavioral and physical health “a true sign of extraordinary systems change.”

Third-Party Billing—An Essential Yet Challenging Component of Sustainability

With the anticipated expansion of Medicaid insurance coverage for low-income families in many states, many of the above integration strategies involved establishing or expanding third-party billing capacity. Many grantees noted the ability to bill Medicaid or other third parties for reimbursable services was essential to their program’s sustainability. Yet grantees varied widely in their capability to expand the number of Medicaid substance abuse providers or access Medicaid reimbursement. By the end of the funding period, nearly one-third (30.2 percent) of grantees had established a mechanism for third-party billing for various services, such as certain therapeutic services, substance abuse treatment services, and (in at least one site) the Strengthening Families Program.

However, grantees continued to experience significant, unresolved challenges with establishing reimbursement structures and rates that cover the more intensive, comprehensive services that are key components of their RPG programs (see Chapter II). The general trend seemed to be that RPG services that Medicaid funding can support will continue, but the more intensive clinical services (e.g., residential treatment services) that are not covered will be available on a more limited basis after the grant period ends.

One grantee created new fee structures and billing systems to accommodate the new array of RPG services. They created a contract for substance abuse treatment providers to bill child welfare directly for family services (e.g., individual, family, or group therapy, comprehensive family assessments, and family group conferences). The grantee provided further financial incentive for increased family involvement by adjusting billing structures to account for each family member participating in treatment service—i.e., the more family members present, the higher the reimbursement level. In addition, these billable services were incorporated into the already-existing Health Maintenance Organization system that covers substance abuse treatment for most counties in the state.

To create a sustainable, viable organization, another grantee formally merged with two other independent nonprofit agencies to form a single, comprehensive child- and family-serving agency. All services and housing are co-located in one location, creating an accessible continuum of care for families. Combining the skills, experience, and resources of a multidisciplinary team of providers minimizes duplication of services, creates a team-based centralized intake, streamlines referrals for needed services, and follows families via data and team staffing. Further, the merger helped bring to scale each agency's existing activities and sustain additional individual reimbursable services. The site is negotiating with the state to establish a contract or daily reimbursement rate for full foster care (24-hour supervised family housing).

In addition to third-party billing, another competitive distinction to leverage additional funding is accreditation or certification. For example, one site obtained Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation for their residential and outpatient substance abuse treatment programs. Such accreditation or certification processes help gain the confidence of both potential clients and third-party payers that the program exceeds minimum levels of service quality.

Sustainability Lessons from the Grantees

The experiences of all 53 grantees offer valuable insights about what it takes to institutionalize and sustain the RPG efforts. Their collective experiences point to the following common factors that helped support sustainability:

- Investment in and commitment to strong, broad-based collaboration that enabled partners to share the financial and other resource needs.
- Early, proactive, and formalized sustainability planning inclusive of all major stakeholders. Sustainability needs to be discussed at program inception and remain a priority throughout program implementation. Key partners who are not included at the outset may be difficult to engage later when there is greater sense of urgency.
- Demonstrated effectiveness in serving families and positive child, adult, and family outcomes as well as documented cost savings. Programs that have a long duration of services (e.g., 12 months or more) may be challenged with securing sufficient participant data in a timely enough manner for productive sustainability discussions. In such cases, partnerships need to identify and provide stakeholders with meaningful short-term outcomes data, if possible.
- The ability to develop new or modify existing billing or contract structures to support the provision and reimbursement of RPG services.

- Extensive and resourceful program marketing and information dissemination to key stakeholders, potential funders, and the larger community to demonstrate how the program changed families' lives. Consider that 73.3 percent of grantees expected to sustain their current model actively marketed and disseminated program outcomes, compared to 41.7 percent of those able to sustain a scaled down version or only specific components.
- Key program and policy leadership, including support from the state legislature. While collaborative relationships and connections are essential to sustainability (refer to Lesson 2), they alone are not sufficient. Grantees note there needs to be clear and consistent leadership and direction; someone who assumes overall responsibility to lead sustainability efforts and follow up on the tasks outlined in the plan.
- A detailed sustainability plan with concrete action steps. In addition, partnerships also must have the flexibility to modify and revise their sustainability plans in response to political, fiscal, leadership, and other contextual changes.

Lesson 11: The Larger Economic and Fiscal Environment has a Notable Impact on Collaborative Service Delivery and Sustainability Planning Efforts

Grantees reported the challenging fiscal climate that persisted throughout the grant period adversely affected their regional partnerships' services and outcomes. They noted state and county budget cuts reduced substance abuse treatment capacity, affected child welfare staffing patterns, impacted contract service dollars, and reduced the level and type of available community support services (outside of RPG-funded services) on which grantees' clients rely.

The Great Recession started in 2007, the year the RPG Program was implemented. Though the recession ended in 2010 and states are beginning to recover, the negative effects of the recession still linger. Acknowledging these contextual impacts is important in understanding grantees' progress and challenges and in interpreting the RPG child, adult, and family outcomes:

- Since 2008, at least 46 states (including 27 of the 29 RPG states) plus the District of Columbia enacted budget cuts that affect services for children and families.⁶⁰
- Thirty-one states (including 19 of the 29 RPG states) addressed budget shortfalls for the fiscal year that began July 1, 2012.⁶¹
- By 2011, 27 states had child poverty rates of 20 percent or more; 18 (66.7 percent) of these are states in which the RPGs are operating. Five of the eight states with the highest increases in child poverty rates from 2007 to 2011 are RPG states.⁶²

⁶⁰ Johnson, N., Oliff, P. & Williams, E. (February 9, 2011). *An Update on State Budget Cuts*. Washington, DC: Center on Budget and Policy Priorities.

⁶¹ Oliff, P., Mai, C. & Palacios, V. (June 27, 2012). *States Continue to Feel Recession's Impact*. Washington, DC: Center on Budget and Policy Priorities.

- From 2007 to 2012, the number of children living with long-term (six months or longer) unemployed parents increased by 278 percent nationwide; in the RPG states, the rate of increase was 300 percent.
- Between 2007 and 2012, the number of people receiving nutrition assistance benefits grew by 77 percent (approximately 20.2 million people); for RPG states, the growth rate was 89 percent.⁶³

The grantees' experiences mirror this larger national context. During the grant period, more than three-fourths (79.2 percent) said the community's broader economic climate affected their RPG program and target population. More specifically, close to half (47.2 percent) cited unemployment and shortage of jobs as a key community contextual event and 39.6 percent mentioned housing issues. For many of the RPG programs, particularly the family drug courts, these conditions (e.g., the inability to find a job or stable housing) made it difficult for participants to meet the criteria to graduate and reunify with their children.

During the grant period, nearly all grantees (88.7 percent) reported that budget cuts and/or staff layoffs affected their projects. The percentage of grantees impacted increased from two-thirds (66.0 percent) in program year two, to a high of 83.0 percent in year four, before decreasing to 44.2 percent in the final program year. For most grantees, cuts persevered throughout the grant period. In addition, well over half (56.6 percent) of grantees were impacted by agency reorganizations during the grant period.

Specifically, during the last two years of the grant period, more than half (55.1 percent) of the partnerships reported reductions or changes in child welfare staffing and/or cuts in available child welfare services. More than one-third (34.7 percent) reported reductions or changes in substance abuse treatment staffing and/or substance abuse treatment services. Moreover, 57.1 percent also reported reductions or changes in other agency staffing (e.g., mental health, courts) and/or other available clinical and community support services (e.g., mental health services, housing, child care).⁶⁴

For one grantee, some type of significant community and contextual event emerged at least once a year, every year throughout the grant. These events ranged from political and economic disasters to natural disasters (e.g., hurricanes, flood). Despite this, the RPG team remained hopeful and persevered. They worked through these challenges to achieve positive outcomes for their families.

⁶² Prior to the recession, 14 states had high child poverty rates. Isaacs, J.B. and Healy, O. (2012). *The Recession's Ongoing Impact on Children, 2012: Indicators of Children's Economic Well-Being*. Washington, DC: Urban Institute and First Focus.

⁶³ Isaacs and Healy (2012).

⁶⁴ Percentage is of 49 grantees; includes six three-year grantees that had no-cost extensions through program year four.

The Far Reaching Impact of Budget and Staff Cuts

More than two-thirds (67.3 percent) of grantees reported these reductions and changes decreased collaborative activities or collaborative service delivery. For example, partners had less time or inclination to participate in sustainability planning or cross-systems training. They made fewer referrals or had to reassign front-line staff that worked with RPG families.

Other significant and related ways in which the grantees said the fiscal environment affected their collaborative partnerships, service delivery, and families' progress are noted below:

- Less overall child welfare involvement, monitoring, and communication about RPG families. Child welfare workers had increased caseloads and responsibilities, and less time for case management, multidisciplinary team meetings, and related service activities.
- Decreased RPG program referrals as primary referral sources closed or reorganized, or new partnering agency staff lacked knowledge about the RPG services and supports. Turnover of key stakeholders required extensive time to orient new personnel to the program model and the importance of the collaboration (see also Lesson 9).
- A less experienced workforce to deal with what many grantees described as a more complex and harder to serve population.
- Delays in permanency and other decisions regarding families' cases, as new workers needed time to familiarize themselves with families' situations.
- Less support for visitation, transportation, drug testing, housing, employment, child care, and other critical support services. Programs in more rural areas seemed to be especially hard hit. The partnerships used many of these direct and contracted child welfare services to help families successfully complete the RPG programs. With child welfare agencies cutting many of these service contracts, grantees had to identify other community-based service providers to work with or reallocate their existing RPG funding.
- Reduced scope or level of services and/or delays or waitlists for families receiving services (particularly substance abuse treatment). Participants may have received interim services, but often not at the recommended level of care or intensity to treat their substance use disorders and address their current needs.
- Less consistency in both staffing and services for families during the course of their child welfare case.

In one site, all partners experienced budget cuts during the grant period, with the child welfare agency making cuts every year. Towards the end of grant, the child welfare agency significantly reduced referrals to the RPG program and began to close out or transition cases, particularly for intact family services. The child welfare agency determined that contracted agencies (rather than the child welfare agency) would instead provide these services. However, the new contract providers stated they would not be compensated for participating in multidisciplinary case staffing and other collaborative efforts the partnership had established. For families still in the RPG program, this meant challenges with transitions, sharing of information, and ensuring they continued to receive the services needed to sustain their progress.

Despite the economic and fiscal environment, the regional partnerships created opportunities to strengthen collaboration and communication. As discussed in Lesson 2, even if grantees were unable to sustain certain interventions, they did sustain their overall collaborative processes. In some sites, budget cuts provided a springboard for robust communication between RPG programs and key stakeholders. These grantees found ways to mitigate the fiscal environment's impact on their collaborative partnerships and service delivery. In several cases, the partnerships stepped up in the face of agency budget cuts to fill critical service gaps (e.g., transportation) and staffing needs (e.g., assisting with treatment groups or case conferencing). One family drug court responded to cuts in county mental health services by contracting with local service providers to provide their RPG clients with needed individual therapy to facilitate positive outcomes.

Early in program year five, one site reported significant staff turnover in child welfare's dedicated family-based services, with 74 of the 97 investigator slots left vacant. The grantee reported that because the child welfare director was fully committed to the RPG family drug court, he expedited hiring for these vacant positions. The grantee stated this was a significant departure from prior experience, when positions remained vacant for extended time periods or were completely frozen.

Sustainability Planning in a Challenging Economic Environment

Grantees repeatedly emphasized the difficulty of planning for sustainability in the given economic and fiscal climate. They recognized funding commitments for their RPG project models cannot be made in isolation and must come after other internal budget and planning decisions. Grantees noted they began the grant project fully aware of the critical need to develop sustainability plans as early as possible. However, they did not anticipate how drastic the economic downturn would be at both the state and local levels.

As one grantee explained, "At the start of the grant award, the collaborative was fully aware of the critical need to develop a sustainability plan as early as possible in order to promote long lasting change for both partnering agencies and clients. However, no one could predict the degree to which the economic downturn would affect funding, resources, and policies at both the state and local level. Due to budget cuts across the social services landscape, it became evident that options were limited in terms of raising the funds necessary for sustaining [RPG] program services beyond the award period."

The majority (86.8 percent) of all grantees reported that federal, state, and county budget cuts were one of the most significant barriers to their sustainability planning at some point during the grant period. The percentage experiencing this major sustainability challenge rose steadily over the course of the grant: from 35.6 percent in program year two, to 69.8 percent in year three, and reached a high of 76.6 percent in year four. In program year five, it subsided to 48.8 percent, as some states' fiscal outlook improved.

Grantees highlighted, in particular, difficulty with engaging state agencies and other key stakeholders in sustainability discussions. While local partnerships may have felt a sense of urgency in sustaining their activities, they reported the state agencies often did not. Grantees described state agencies as being in “survival mode,” focused on budget solutions and immediate day-to-day operations.

In addition, changes in state agency leadership (due to turnover or retirements) were often problematic for grantees. The relationships and support they had cultivated with key decision makers gave way to uncertainty as new leaders came in. This type of environment made it difficult to engage others in discussions about longer-term outcomes, the benefits of sustaining or expanding programs, redirection of funds, or how to absorb the RPG services and functions (see Lesson 10 about the importance of integration).

Grantees stressed the importance of being strongly connected to state child welfare, substance abuse treatment, and other key systems to monitor budget, policy, and practice changes that could affect RPG services. As one grantee recommended to others, “Keep state and local leaders informed, understand the politics, and understand what drives decisions.” Grantees also cited the need for continued outreach to engage key stakeholders, strengthen and maintain their program's visibility, and disseminate information on their positive outcomes.

The Child Welfare Policy Environment

In addition to fiscal challenges throughout the five-year grant period, child welfare systems around the country enacted various policy reforms at the state and county levels that changed the nature of child welfare caseloads. In general, child welfare systems are increasingly providing front-end services to help keep families together and prevent removal of children. As a result, the number of children who entered foster care decreased from 307,000 in 2005 (its highest point) to 252,000 in 2011.⁶⁵ However, while annual decreases in the number of children entering foster care ranged from 12,000 to 20,000 between 2006 and 2009, the number did not change from 2009 to 2010 and decreased by 3,000 from 2010 to 2011.

⁶⁵ Administration for Children and Families. *Trends in Foster Care and Adoption – FY 2002 to FY 2011*. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/trends_fostercare_adoption.pdf. In addition, several states and counties (Florida, Ohio, Oregon, and two California counties) have attributed the implementation of IV-E flexible funding waivers to large reductions in their foster care populations. Casey Family Programs (2010). *Ensuring Safe, Nurturing and Permanent Families for Children: The Need to Reauthorize and Expand Title IV-E Waivers*. Seattle, WA: author.

Changes in child welfare trends also are evident in the increase in alternative response cases, from 205,571 in 2006 to 361,907 in 2011.⁶⁶ Further, in 2011, 9.8 percent of the approximately 2 million reports referred to child protective services for an investigation had a disposition of alternative response,⁶⁷ compared to 9.2 percent in 2010.⁶⁸

These larger contextual changes affected grantees at the local level. During the course of the grant, 45.3 percent of grantees said changing child welfare trends in their target geographic areas affected program referrals and client engagement. Most notably, these trends included a shift to alternative or differential response cases in which families (including those with closed child welfare cases) may choose to participate in RPG services voluntarily.

For some partnerships, voluntary cases were included as part of their original target population. However, most grantees had to adjust and expand their population(s) served to include these types of cases. Grantees that served alternative or differential response families often struggled with engaging families and having them voluntarily participate in and complete the RPG programs, particularly those with lengthy (e.g., 9 to 12 months) or more intensive (e.g., residential) services.

As grantees increased outreach and engagement of voluntary cases, they found a need for increased communication and collaboration with child welfare, in particular regarding when to close cases. To address substance abuse issues in voluntary cases, grantees also noted the core RPG partners, in the absence of judicial oversight, must collaborate to reinforce with parents the expectation and importance of successful treatment completion. Grantees continued to work through these issues during the course of the grant. Yet the impact was not all negative. One grantee stated that differential response facilitated collaboration, as families became less wary of child welfare involvement and community providers were more apt to share client information with project staff without fearing families would be immediately separated.

As previously stated, these (and other) community and contextual impacts are important to keep in mind when considering the RPG child, adult, and family outcomes presented in Chapters VI through X. The grantees' performance measure results are all the more impressive given the many external obstacles that occurred during the majority of the grant period. Given the collaboratives' strength, resilience, perseverance, and commitment to families, they were largely able to respond and adapt to these significant challenges.

⁶⁶ U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2012). *Child Maltreatment 2011*. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

⁶⁷ Aveni, M. and Zikratova, L. (February 7, 2013). *Child Maltreatment 2011: Key Findings and Additional Analyses*. Webinar presented by the Administration on Children, Youth and Families, Children's Bureau.

⁶⁸ Yuan, Y. and Aveni, M. (March 26, 2012). *Child Maltreatment 2010: Key Findings and Additional Analyses*. Webinar presented by the Administration on Children, Youth and Families, Children's Bureau; available at: <http://nrccps.org/information-dissemination/child-maltreatment-data/child-maltreatment-2010-data/>.

CHAPTER IV: RPG PERFORMANCE MEASUREMENT APPROACH AND METHODOLOGY

INTRODUCTION AND OVERVIEW

The RPG Program authorizing legislation required that the Reports to Congress address the 23 measures established to assess grantees’ performance in the domains of Safety, Permanency, Recovery, Well-being (child, adult, and family), and Systems Collaboration (Table 12 below).⁶⁹

Table 12: Regional Partnership Grant Program Performance Measures

<i>Safety</i>
<ul style="list-style-type: none"> • Children remain at home: Percentage of children identified as at risk of removal from the home who are able to remain in the custody of a parent or caregiver through RPG case closure • Occurrence of child maltreatment: Percentage of children who had an initial occurrence and/or recurrence of substantiated/indicated child maltreatment within 6, 12, 18, and 24 months after enrolling in the RPG program
<i>Permanency</i>
<ul style="list-style-type: none"> • Average length of stay in foster care: For children discharged from foster care, their average length of stay (in days) from date of most recent entry into such care until date of discharge • Re-entries to foster care placement: Percentage of children returned home from foster care that re-entered foster care in less than 6, 12, 18, and 24 months • Timeliness of reunification: Percentage of children who were reunified in less than 12 months from the date of the most recent entry into foster care • Timeliness of adoption or guardianship: Of children placed in foster care, percentage of children who, in less than 24 months from the date of the most recent foster care placement, achieved: a) a finalized adoption or b) legal guardianship
<i>Recovery</i>
<ul style="list-style-type: none"> • Access to treatment: Percentage of parents or caregivers who were able to access timely and appropriate substance abuse treatment; number of days between program entry and treatment entry • Retention in substance abuse treatment: Percentage of parents or caregivers referred to substance abuse treatment who remained until treatment completion; average length of stay in treatment for referred parents or caregivers • Substance use: Percentage of parents or caregivers in substance abuse treatment who report a reduction in substance use, as measured by the number of days use in the past 30 days at treatment intake and discharge • Parents or caregivers connected to supportive services: Percentage of parents or caregivers who were assessed for and received supportive services that include: a) primary medical care, b) dental care, c) mental health, d) child care, e) transportation, f) housing assistance, g) parenting training/child development education, h) domestic violence services, i) employment/vocational education or training, j) continuing care/recovery support services, l) alternative therapies/natural healing practices, and k) other supportive services • Employment: Percentage of parents or caregivers participating in substance abuse treatment who are: a) employed full time, b) employed part time, and c) currently enrolled in an educational or vocational training program

⁶⁹ The 23 performance measures were established through a detailed legislatively mandated consultative process involving the Children’s Bureau, SAMHSA, the ACF Office of Planning, Research and Evaluation (OPRE), the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), the HHS Office of the Assistant Secretary for Resources and Technology (ASRT), and representatives of the regional partnership grantees. See the First Report to Congress (http://www.acf.hhs.gov/programs/cb/pubs/targeted_grants/targeted_grants.pdf) for a description of the consultative process.

Table 12: Regional Partnership Grant Program Performance Measures

<ul style="list-style-type: none"> • Criminal behavior: Percentage of parents or caregivers who show a decrease in criminal behavior, as measured by the number of arrests in the 30 days prior to treatment intake and discharge
<p>Child, Adult, and Family Well-Being</p> <ul style="list-style-type: none"> • Prevention of substance-exposed newborns: Percentage of pregnant women who had a substance exposed newborn (first or subsequent), as detected at birth • Children connected to supportive services: Percentage of children who were assessed for and received the following supportive services: developmental services, mental health or counseling, primary pediatric care, substance abuse prevention and education, substance abuse treatment, educational services, and other supportive services • Improved child well-being: Percentage of children who show an increase in socio-emotional, behavioral, developmental, and/or cognitive functioning • Adult mental health status: Percentage of parents or caregivers who show an improvement in mental health functioning • Parenting capacity: Percentage of parents or caregivers who demonstrate increased parental capacity to provide for their children’s needs and family’s well-being • Family relationships and functioning: Percentage of parents or caregivers who show improved parent-child and other family interactions • Risk and protective factors: Percentage of parents or caregivers who show a decrease in risk factors associated with reasons for service and/or an increase in protective factors to prevent child maltreatment
<p>Systems Collaboration</p> <ul style="list-style-type: none"> • Coordinated case management: Percentage of families who receive appropriate, coordinated case management services. Percentage of families who: a) report active involvement in various aspects of the case planning process, including identifying strengths, needs, and needed services, and establishing and evaluating progress toward goals, b) receive joint case management services coordinated between a substance abuse treatment provider and a child welfare agency, and c) receive a cross-agency assessment conference every 90 days or less • Substance abuse education and training for foster care parents and other substitute caregivers: Percentage of foster parents or substitute caregivers who received education and training about: a) addiction and substance abuse treatment, b) special needs of children who have experienced maltreatment and whose parents have a substance use disorder, and c) family recovery issues • Collaborative capacity: Regions have new or increased ability to address parental or caregiver substance abuse and its effect on children, as measured by increased cross-systems understanding and collaborative activities • Capacity to serve families: Regions have new or increased capacity to serve families in which a parent or caregiver has an identified substance use disorder and there is current or potential involvement with the child welfare system: a) percentage of regional partnership member agencies that increased the number of appropriate treatment programs for the targeted region, and b) among those partner agencies, increase in the number or percentage of families served or the number or percentage of treatment slots available in the targeted region

Given the variance and diversity in program-specific strategies and target populations across the 53 projects, grantees only reported on the RPG measures that aligned with their partnership’s activities, goals, and intended outcomes. Thus, the number of grantees reporting on each performance measure varied. Grantees were not required to report on all 23 measures.

Grantees submitted their case-level child and adult data to a web-based RPG Data Collection and Reporting System.⁷⁰ The RPG Data System links data for children and adults together as a

⁷⁰ During the first year of the RPG Program, HHS (with the Office of Management and Budget approval) developed an extensive web-based RPG Data Collection and Reporting System to compile indicator data across all 53 grantees. Grantees began submitting their data to the RPG Data System in December 2008 and then uploaded their latest cumulative data files in June and December of each program year. Their final data upload was in December 2012.

family unit and follows clients served over the course of the grant project, making it the most extensive quantitative dataset currently available on outcomes for children, adults, and families affected by substance abuse and child maltreatment.

There also was variance in grantees' local project evaluation approaches, as sites had responsibility for developing their own evaluation plans responsive to their overall program approach and model, specified outcomes, and local community context. HHS encouraged, but did not require, grantees to include a control or comparison group in their evaluation design. HHS did note if a comparison group was not proposed, the applicant was to provide "a reasonable explanation for not using a comparison group and offer another, equally rigorous approach to evaluating the influence of the strategy/intervention on outcomes."

Those grantees with a comparison group had the discretion to identify and select what they deemed an appropriate comparison group based on their program models, target populations, and availability of comparison data. As indicated below, some grantees matched their comparison group with children and families receiving RPG interventions on key characteristics. Other grantees proposed only unmatched comparison groups. Thus, grantees' local evaluations varied in planned rigor, from descriptive studies that focused on implementation to randomized controlled trials of family and child outcomes. See the next section for more information on grantees' evaluation designs.

Due to the flexibility and discretion that HHS allowed grantees in developing both their program models and local evaluation designs, assessment of the overall RPG Program's progress (for this initial five-year grant period) was not designed as or intended to be a cross-site evaluation.⁷¹ A cross-site evaluation that allows HHS to test for and establish a definitive causal link that attributes improvements in child, adult, and family outcomes to the RPG initiative was not appropriate given the original grant program design.

A cross-site evaluation involving the 53 grantees was not appropriate given the original grant program design, which allowed for differences in program models and local evaluation designs. However, despite the variation, HHS was able to capture the full breadth, depth, and scope of grantees' programs and cross-systems collaborative progress using a mixed-methods research design that included qualitative process evaluation data as well quantitative performance measures.

HHS implemented a performance measurement approach to track grantees' ongoing progress against program goals and identify how grantees modified their programs as they learned what worked and what needed strengthening (see Chapters II and III). This mixed-methods approach used multiple quantitative and qualitative data sources to provide a comprehensive descriptive and analytical picture of the 53 grantees' performance. (See Appendix A for a full description of the RPG Program data sources.)

⁷¹ The Child and Family Services Improvement and Innovation Act (P.L. 112-34) of 2011 reauthorized a second round of regional partnership grants for fiscal years 2012 to 2016. HHS is conducting an enhanced cross-site evaluation with this second round of 17 grantees and will publish an evaluation report for those grants in December 2017.

The qualitative and quantitative information collected across all program sites produced a more in-depth understanding of grantees’ progress than may be found in individual project evaluations. Through this five-year performance measurement approach, HHS used all of the information to assess progress toward the broad, common RPG Program goal: “To increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse.”

To guide the performance measurement, HHS developed a comprehensive program logic model to illustrate the interrelationships between specific RPG program activities and services and the safety, permanency, recovery, well-being, and systems collaboration performance measures. The logic model (see Appendix B) served as a conceptual framework for the data analyses and testing relationships between specific program services and outcomes.

OVERVIEW OF GRANTEES’ LOCAL PROJECT EVALUATION DESIGNS

As stated above, HHS did not specifically require grantees to include a control or comparison group; grantees had responsibility for evaluating their own projects in relation to their own objectives. As Table 13 shows, 4 grantees (7.5 percent) implemented an experimental research design with a randomized control group, while the majority of grantees, 38 or 71.7 percent, implemented a quasi-experimental research design. Of the 38 grantees with a quasi-experimental design, more than half (21 grantees) implemented a same time comparison group and the remaining 17 grantees implemented a historical comparison group. The final 11 grantees (20.8 percent) had pre-experimental designs with no comparison group.

Table 13: Grantee Research Designs		
Type of Research Design	Number of Grantees	Percent of Grantees
Experimental Treatment with Randomized Control Group	4	7.5%
Quasi Experimental Treatment with Comparison Group	38	71.7%
<i>Same Time Comparison Group</i>	21	55.3%
Matched Population Level Same Time Comparison	8	21.1%
Matched Case Level Same Time Comparison	10	26.3%
Unmatched Same Time Comparison	2	5.3%
Aggregate Same Time Comparison	1	2.6%
<i>Historical Comparison Group</i>	17	44.7%
Matched Population Level Historical Comparison	5	13.2%
Matched Case Level Historical Comparison	4	10.5%
Aggregate Historical Comparison	6	15.8%
Unmatched Historical Comparison	2	5.3%
Pre-Experimental Treatment With No Comparison Group	11	20.8%

Grantees with a control or comparison group implemented different methodologies for obtaining these data.⁷² Given the variation in grantees' use of comparison groups in their evaluation designs, there were statistically significant differences between these grantees' participant (i.e., treatment) and control/comparison groups on several key child and adult demographic characteristics. Due to the differences in grantees' comparison group populations, HHS did not conduct statistical tests of significance between aggregate RPG Program participant and control/comparison groups on the performance measures for this final report.

Rather, this report highlights descriptive statistics for each performance measure, with a primary focus on grantees' RPG participant group results. However, if a subgroup of grantees submitted sufficient control/comparison group data on a given measure, a brief summary of those comparison group findings also is provided. This supplemental descriptive information offers additional contextual data on grantees' performance in relation to their own control or comparison groups.⁷³

To provide additional context for understanding RPG Program performance, national child welfare data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS) and national substance abuse data from the National Outcomes Measures (NOMs) and Treatment Episode Data Set (TEDS) are provided, where appropriate and available. (See Appendix E for a brief description of these existing data systems.) These state contextual subgroup data represent the 29 states in which the RPGs are operating. The state contextual data are not intended to serve as a comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants.

RPG PERFORMANCE MEASUREMENT METHODOLOGY, ANALYTIC APPROACH, CAVEATS, AND LIMITATIONS

The following section outlines the RPG performance measurement methodology, analytic approach, and important data caveats and limitations. As discussed briefly below, the data collection and reporting process and the methodological approach to calculating and analyzing the performance measure results varied by outcome domain.

Safety, Permanency, and Recovery Outcomes

The majority of the 12 performance measures that comprise the Safety, Permanency, and Recovery outcome domains (refer to Table 12 above) align with existing standardized performance measures in federal child welfare and substance abuse treatment outcome reporting systems (e.g., AFCARS, NCANDS, TEDS) and thus exist in a state or county's automated child welfare and substance abuse treatment data systems. Each grantee submitted standardized case

⁷² The proposal review criteria in the RPG Program Announcement stated that an applicant's comparison group (if applicable) and program treatment group should be assigned at random or matched on key characteristics, and if not, the applicant should provide a reasonable explanation of how it will identify and address pre-existing differences between the comparison group and treatment group.

⁷³ For the overall descriptive findings presented for each performance measure, all grantees' participant (i.e., treatment) group data were combined. The additional analyses involving subgroups of grantees with control or comparison group data on selected measures were limited to grantees with a sample size of 35 or more for both their participant and comparison/control groups.

level client demographic information and the required data elements to calculate these measures in a uniform file format to ensure consistency across grantees.⁷⁴ Data quality and consistency was increased further by two immediate levels of automated quality assurance checks that addressed invalid coding (e.g., a date that has not yet occurred) and potential relational inconsistencies or errors (e.g., a substance abuse assessment that took place after substance abuse treatment entry instead of prior to treatment admission).

For each measure, RPG participant group data were aggregated across grantees and analyzed using IBM SPSS software. Data analyses for this report (see Chapters VI–VIII) included:

- Basic descriptive statistics (e.g., frequencies, means, median, and ranges) on the performance measures for the RPG participant groups. As explained above, statistical tests of significance between grantees' aggregated participant and comparison groups on the performance measures are not presented due to differences in demographic characteristics between the groups and varying local evaluation designs.
- Performance measure findings by selected child and adult demographics (e.g., age, gender, race/ethnicity, program year) for the RPG participant groups.
- National contextual child welfare and substance abuse treatment data (e.g., AFCARS, NCANDS, NOMs, TEDS) for the states in which the RPGs are operating, where appropriate and available.⁷⁵ The state contextual subgroup data do not serve as a true real-time comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants. However, as previously stated, they provide additional context for understanding grantees' performance measure results.

Qualifications are needed in reviewing such a large and complex data set that represents 53 grantees that implemented different program models and strategies and served diverse target populations. Still, these data provide an unprecedented opportunity to assess the projects on child welfare and substance abuse performance measures. Listed below (Table 14) are several important caveats to consider when reviewing the performance measure analyses. More detailed data analysis, interpretation, and clarification issues are included within each performance measure discussion and in Appendix F.

⁷⁴ A few grantees were only able to collect aggregate rather than case-level data for their comparison groups. The analyses excluded these aggregate data. Refer to the Second Report to Congress (http://www.cffutures.org/files/RPG_Program_Second_Report_to_Congress.pdf) for additional information on the data submission process.

⁷⁵ For the applicable child indicators, RPG participant data are presented in relation to the median performance (50th percentile) based on the states' 2011 AFCARS and NCANDS data. For the applicable adult indicators, RPG participant data are presented in relation to the RPG states' 2010 TEDS or NOMs data.

Table 14: Safety, Permanency, and Recovery Performance Measure Data—Important Caveats and Limitations

- ***The RPG Program Performance Measurement was not designed as a cross-site evaluation.*** A cross-site evaluation requires that all sites in a given project implement the same model and seeks to answer if that particular model is effective across all sites and can be replicated. The RPG findings presented in this report represent 53 grantees that had the same overarching project goals (to improve child, adult, and family outcomes), but did not implement or test the same set of services, interventions, or program models.
- ***Grantees implemented different methodologies for obtaining control or comparison group data, if applicable to their project.*** HHS did not specifically require grantees to include a control or comparison group in their local evaluation design. The 42 grantees that collected control or comparison group data had the discretion to identify and select what they deemed an appropriate control or comparison group. As the RPG Program was not designed as a cross-site evaluation, attempts to define and control for site variability at the grantee level were not required and were beyond the scope of the analyses.
- ***The results presented in this report may differ from prior interim findings.*** During the course of the project, grantees uploaded an updated, cumulative data file every six months, with a final data set submitted at the end of the grant. The overall results in this final report may differ somewhat from the interim trends presented in prior reports to Congress, as the number of children, adults, and families that grantees served increased and grantees provided more complete data for their final data uploads.
- ***Contextual and community factors may have impacted grantees' outcomes.*** The 53 regional partnerships operated within broader communities and systems of care. As such, the partnerships, programs, and families served were impacted by local conditions including the service array available in different communities and the current economic environment. State and county budget constraints and reductions impacted the grantees in important ways (see Chapter III). These conditions persisted for the duration of the RPG Program.
- ***National child welfare and substance abuse treatment outcomes provide important contextual perspective, but may reflect a broader population of children and adults than the RPG families.*** National child welfare (e.g., AFCARS, NCANDS) and substance abuse treatment (e.g., NOMs, TEDS) data are instructive in helping understand RPG performance within the broader context of these systems' performance measures. Yet it is important to recognize families in the RPG programs likely represented more difficult or complex cases (e.g., significant co-occurring substance abuse and mental health disorders including trauma and domestic violence, long histories of child welfare involvement, multiple risk factors compounded over time) than all child welfare cases or substance abuse treatment admissions represented in the state-level data. Further, the state contextual data are not intended to serve as a comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants, as these data do not reflect random assignment or matched characteristics of RPG participants.

Child, Adult, and Family Well-Being Outcomes

The Child, Adult, and Family Well-Being outcome domain includes seven performance measures (refer to Table 12). Data collection and analysis for two of these measures (prevention of substance-exposed newborns and children connected to supportive services) is similar to that of the safety, permanency, and recovery measures outlined above. Each grantee submitted standardized case-level information to calculate these measures in a uniform file format. Basic descriptive statistics were analyzed and are presented in Chapter IX.

Current state and county child welfare or substance abuse treatment data systems do not include standardized data elements for the other five well-being measures: child well-being, adult mental health, parenting capacity, family relationships and functioning, and risk and protective factors. Grantees assessed these five measures using valid and reliable clinical instruments they identified as appropriate for their specific program model and target population. HHS did not require grantees to use specific clinical instruments or the same instruments to measure these indicators. Therefore, there was variability among grantees in which instruments they selected, how they used them, and the specific data variables they collected.

Across all grantees, more than 50 different instruments were used to measure these concepts. In addition, grantees often used more than one instrument or method to measure a child's, adult's, or family's progress. Further, given the interrelated nature of the well-being measures, grantees often assessed multiple measures with the same instrument (though they may have used a specific subscale or domain for a given well-being measure). Thus, a particular instrument may cut across multiple well-being measures.

Among the myriad of instruments grantees used, HHS identified nine of the most commonly selected⁷⁶ valid and reliable instruments expected to yield sufficient sample sizes over the course of the grant period for analysis:

- Addiction Severity Index (ASI)
- Adult-Adolescent Parenting Inventory-2 (AAPI-2)
- Ages and Stages Questionnaire (ASQ)
- ASQ Social-Emotional (ASQ-SE)
- Beck Depression Inventory
- Child Behavior Checklist (CBCL)
- North Carolina Family Assessment Scales (NCFAS, NCFAS-G, NCFAS-R, and NCFAS G+R)
- Parenting Stress Index (PSI)
- Protective Factors Survey

Thirty-five grantees used one or more of these nine instruments. Grantees submitted case-level data files containing the instrument-specific scores for specified administration time points. While most grantees administered instruments to clients at RPG entry (i.e., baseline) and discharge, some also conducted interim or post-discharge follow-ups. Each of the case-level instrument-specific data files were standardized across grantees (i.e., made consistent in submission of data elements and format) and combined into a uniform database for each of the

⁷⁶ Instruments selected by three or more grantees.

nine specified instruments. Grantees using other instruments or methods to assess well-being reported findings in their Semi-Annual Progress Reports, local evaluation reports, and/or Final Progress Reports.

Analyses for these five well-being measures (see Chapter IX) included:

- Descriptive statistics to obtain overall instrument and/or subscale score means
- Descriptive statistics to provide a snapshot of RPG children and adults at baseline (where available)
- Multivariate analyses of variance to test for improvements from baseline to discharge

Due to insufficient comparison group sample sizes,⁷⁷ well-being analyses for this report were limited to the RPG participant group data. Norm data or empirical research on use of an instrument in the general population is included in Appendix G for comparative context when available.

Grantees submitting instrument-specific data to measure well-being identified several key methodological issues to consider when interpreting these data and for future analyses (see Table 15 below). More detailed data analysis, interpretation, and clarification issues are included in Chapter IX and Appendix F.

⁷⁷ Grantees' ability to collect and report comparison group data for the well-being measures was more limited because it required significant primary data collection efforts. In contrast, grantees largely obtained comparison data on the standardized child and adult measures through existing administrative data sets.

Table 15: Child, Adult, and Family Well-Being Performance Measure Data—Important Caveats and Limitations

- **The data represent a small subset of all grantees reporting these measures.** The well-being data presented encompass a limited number of grantees that selected one or more of the nine identified instruments. Additional grantees used other clinical instruments and methods to measure these indicators and reported findings in their Semi-Annual or Final Progress Reports or local evaluation reports. Because the subset of grantees that selected the identified instruments represents a small percentage of all children, adults, and families served by the larger RPG Program, these data must be interpreted with caution and cannot be generalized to the whole RPG population.
- **The data analyses align with HHS’s overall performance measurement approach, which does not control for site variability at the individual grantee level.** As previously stated, HHS used a performance measurement approach to review grantees’ progress. As HHS did not design or intend to conduct a cross-site evaluation of the overall RPG Program, attempts to define and control for site variability at the grantee level were not required and beyond the scope of the analyses. The well-being data analyses presented are appropriate and align with HHS’s overall performance measurement approach. Appendix F provides supplementary statistical results to test whether certain results varied by individual grantee.
- **Differences in intended use of instruments.** HHS did not require grantees to use specific clinical instruments or the same instruments to measure these indicators. Thus, there was variability among grantees regarding which instruments they used and how they used them. Some grantees reported they used their instruments for evaluative purposes (i.e., to provide data for the performance measure), while others used their selected instruments (e.g., the ASQ and ASQ-SE) more as a screening or assessment tool to help inform treatment and service provision.
- **Limitations in measuring complex constructs with a single instrument.** Many grantees indicated they did not rely on only one instrument to assess such complex constructs as child well-being, adult mental health, parenting capacity, family relationships and functioning, and risk and protective factors. Rather, they used a given instrument in combination with other instruments or methods to provide a more comprehensive measure of a given well-being construct.
- **Capacity of instruments to measure change given variation in the duration of overall RPG programs and individual services within a RPG program.** Not all instruments selected may be sensitive enough to detect change given the variation across grantee programs in length and intensity of services. As such, administration of the instruments, in particular at discharge or interim follow-up points, differed for clients, depending on the grantee, duration of specific RPG interventions, and program model. Further, some constructs such as adult depression or child developmental status may be harder to affect than other constructs such as social support or parenting behaviors. In such cases, the duration of the intervention needs to be sufficient for the selected instrument to detect change.
- **Severity and complexity of RPG clients’ needs and variation in target populations.** Grantees targeted at-risk populations with many co-occurring issues and complex needs. The clinical severity of the grantees’ populations is evident in many of the baseline instrument scores presented in the report. Grantees have noted that some clients’ behaviors or problems may be so complex or severe that the instrument may not capture change or significant progress in the timeframe they received RPG services, even though the client showed signs of improvement while in the RPG program. In addition, the target populations served and complexity of client needs may be dramatically different among grantees that used the same instrument. This may reduce the effects of targeted program services on these measures across grantees and can affect the interpretation of baseline and change scores.

Systems Collaboration Outcomes

The Systems Collaboration outcome domain (Chapter X) focuses on four performance measures that reflect grantees' efforts to strengthen collaborative practice among the substance abuse treatment, child welfare, court, and other service systems and increase their capacity to serve families. Grantees reported on two of these measures (coordinated case management and substance abuse education and training for foster care parents and other substitute caregivers) in their Semi-Annual Progress Reports. Basic descriptive statistics are provided for these two measures.

All grantees measured collaborative capacity (the third performance measure in this domain) using the Collaborative Capacity Instrument (CCI). The CCI is a reliable and valid self-assessment tool that measures the 10 key elements of cross-systems linkages outlined in Chapter III. Grantees completed a baseline CCI in program year one, an interim CCI in the program year three, and a final CCI in program year five. Data were aggregated across grantees and analyses included basic descriptive statistics and significance tests to assess changes in collaborative capacity from baseline to follow-up administrations.

For service capacity (the fourth measure in this outcome domain), HHS assessed the extent to which grantees met their own projections for the total number of children and adults to be served by their projects. Please refer to Chapter X for additional information.

Presentation of Performance Measure Results

Chapters VI through X present the performance measure results for participants served over the course of the RPG Program (September 30, 2007 to September 30, 2012). The discussion of each RPG performance measure includes:

- Key findings or highlights from the data analyses
- Summary table(s) with overall results for RPG Program participants
- State contextual child welfare and substance abuse data for the states in which the RPGs are operating (where appropriate)
- Brief descriptive summary results for grantees with a control or comparison group
- Pertinent background or contextual information related to the measure's definition or calculation (where needed)
- Noteworthy data analysis, interpretation, and clarification issues

SUMMARY

The RPG Program used a number of qualitative and quantitative data sources to provide a comprehensive descriptive and analytical picture of the 53 grantees' performance. Chapter III highlighted qualitative results of grantees' collective progress in meeting families' needs through cross-systems collaborative efforts. Chapter V provides a brief descriptive profile of the children

and adults who have received RPG services, while Chapters VI through X present the safety, permanency, well-being, recovery, and systems collaboration program outcomes.

A cross-site evaluation study that allows HHS to test for and establish a definitive causal link that attributes improvements in child, adult, and family outcomes to the RPG initiative was not appropriate given the original program design (for this initial grant period). However, as the broadest cross-systems performance measurement effort of its kind to date, these results provide an essential foundation for examining the RPG Program's potential to build capacity to serve families, achieve systems and organizational changes, and achieve desired outcomes. Further, through the multiple quantitative and qualitative data sources used, it is possible to describe how the grantees' efforts have affected program outcomes. As a result, HHS is able to draw valuable programmatic and evaluation lessons learned to inform future efforts to serve these families.

CHAPTER V: RPG PROGRAM PARTICIPANT PROFILES

Over the course of the initial five-year grant period, the 53 regional partnerships served 15,031 families including 25,541 children and 17,820 adults (Table 16). Grantees reported a number of core demographic variables that describe the population served by the RPG Program and provide context for understanding the RPG performance measures. This chapter provides a descriptive profile of children and adults served across all 53 grantees. The chapters that follow (VI through X) summarize grantees' performance measure results.

Children	25,541
Adults	17,820
Families	15,031

GENERAL INFORMATION ABOUT FAMILIES SERVED BY GRANTEES

Summary of Findings

- The average number of RPG participant families served per grantee was 284, ranging from a low of 62 to a high of 1,886. This broad range reflects the diversity of the 53 grantees' program models, geographic regions served, and target client populations. For example, three-year grantees and those sites providing a more intensive residential program with a longer duration of services served a more limited number of families than grantees operating multiple sites or larger scale programs.
- Of the families served and for whom RPG program case closure information was available, 83.9 percent had been discharged from the RPG program by the end of the grant period, while 16.1 percent were still active cases and receiving RPG services.⁷⁸ Grantees could still be serving some families beyond the grant period because they sustained their program or they received a no-cost extension or two-year extension grant.
- Among discharged families, the mean duration of services was 251 days or 8.2 months.⁷⁹ However, 14 of the grantees provided services to families, on average, for more than a year.

⁷⁸ Analysis excludes two grantees whose program models do not fit this type of analysis. One grantee provides primarily prevention (not intervention) services; the other grantee's model is more fluid and individuals within the same family may re-enter the program at different and multiple points over time.

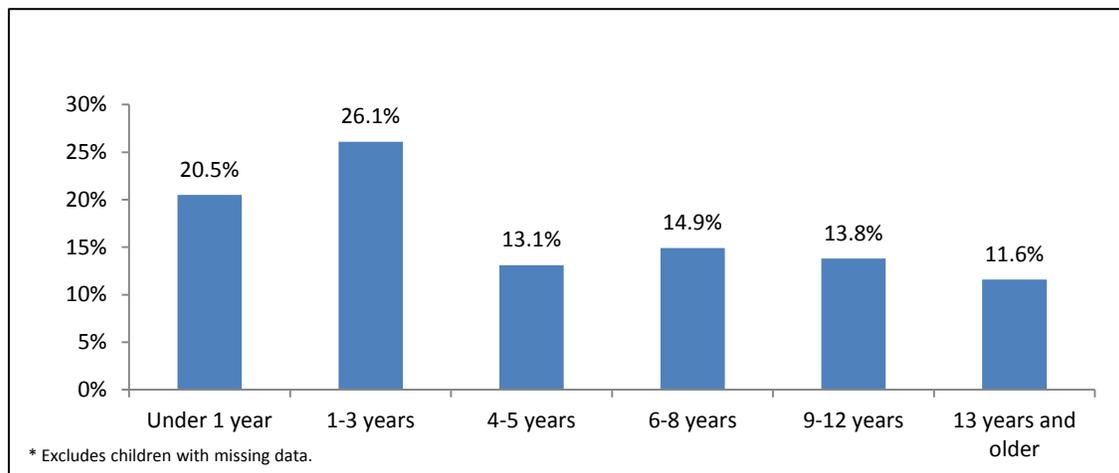
⁷⁹ A family may include multiple adults and/or children. Duration of services is for 9,739 closed cases; excludes 646 cases missing data needed to determine duration of services. These data include all program discharges, whether successful or unsuccessful. The RPG Data System does not include detailed information on a family's RPG program discharge status (only on an individual's substance abuse treatment discharge status). However, grantees may be collecting and reporting this information in their local project evaluations.

CHILD DEMOGRAPHIC DATA

*Summary of Findings*⁸⁰

- Grantees served approximately equal numbers of girls and boys.
- On average, the 24,042 children for whom age data were available were 5.7 years of age at RPG enrollment. Yet well over half (59.7 percent) were aged 0 to 5 years. As Figure 4 below shows, one-fifth (20.5 percent) were infants less than 1 year old; approximately one-fourth (26.1 percent) were 1 to 3 years old; and 13.1 percent were aged 4 to 5 years. Among school-aged children, 14.9 percent were aged 6 to 8 years, 13.8 percent were aged 9 to 12 years, and the remaining 11.6 percent were 13 years or older.

Figure 4: RPG Program Participant Children, Percentage by Age Group
(N=24,042*)

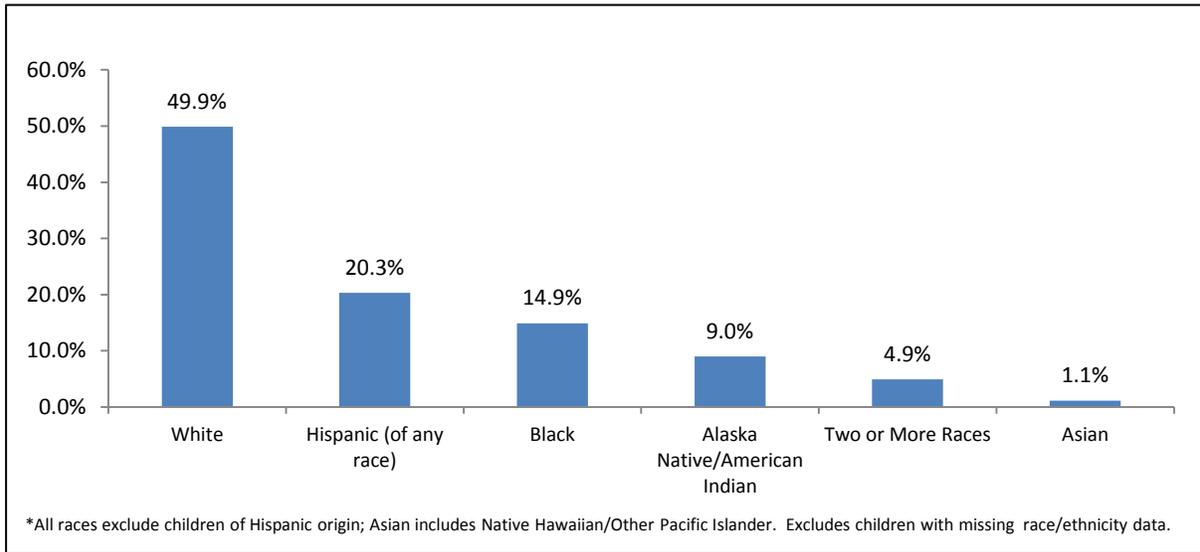


- Tribal grantees, in particular, served a significantly greater percentage of older children than other grantees. For instance, 46.5 percent of the children served by the tribal grantees were 9 years and older, compared to 23.7 percent for all other grantees ($p < .001$).
- As Figure 5 shows, children in the RPG Program were predominantly White (49.9 percent). Approximately one-fifth (20.3 percent) were Hispanic, while 14.9 percent were Black and 9.0 percent were Alaska Native/American Indian. A very small percentage of children served were multiracial (4.9 percent) or Asian (1.1 percent).⁸¹

⁸⁰ All analyses exclude cases with missing data; percentages may not add to 100 due to rounding.

⁸¹ All races exclude children of Hispanic origin; Asian includes Native Hawaiian/Other Pacific Islander.

**Figure 5: RPG Program Participant Children, Percentage by Child's Race/Ethnicity
(N=22,469*)**



- Slightly more than one-third (34.5 percent) of children had a history of maltreatment that was not associated with their current RPG program enrollment. Grantees stated that a family with a history of child welfare involvement that pre-dates their RPG participation often adds to the complexity of their needs and can make client engagement more challenging (see Chapter X for further discussion).

ADULT DEMOGRAPHIC DATA

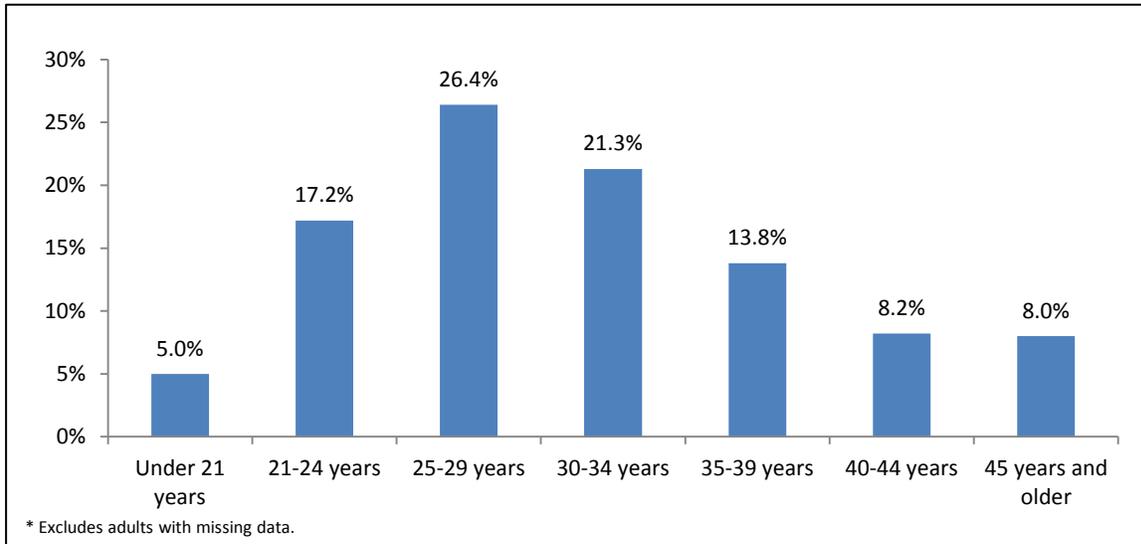
*Summary of Findings*⁸²

In general, adult RPG participants tended to be White females in their late 20s or early 30s who had never been married and were the biological mother and primary caregiver of the child(ren) receiving services. Further, adult RPG participants were likely to be unemployed and receiving public assistance at the time of program enrollment.

- Nearly three-fourths (72.2 percent) of adult RPG participants were females. Men comprised 27.8 percent of all adults served, but several grantees targeted their outreach to fathers. Males represented 35 percent or more of the participants among 13 grantees.
- The mean age among adults at time of RPG enrollment was 31.4 years. Nearly half of all adults were 25 to 34 years old. As Figure 6 below shows, a small percentage (5.0 percent) were under 21 years of age, while 17.2 percent were 21 to 24 years old. The largest proportion of adults was 25 to 29 years (26.4 percent), followed by 30- to 34-year-olds (21.3 percent). Those 35 to 39 years old comprised 13.8 percent of all adults. A roughly equal percentage of adults were 40 to 44 years old (8.2 percent) or 45 years and older (8.0 percent).

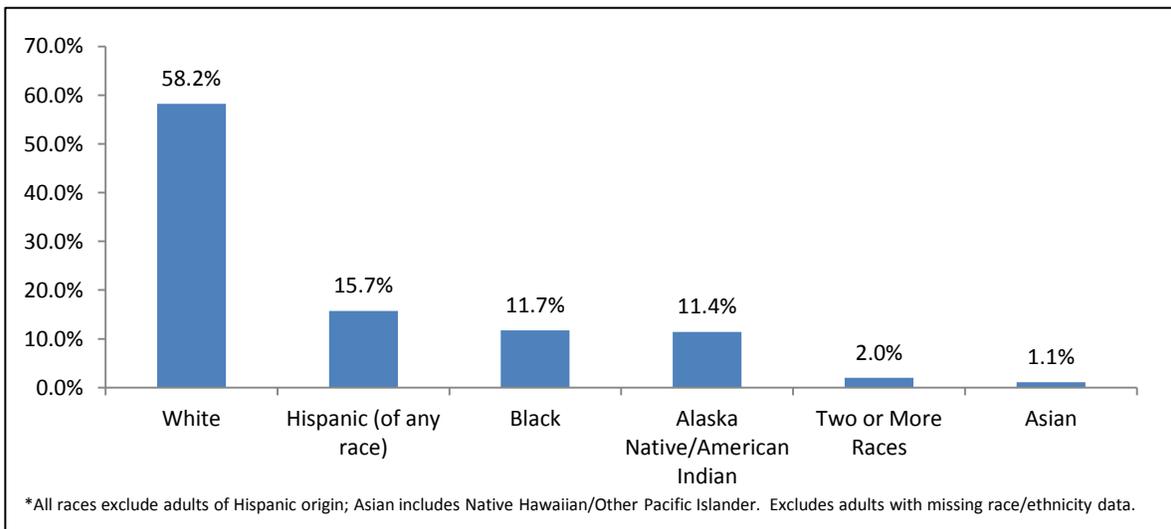
⁸² All analyses exclude cases with missing data; percentages may not add to 100 due to rounding.

Figure 6: RPG Program Participant Adults, Percentage by Age Group
(N=17,388*)



- Similar to the child participants, the majority of adults were White (58.2 percent), followed by Hispanic (15.7 percent), Black (11.7 percent), and Alaska Native/American Indian (11.4 percent). A very small percentage were multiracial (2.0 percent) or Asian (1.1 percent), as Figure 7 shows.

Figure 7: RPG Program Participant Adults, Percentage by Race/Ethnicity
(N=16,719*)



- The majority (83.0 percent) of adults enrolled in the RPG programs were the primary caregivers of the children receiving RPG services.⁸³ Most adults were the biological parent of the children receiving services; 75.9 percent were the biological mother and 16.1 percent

⁸³ A primary caregiver is defined as the person who has consistently assumed responsibility for the housing, health, and safety of the child(ren) and who carries out and/or oversees the tasks related to the daily lives of the child(ren), which includes caring for their physical, educational, social, emotional, and other needs.

were the biological father. The remaining 8.0 percent had some other relationship to the child.⁸⁴

- 7.4 percent of women were pregnant at the time of RPG program or substance abuse treatment entry.
- Nearly one-fourth (24.3 percent) of all adults served were married at time of RPG enrollment.
- Over half of all adults (57.5 percent) had 12 to 15 years of education (the equivalent of high school and some additional education or training). Yet a substantial percentage (39.2 percent) had less than 12 years of education at time of RPG enrollment. A small group of adults (3.4 percent) had 16 years or more of schooling.
- Approximately one-fourth (25.3 percent) of adults were employed (full or part time) at the time of RPG enrollment. However, the largest proportion (47.1 percent) was unemployed; in fact, 12 grantees served an adult population that was 70 percent or more unemployed. The remaining 27.5 percent of all adult RPG participants were not in the labor force (e.g., students, homemakers, disabled, inmates of an institution).
- Given the employment status of adults in the RPG Program, it follows that the majority either were receiving public assistance (31.2 percent) or had no primary source of income (25.2 percent). Slightly more than one-fourth (26.1 percent) had wages or a salary as their primary income source. The remaining adults (10.4 percent) reported other types of income⁸⁵ including disability (5.5 percent) or retirement/pension (1.7 percent) as their primary support.
- Most adults (76.0 percent) were living independently at time of RPG enrollment. A smaller proportion of participating adults were homeless (11.6 percent) or living in a dependent, supervised setting, such as jail or prison, a halfway house, or group home (12.4 percent).
- More than one-third (36.5 percent) of all adults were prior perpetrators of child maltreatment and had a history of child welfare system involvement (not associated with their current RPG program participation).
- For nearly one-third (32.0 percent) of adults, involvement with methamphetamine (use or production) was identified as a contributing factor to the risk of child maltreatment.

⁸⁴ Includes stepmother/father, adoptive mother/father, foster mother/father, presumptive father, grandmother/grandfather, aunt, uncle, significant other, or other relationship not otherwise specified.

⁸⁵ Other sources of support may include alimony, child support, or other income not mentioned.

CHAPTER VI: IMPROVE CHILD SAFETY

INTRODUCTION

This chapter presents results for two RPG performance measures related to grantees' progress in improving child safety:

- Children remain at home
- Child maltreatment

More than 9 in 10 (92.0 percent) children in the RPG Program who were in the custody of their parent or caregiver at the time of RPG program enrollment remained at home through RPG program case closure. The percentage of children who remained at home significantly increased through program implementation from 85.1 percent in program year one to 96.4 percent in program year five.

Within the first six months following their RPG Program enrollment, 95.8 percent of participating children did not experience maltreatment. Further longitudinal analysis of maltreatment occurrence at 12, 18, and 24 months post-RPG enrollment showed slight increases in the occurrence of substantiated child maltreatment over time. The cumulative percentage of children maltreated at any point within 24 months was 10.4 percent. Consistent with national child maltreatment data, the majority of children who experienced maltreatment were neglected. More detailed findings related to these measures follow in the next subsections.

Children Remain at Home⁸⁶

Percentage of children identified as a risk of removal from the home who are able to remain in the custody of a parent/caregiver through case closure

Summary of Findings

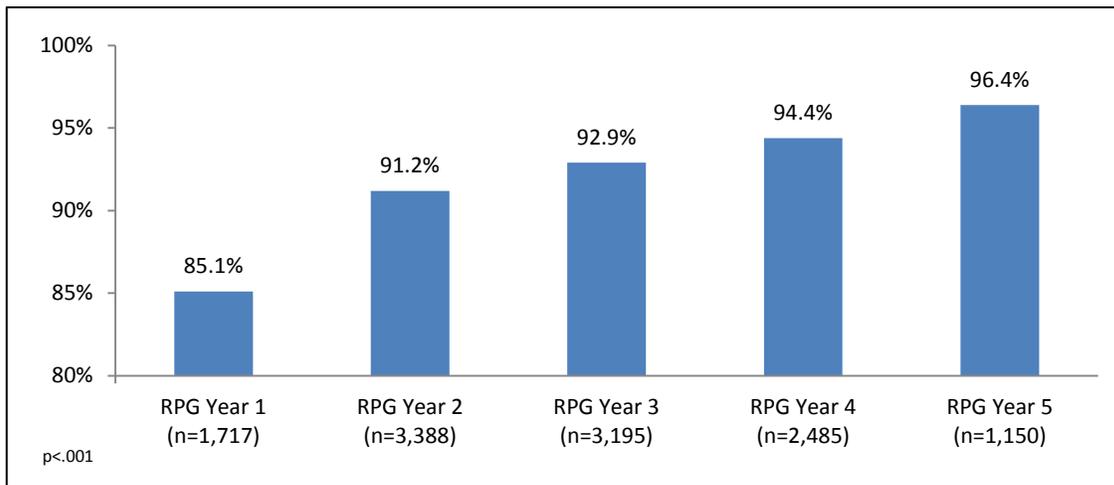
- The majority of children (78.6 percent) in the RPG Program were in the custody of a parent/caregiver at time of RPG Program enrollment.
- Of the 11,938 children in-home at time of RPG Program entry, nearly all (92.0 percent or 10,977) remained in their parent's or caregiver's custody through RPG Program case closure. Only 8 percent (961 children) were removed prior to RPG case closure (Table 17).

⁸⁶ Forty-three grantees reported indicator data for their RPG participant groups (N=18,526). Case closure (N=15,195) refers to discharge from the grantee's program.

Table 17: Summary Results—Children Remain at Home through RPG Program Case Closure ⁸⁷		
	Number	Percent
Total Number of Children In-Home at Time of RPG Program Enrollment	11,938	100.0%
Remained In-Home through Case Closure	10,977	92.0%
Removed from Home Prior to Case Closure	961	8.0%

- The proportion of children who remained in-home through RPG case closure increased significantly over the course of the RPG Program ($p < .001$). During the early grant period, it increased from 85.1 percent in program year one ($n=1,717$), to 91.2 percent in year two ($n=3,388$), and to 92.9 percent in year three ($n=3,195$). Performance continued to improve during the latter part of the grant period, increasing from 94.4 percent in program year four ($n=2,485$) to 96.4 percent in the final program year ($n=1,150$). See Figure 8 below.

Figure 8: Percentage of Children Who Remained at Home, by RPG Program Year



- Girls and boys in the RPG programs were equally likely to remain at home through case closure.
- Children who remained at home through case closure were significantly older (Mean=6.0 years) than children who were removed prior to case closure (Mean=4.6 years; $p < .001$).
- The proportion of children who remained at home until case closure was significantly associated with child race/ethnicity ($p < .001$). Higher proportions of Asian-Pacific Islander (96.4 percent) and Hispanic children (94.1 percent) remained at home, compared to Black (92.1 percent), multiracial (91.9 percent), White (90.8 percent), and Alaskan Native/American Indian children (88.2 percent).

⁸⁷ Remained at home includes children who were never removed from the home or removed after the RPG case closure date; removed from the home includes children removed on or before RPG case closure. Grantees report data on all removals from a parent's/caregiver's care regardless of whether the removal was associated with a substantiated/indicated maltreatment incident.

- Twenty-one grantees reported comparison group data on this measure. Among 10 of these 21 grantees, higher proportions of children in the grantees' RPG programs remained at home than among children in the comparison condition. Among eight grantees, however, the proportions of children who remained at home through case closure were higher in the comparison condition. For three grantees, 100 percent of children in both the RPG and comparison conditions remained at home. Considering these 21 grantees collectively, 93.2 percent of the 5,895 children in these grantees' RPG programs remained at home through case closure, compared to 88.6 percent of the 4,074 children in their comparison conditions.

Occurrence of Child Maltreatment

Percentage of children who had an initial occurrence and/or recurrence of substantiated/indicated child maltreatment within 6, 12, 18, and 24 months after enrolling in the RPG Program^{88, 89, 90}

Summary of Findings

- A total of 4.2 percent of 22,558 children in the RPG Program experienced child maltreatment within six months of program enrollment. This rate is substantially less than the 2011 median rate of 5.8 percent maltreatment recurrence within six months for the 25-state contextual subgroup (Table 18).

Table 18: Substantiated/Indicated Child Maltreatment within Six Months after RPG Program Enrollment (Median Performance)

	Children in the RPG Program (N=22,558)	25-State Contextual Subgroup Data ⁹¹
Percentage of Children who had Substantiated/Indicated Maltreatment within Six Months after RPG Program Enrollment	4.2%	5.8%

Notes: RPG data represent 44 grantees reporting case-level maltreatment data; analysis excludes 1,620 cases missing data elements needed to calculate time of maltreatment in relation to RPG program entry. The state contextual subgroup data are the 2011 NCANDS median results for the 25 states in which the 44 RPG programs are located. A lower percentage is better. The state contextual data are not intended to serve as a comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants. The state contextual data performance measure operational definition is: Of all children who were victims of substantiated or indicated maltreatment allegation during the first 6 months of most recent fiscal year, percent who were victims of another substantiated/indicated maltreatment allegation within 6 months following that maltreatment incident.

⁸⁸ Issues of timing between an initial incidence of maltreatment and the filing of subsequent reports during the court processes and investigation phases of a case may affect the results.

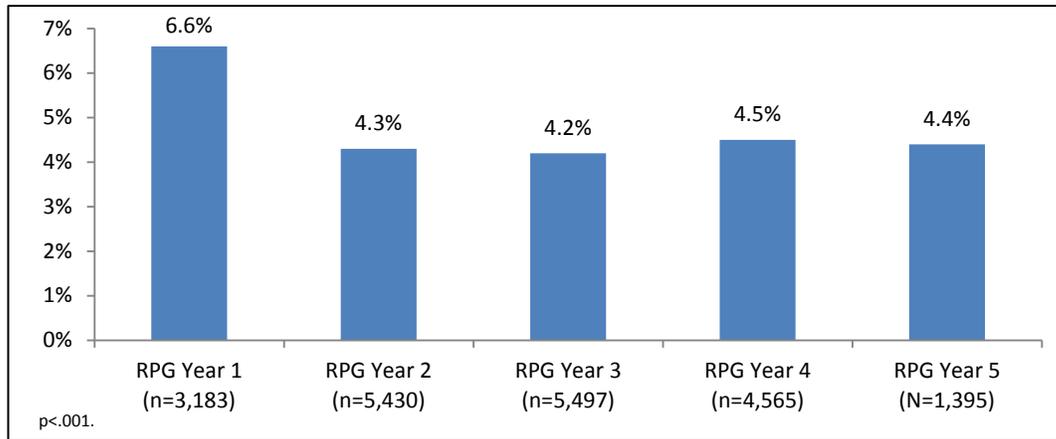
⁸⁹ The calculation of recurrence may also reflect multiple reports regarding the same incident.

⁹⁰ This indicator is intended to capture maltreatment that occurs after RPG enrollment; it does not reflect maltreatment that may have led to the family's referral or entry into RPG program.

⁹¹ Source: Child Welfare Outcomes Report Data Site. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <http://cwoutcomes.acf.hhs.gov/data/overview>; accessed April 3, 2013. Of all children who were victims of a substantiated/indicated maltreatment allegation during the first six months of the most recent fiscal year, percentage who were victims of another substantiated/indicated maltreatment allegation within six months following that maltreatment incident. This occurrence of maltreatment within six months (180 days) of the first occurrence usually is referred to as "recurrence."

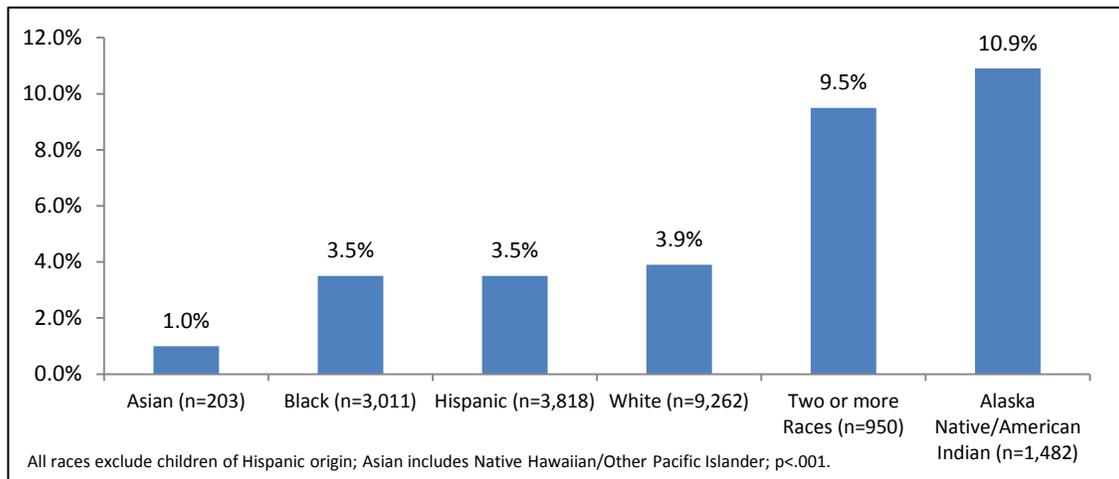
- The percentage of children in the RPG Program who experienced child maltreatment within six months of enrollment was significantly different across program years ($p < .001$). The rate of maltreatment decreased from 6.6 percent in program year one to 4.3 percent in program year two, and declined further to 4.2 percent in program year three. However, among children who enrolled in program year four, the rate of maltreatment within six months of their program enrollment rose to 4.5 percent, before declining again slightly to 4.4 percent in program year five (see Figure 9).

Figure 9: Percentage of RPG Children Experiencing Maltreatment within Six Months after RPG Program Enrollment, by RPG Program Year



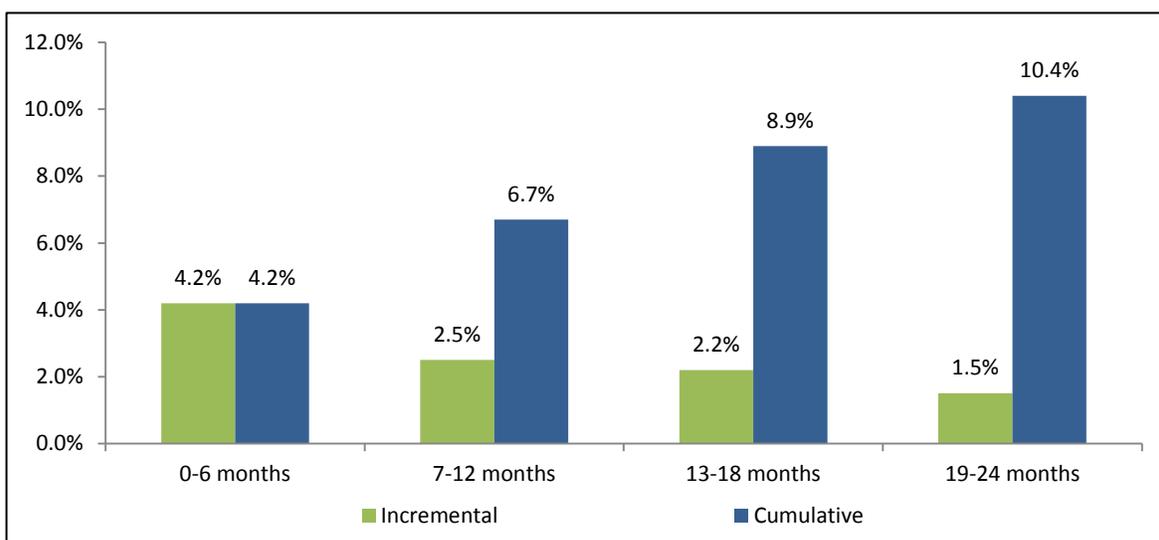
- There were no gender differences among proportions of children maltreated within six months of RPG Program enrollment.
- Figure 10 illustrates a significant difference in rates of maltreatment within six months of RPG Program enrollment by child race/ethnicity ($p < .001$). Lower proportions of Asian (1.0 percent), Black (3.5 percent), Hispanic (3.5 percent), and White children (3.9 percent) experienced maltreatment, compared to multiracial (9.5 percent) and Alaska Native/American Indian children (10.9 percent).

Figure 10: Percentage of RPG Children Experiencing Maltreatment within Six Months after RPG Program Enrollment, by Child's Race/Ethnicity



- HHS also examined maltreatment occurrence at 12, 18, and 24 months following a family’s RPG Program enrollment. This includes families who may have been discharged from the RPG Program and were no longer receiving RPG services. Figure 11 shows the *incremental* proportion of children experiencing maltreatment at 6, 12, 18, and 24 months: 4.2 percent, 2.5 percent, 2.2 percent, and 1.5 percent, respectively. The overall *cumulative* percentage of children experiencing maltreatment thus went from 4.2 percent at 6 months, to 6.7 percent at 12 months, to 8.9 percent at 18 months, and to an overall proportion of 10.4 percent at 24 months.

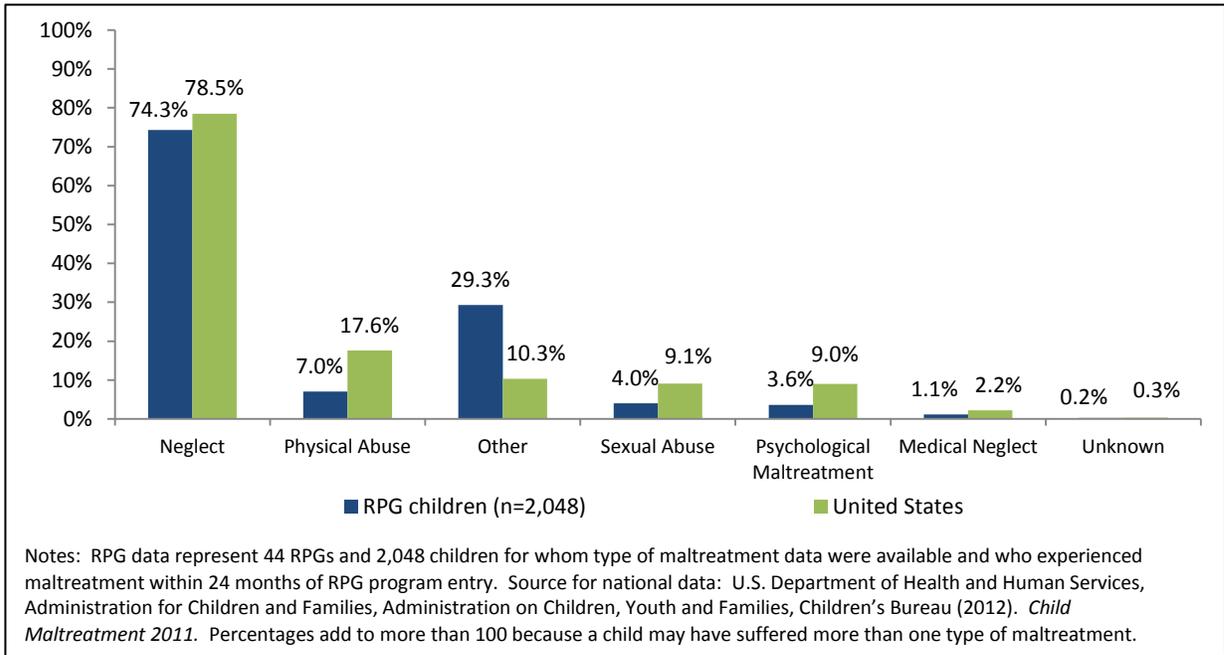
Figure 11: Incremental and Cumulative Percentage of Children Experiencing Maltreatment within 6, 12, 18, and 24 Months after RPG Program Enrollment



- Figure 12 shows the majority of children in the RPG Program who experienced maltreatment were neglected (74.3 percent), which is consistent with national data (78.5 percent). The percentage of child victims in the RPG Program who experienced physical abuse (7.0 percent), sexual abuse (4.0 percent), and psychological or emotional maltreatment (3.6 percent) was generally lower than children nationally (17.6 percent, 9.1 percent, and 9.0 percent, respectively). Only a small percentage of children in the RPG Program experienced medical neglect (1.1 percent), which also is similar to national trends (2.2 percent). Finally, 29.3 percent of child maltreatment victims in the RPG Program experienced other types of maltreatment, which was substantially higher than the national average (10.3 percent). Other types of maltreatment may include “threatened abuse,” “parent’s drug or alcohol abuse,” “lack of supervision,” “safe relinquishment of a newborn,” or other maltreatment that does not fit into the federal NCANDS categories.⁹²

⁹² U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau (2012). *Child Maltreatment 2011*. Available from <http://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf>. Percentages sum to more than 100 percent because a child may have experienced more than one type of maltreatment.

Figure 12: Child Maltreatment Victims—RPG Program and United States, Percentage by Type of Maltreatment



- Twenty-seven grantees reported comparison group data on substantiated child maltreatment within six months of program enrollment. For 12 grantees, maltreatment rates were lower among children in their RPG program than among their own comparison group children. Thirteen grantees’ children in the comparison conditions had lower rates of maltreatment than children in their RPG programs. Two grantees reported no maltreatment within six months for both their participant and comparison group children. Considering these 27 grantees collectively, 3.5 percent of the 12,693 children in the RPG programs experienced maltreatment within six months of program enrollment, compared to 4.1 percent of the 7,098 children in comparison conditions.

CHAPTER VII: IMPROVE PERMANENCY

INTRODUCTION AND HIGHLIGHTS

This chapter presents four performance measures that reflect grantees progress in improving permanency outcomes for children:

- Average length of stay in foster care
- Timeliness of reunification
- Timeliness of permanency to a finalized adoption or legal guardianship
- Re-entries to foster care following reunification

Grantees reported permanency data on more than 4,000 children discharged from foster care over the course of the grant period. Children discharged from foster care for all reasons combined (n=4,078) had a median length of stay in care of 11.1 months. However, approximately one-fourth (24.7 percent) of these children were discharged in less than six months.

The majority, 83.0 percent, of children in the RPG Program exiting foster care were discharged to reunification. Among children reunified over the course of the grant, the median length of stay for the most recent entry into foster care was 9.5 months. Nearly two-thirds (63.6 percent) of these children were reunified within 12 months and 17.9 percent were reunified in less than 3 months.

Timely reunification rates (i.e., within 12 months) increased steadily and significantly over the course of the RPG Program, from 55.4 percent in program year one to 72.9 percent in program year four. This supports the second key program implementation lesson (see Chapter III) that it takes adequate time to establish effective, broad-based cross-systems collaboration and comprehensive, integrated services to facilitate positive family outcomes.

Infants and young children less than one year of age had significantly higher rates of reunification within 12 months (72.7 percent) than children of all other ages (61.5 percent). Only 7.3 percent of all participating children who were reunified re-entered foster care at any point within 24 months following reunification.

In general, grantees' program models focused on reunification efforts, where appropriate. As a result, only a small number (n=464) of all participating children were discharged to a finalized adoption or legal guardianship. Among children discharged to this type of permanency placement, nearly three-fifths (58.6 percent) achieved such permanency within 24 months.

Overall, families participating in the RPG programs may experience somewhat longer lengths of stay in foster care (relative to the broader child welfare population) given the intensive nature of many grantees' program models and long duration of services to meet families' complex needs (see Chapter V). In addition, grantees may have served families whose children already had

been removed and in foster care for quite some time before the family became involved in the RPG program.

More detailed performance measure results follow. For selected measures, the analyses also include additional information on a very small subgroup of children in foster care whose removal from the home had occurred *after* they were discharged from the grantee's RPG program and no longer receiving RPG services. It is important to note these additional data represent a fraction of the total foster care discharges reported by grantees. Given the limited nature of these data, these particular results should be interpreted with caution. Rather, the intent is to highlight that among the subgroup of children with longer-term data, there was an extremely small number removed subsequent to RPG program activities. Further research is needed in this area to better understand the needs of these families and assess the longer-term impact of the RPG and similar programs in preventing future foster care placement.

Average Length of Stay in Foster Care⁹³

For children discharged from foster care, average length of stay (in days) from date of most recent entry into such care until date of discharge

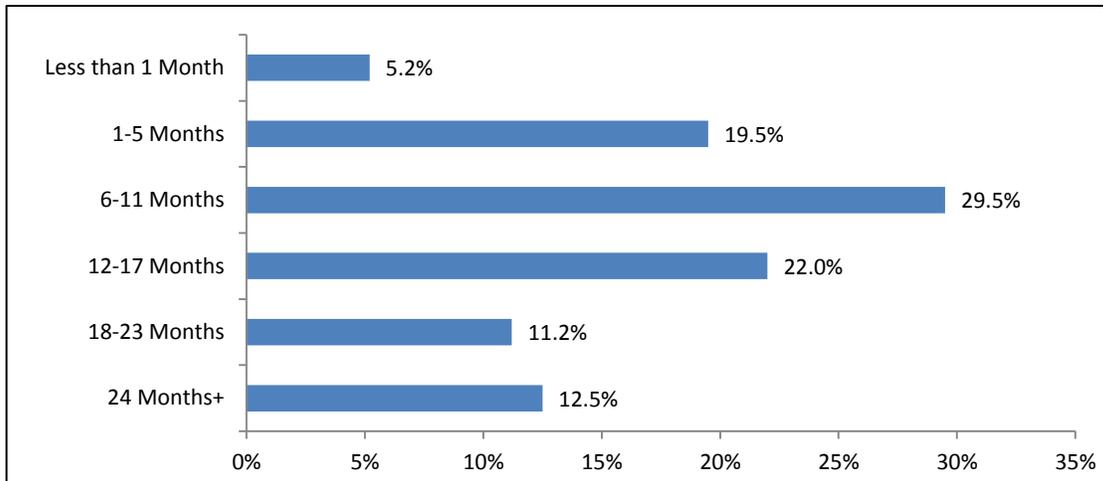
Summary of Findings

- The majority of children exiting foster care were discharged to reunification (83.0 percent); 10.5 percent were discharged to a finalized adoption, 4.9 percent to legal guardianship, and the remaining 1.6 percent were discharged for other reasons.⁹⁴
- Children in the RPG Program discharged from foster care for all reasons combined had a median length of stay in care of 11.1 months. Approximately one-fourth (24.7 percent) of children were discharged from foster care in less than 6 months and more than half (54.2 percent) were discharged in less than 12 months.
- More specifically, 5.2 percent of children were discharged in less than 1 month and 19.5 percent within 1 to 5 months, while 29.5 percent were discharged within 6 to 11 months. Slightly more than one-fifth (22.0 percent) were discharged in 12 to 17 months, 11.2 percent in 18 to 23 months, and the remaining 12.5 percent in 24 months or more (see Figure 13).

⁹³ Thirty-four grantees reported data on this performance indicator for 4,078 children.

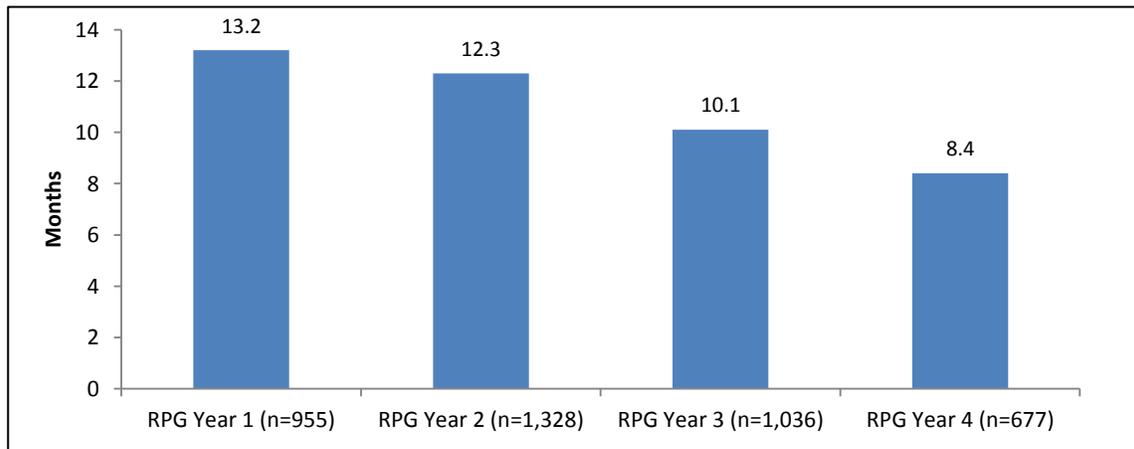
⁹⁴ Per federal reporting, discharges coded as "living with other relative" are counted as a valid reunification. Other discharge reasons include emancipation, transfer to another agency, runaway, or death of child.

**Figure 13: Percentage of Children Discharged from Foster Care within Specified Time Intervals
(All Discharges, N=4,078)**



- The median length of stay in foster care decreased steadily over the course of the RPG Program. It decreased from 13.2 months (n=955) in year one to 12.3 months (n=1,328) in year two, to 10.1 months (n=1,036) in year three, to 8.4 months (n=677) in year four (see Figure 14).⁹⁵

Figure 14: Among Children in RPG Discharged from Foster Care during the RPG Program, Median Length of Stay in Foster Care in Number of Months, by Program Year



- Among the 3,340 children reunified with their families, the median length of stay in foster care was 9.5 months. This was 2.0 months longer than the state contextual subgroup median of 7.5 months (see Table 19). It is possible that children in the RPG Program had a longer length of stay in foster care because their parents were receiving more intensive services to address substance use disorders and other complex needs as part of their permanency plans. (The median length of stay for adults completing substance abuse treatment was 7.6 months; see Chapter VIII). The state contextual data are not limited to children removed from the

⁹⁵ Program year reflects when a child enrolled in the RPG Program. The trend analysis does not include program year five due to the proportionately smaller number of foster care discharges (n=80). For children enrolled in the last year of the program, information on their foster care status may not have been available by the reporting period cutoff date.

home due to parental substance use. See also Timeliness to Reunification for additional performance measure results.

- Among the 418 children discharged to a finalized adoption, the median length of stay in foster care was 24.2 months. This was substantially shorter than the state contextual subgroup median of 29.3 months (see Table 19). See Timeliness to Permanency for additional performance measure results.

Table 19: Length of Stay for Children Discharged from Foster Care—Median Number of Months		
	Children in the RPG Program	State Contextual Subgroup Data⁹⁶
Discharge to Reunification (n=3,340)	9.5 months	7.5 months
Discharge to Finalized Adoption (n=418)	24.2 months	29.3 months

Notes: Thirty-four grantees reported any discharges to reunification. The state contextual subgroup data for discharge to reunification are the 2011 AFCARS results for the 22 states in which these 34 RPG programs are located. The state contextual data definition is: Of all children discharged from foster care to reunification, and who had been in foster care for eight days or longer, median length of stay from date of latest removal. This operational definition differs slightly from the RPG measure in that it is limited to children who had been in foster care 8 days or longer. Twenty-two grantees reported any discharges to a finalized adoption. The state contextual data for discharges to adoption reflect the 16 states in which these 22 RPGs are located. The state contextual data definition specifies of all children discharged from foster care to a finalized adoption during a given fiscal year, median length of stay from date of latest removal until date of discharge. The RPG measure differs slightly in that it is not time limited to adoptions in a given fiscal year. The state contextual data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants.

- Eleven grantees reported sufficient comparison group data on this measure. For nine of these grantees, children in their RPG program had a shorter median length of stay in foster care than their own comparison group children. The other two grantees' comparison group children had shorter lengths of stay in foster care than their participant children. Collectively, these 11 grantees' comparison children receiving services as usual indicated a median length of stay in foster care of 16.6 months.
- Just over a quarter of grantees (n=14) reported data on foster care length of stay for a very small subgroup of 71 children who had been removed from their home on or after the day of discharge from RPG services. These children had a median length of stay in foster care of 6.6 months (all discharge reasons combined).
- Among the 14 grantees in this subgroup, the number of children removed post-RPG program discharge ranged from 1 to 14. Three grantees accounted for nearly half of these discharges (47.9 percent). This is a function of proportionality for two of these grantees (i.e., the number of children they served overall). The reason for the third grantee is unclear, but may be due to greater capacity to report extensive longitudinal data or their program model.
- These subgroup data represent a fraction (1.7 percent) of all foster care discharges for RPG participant children. These results should be interpreted with caution. Although these

⁹⁶ Source: Child Welfare Outcomes Report Data Site. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <http://cwoutcomes.acf.hhs.gov/data/overview>; accessed April 9, 2013.

limited data suggest very few children were removed from the home subsequent to RPG program activities, further research is needed to better understand the needs of these families and assess the longer-term impact of the RPG and similar programs on permanency outcomes.

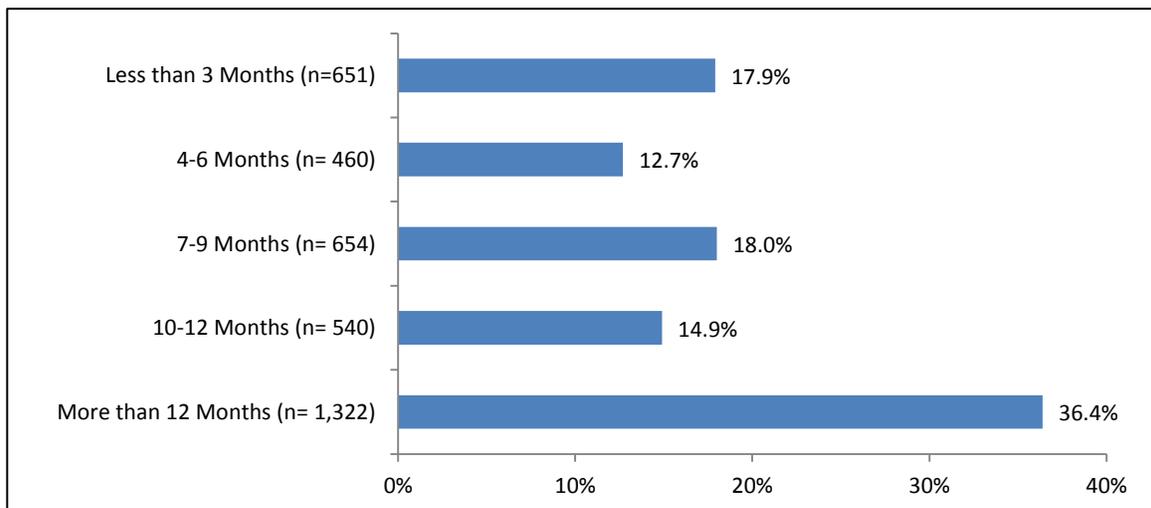
Timeliness of Reunification⁹⁷

Percentage of children who were reunified in less than 12 months from the date of the most recent entry into foster care

Summary of Findings

- Overall, nearly two-thirds (63.6 percent) of children were reunified in less than 12 months. More specifically, as Figure 15 shows, 17.9 percent of children were reunified in less than 3 months, 12.7 percent were reunified in 4 to 6 months, 18.0 percent within 7 to 9 months, and 14.9 percent in 10 to 12 months. More than one-third (36.4 percent) were reunified in more than 12 months.

Figure 15: Percentage of RPG Children Reunified within Specified Time Intervals (N=3,627)



- The proportion of children participating in the RPG Program who reunified within 12 months (63.6 percent) is somewhat lower than the contextual 22-state subgroup median of 69.4 percent (Table 20).

⁹⁷ Thirty-eight grantees reported data for this measure among which 36 grantees reported between 1 and 755 reunifications involving children in the RPG Program.

Table 20: Children Reunified Within Less than 12 Months (Median Performance)		
	Children in RPG (N=3,627)	22-State Contextual Subgroup Data⁹⁸
Percentage of Children who were Reunified in Less than 12 Months	63.6%	69.4%

Notes: RPG data represent 35 grantees reporting any reunifications. The analysis excludes 170 reunified children due to missing data elements needed to calculate time to reunification. In cases of multiple reunifications for a child (n=109), time to reunification was calculated for the most recent reunification. The state contextual subgroup data are the 2011 AFCARS results for the 22 states in which these 35 RPG programs are located. The state contextual data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants. The state contextual data performance measure operational definition is: Of all children discharged from foster care to reunification who had been in foster care for eight days or longer, percentage who were reunified in less than 12 months from date of latest removal from home.

- Girls and boys in the RPG program were equally likely to reunify within 12 months.
- Time to reunification is significantly associated with children’s age group (p<.001). The highest proportion of children reunified within 12 months were infants and young children less than one year of age (72.7 percent); children aged 6 to 8 years had the lowest proportion (55.6 percent) reunified within 12 months (see Table 21).

Table 21: Percentage of Children Reunified Within 12 Months, by Age Group	
Less than 1 Year (n=663)	72.7%
1 to 3 Years (n=1082)	66.1%
4 to 5 Years (n=525)	63.4%
6 to 8 Years (n=568)	55.6%
9 to 12 Years (n=517)	56.5%
13 Years and Older (n=270)	61.5%

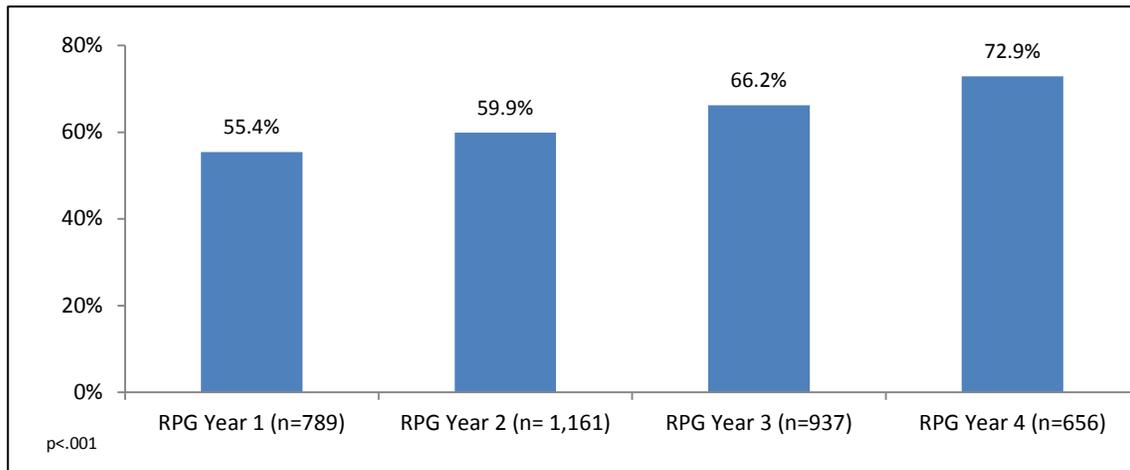
p<.001

- Rates of reunification also differed significantly by child race/ethnicity (p<.001). Larger proportions of White (n=1,938, 66.7 percent), Alaska Native/American Indian (n=300, 64.3 percent), and Hispanic (n=554, 61.7 percent) children were reunified within 12 months than multiracial (n=340, 54.4 percent) or Black (n=344, 52.0 percent) children.
- Timeliness of reunification (i.e., within 12 months) increased steadily and significantly over the course of the RPG Program (p<.001). It increased from 55.4 percent (n=789) in program year one to 59.9 percent (n=1,161) in year two, to 66.2 percent (n=937) in year three, to 72.9 percent (n=656) in year four (see Figure 16).⁹⁹

⁹⁸ Source: Child Welfare Outcomes Report Data Site. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. <http://cwoutcomes.acf.hhs.gov/data/overview>; accessed March 15, 2013.

⁹⁹ Program year indicates when a family enrolled in the RPG Program. The trend analysis does not include program year five because of the small number of reunifications (n=82). Information regarding foster care status may not have been available by the reporting period cutoff date for children enrolled in the last year of the program.

Figure 16: Percentage of Children Reunified Within 12 Months, by Program Year



- Seven grantees reported sufficient comparison group data on reunification rates within 12 months. Five grantees' children in their RPG program had higher timely reunification rates than their own comparison group, while two grantees' comparison children had higher timely reunification rates than their participant children. Descriptive statistics for the seven grantees' comparison children receiving services as usual indicated that 54.9 percent reunified within 12 months.
- Just over a quarter of grantees (n=14) reported data on timeliness of reunification for a subgroup of 58 children who had been removed from their home on or after the day of discharge from RPG services. These children had a median length of stay in foster care of 3.1 months and 87.9 percent were reunified within 12 months.
- Among the 14 grantees in this subgroup, the number of children removed post-RPG program discharge ranged from 1 to 11. Three grantees accounted for 48.3 percent of these cases. This is a function of proportionality for two of these grantees (i.e., the number of children they served overall). The reason for the third grantee is unclear, but may be due to greater capacity to report extensive longitudinal data or their program model.
- These subgroup data represent a fraction (1.6 percent) of all reunifications for RPG participant children. These results should be interpreted with caution and do not support generalizations. Further research is needed to better understand the needs of these families and assess the longer-term impact of the RPG and similar programs on permanency outcomes.

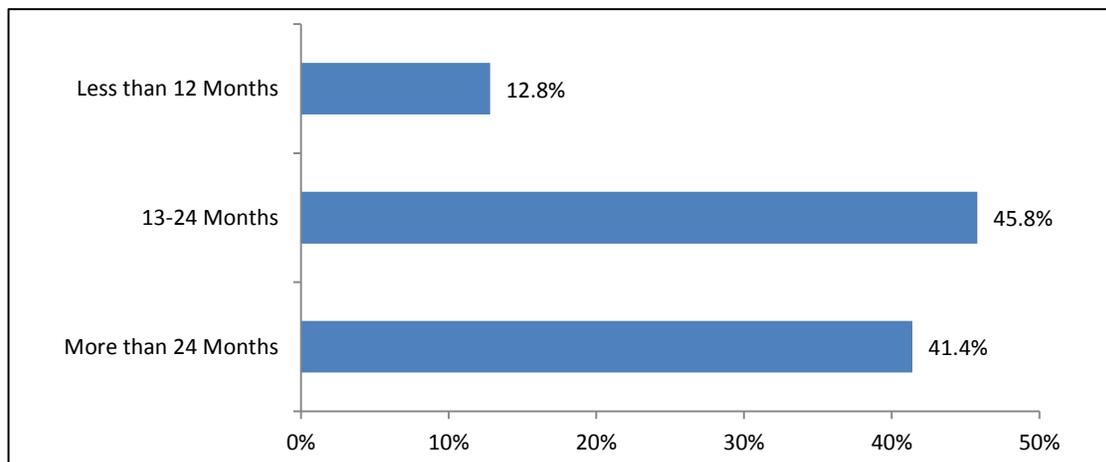
Timeliness of Permanency to Adoption or Guardianship¹⁰⁰

Percentage of children placed in foster care who, in less than 24 months from the date of the most recent entry into foster care, achieved: a) a finalized adoption or b) legal guardianship

Summary of Findings

- A total of 464 participant children were discharged from foster care to a finalized adoption or legal guardianship.¹⁰¹ Of these children, 72.0 percent exited to a finalized adoption and 28.0 percent were discharged to relative guardianship.
- Among the 452 children with data necessary to compute time intervals, 58.6 percent were discharged to adoption or legal guardianship within 24 months. More specifically, 12.8 percent were discharged in less than 12 months and 45.8 percent in 13 to 24 months. The remaining 41.4 percent exited foster care after 24 months (see Figure 17).

Figure 17: Percentage of Children Discharged to Adoption or Relative Guardianship within Specified Time Intervals (N=452)



- Among the children who were discharged to adoption, 50.3 percent achieved a finalized adoption within 24 months. This exceeded the median of 33.7 percent for the 15 states in which the RPGs who reported any adoptions are located (see Table 22 below).

¹⁰⁰ Twenty-nine grantees reported data for this measure.

¹⁰¹ As noted previously, only 10.5 percent of children in the RPG programs exiting foster care were discharged to a finalized adoption and 4.9 percent to legal guardianship.

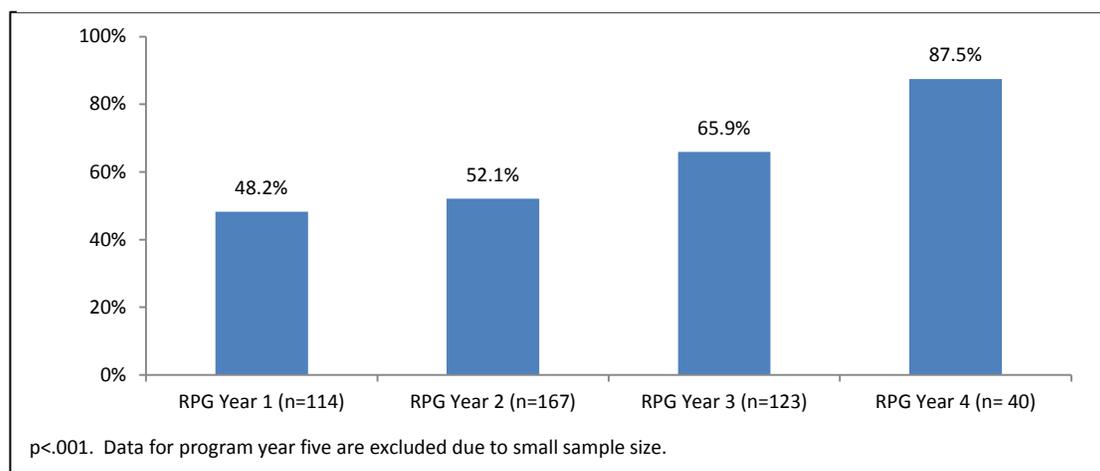
Table 22: Children Discharged to a Finalized Adoption within 24 Months (Median Performance)

	Children in RPG Program (N=164)	15-State Contextual Subgroup Data ¹⁰²
Percentage of Children who Exited to a Finalized Adoption in Less than 24 Months	50.3%	33.7%

Notes: RPG data represent 18 grantees that reported any finalized adoptions. The state contextual subgroup data are the 2011 AFCARS results for the 15 states in which these 18 RPG programs are located. The state contextual data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants. The state contextual data performance measure operational definition is: Of all children discharged from foster care to a finalized adoption during the given fiscal year, percentage discharged in less than 24 months from the date of the latest removal until date of discharge. The RPG measure differs slightly in that it is not time limited to adoptions in a given fiscal year, but looks at all adoptions of RPG children during the grant period.

- More than three-fourths (80.2 percent) of children discharged to legal guardianship achieved permanency within 24 months.
- The percentage of children in the RPG Program who achieved a timely adoption or legal guardianship (i.e., within 24 months) increased over time ($p < .001$). As Figure 18 shows, the percentage increased from 48.2 percent ($n=114$) in program year one, to 52.1 percent ($n=167$) in program year two, to 65.9 percent ($n=123$) in year three, to a high of 87.5 percent ($n=40$) in year four.¹⁰³

Figure 18: Percentage of Children Achieving a Finalized Adoption or Legal Guardianship in Less than 24 Months, by RPG Program Year



- A larger proportion of boys (62.8 percent) than girls (54.3 percent) achieved timeliness of adoption or legal guardianship (not statistically significant).

¹⁰² Source: Child Welfare Outcomes Report Data Site. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. <http://cwoutcomes.acf.hhs.gov/data/overview>; accessed March 15, 2013.

¹⁰³ Program year indicates when a family enrolled in the RPG Program. The trend analysis does not include program year five due to a small number of discharges to adoption or legal guardianship ($n=8$). Information on foster care status may not have been available by the reporting period cutoff date for children enrolled in the last year of the program.

- Although the differences are not statistically significant and the numbers are few, larger proportions of Hispanic (n=84, 63.1 percent), Alaska Native/American Indian (n=36, 61.1 percent) and White (n=247, 59.1 percent) children were discharged to adoption or guardianship within 24 months than multiracial (n=23, 52.2 percent) or Black (n=57, 49.1 percent) children.
- Eight grantees reported data on timeliness of adoption or guardianship for a subgroup of 47 children who had been removed from their home on or after the day of RPG program discharge. Nearly all (93.6 percent) of these children achieved a finalized adoption or legal guardianship within 24 months.
- Among the eight grantees in this subgroup, the number of children removed post-RPG program discharge ranged from 1 to 19. Two grantees accounted for 61.7 percent of these cases. This is a function of proportionality for one grantee (i.e., the number of children they served overall). The reason for the other grantee is not known, but may be due to greater capacity to report extensive longitudinal data or their program model.
- These subgroup data represent a small proportion (9.2 percent) of all discharges to adoption or guardianship for RPG participant children and a comparatively small number of grantees. These results represent too few cases to support generalizations. Further research is needed to better understand the needs of these families and assess the longer-term impact of the RPG and similar programs on permanency outcomes.

Re-entries to Foster Care¹⁰⁴

Percentage of children returned home from foster care that re-entered foster care in less than 6, 12, 18, and 24 months

Summary of Findings

- Thirty-six grantees reported that 3,861 children who were in out-of-home care were reunified with their parent(s).¹⁰⁵ Only 283 (7.3 percent) of these children re-entered foster care at any point within 24 months following reunification.¹⁰⁶ This small number of re-entries occurred in 17 RPG programs and three grantees accounted for approximately two-thirds (66.4 percent) of all the re-entries. It is noteworthy that more than half (19) of the grantees reporting on this measure had no re-entries to foster care among their reunified children.

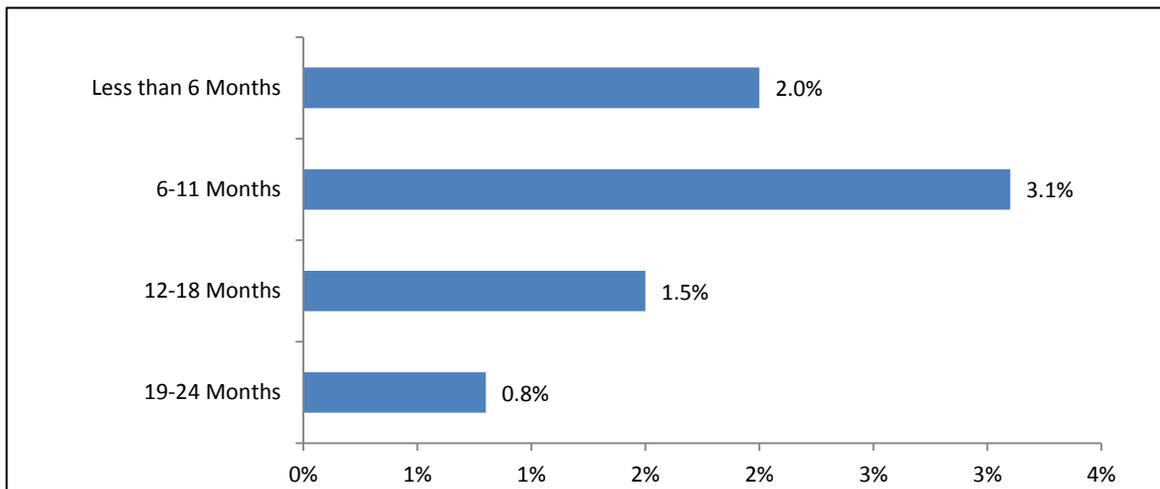
¹⁰⁴ Thirty-eight grantees reported data for this measure, of which 36 reported between 1 and 755 reunifications.

¹⁰⁵ Includes children who were already in foster care at time of RPG enrollment as well as those who entered foster care after RPG enrollment.

¹⁰⁶ A number of possible factors contribute to foster care re-entry, including a lack of needed aftercare services to support families after they reunify and the additional oversight that these families experience while participating in the RPG program.

- As Figure 19 shows, the largest proportion (3.1 percent) of children who re-entered foster care did so within 6 to 11 months of being reunified. Two (2.0) percent of children re-entered foster care in less than 6 months of being reunified, while 1.5 percent re-entered in 12 to 18 months, and 0.8 percent re-entered in 19 to 24 months.

Figure 19: Percentage of Children who Re-Entered Foster Care after Reunification, within Specified Intervals (N=283)



- The percentage of children served by RPGs who re-entered foster care within 12 months (5.1 percent) was substantially lower than the median rate of 13.1 percent for the 22 states in which the RPGs are located (see Table 23).

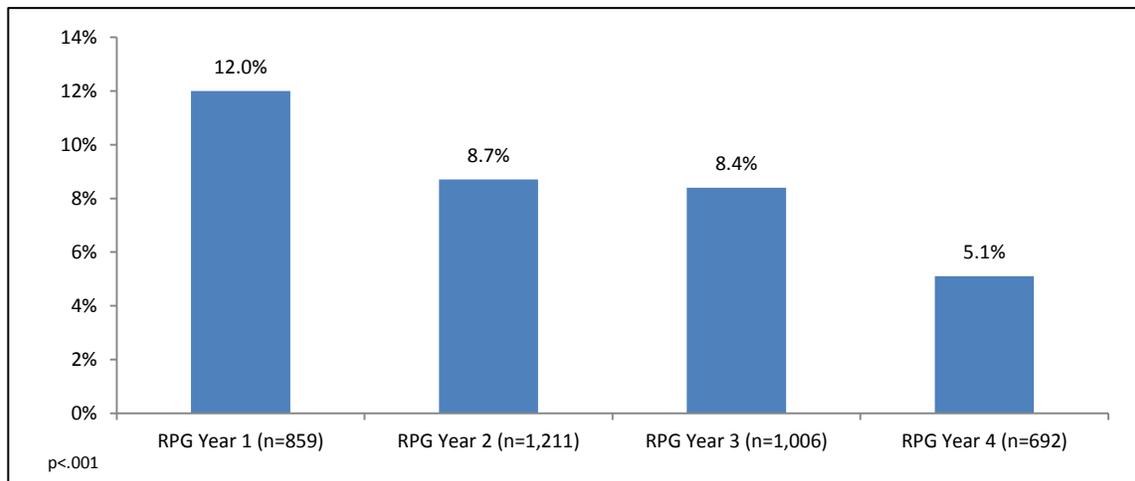
Table 23: Children Reunified Who Re-entered Foster Care in Less than 12 Months (Median Performance)		
	Children in the RPG Program (N=3,575)	22-State Contextual Subgroup Data¹⁰⁷
Percentage of Children Reunified who Re-entered Foster Care in Less than 12 Months	5.1%	13.1%

Notes: RPG data represent 36 grantees and are limited to the 3,575 reunified children for whom time to re-entry data were provided. The state contextual subgroup data are the 2011 AFCARS results for the 22 states in which the 36 RPG programs are located. On this measure, a lower percentage is better. The state contextual data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants. The state contextual data performance measure operational definition is: Of all children discharged from foster care to reunification in the 12-month period prior to a given fiscal year, percentage who re-entered foster care in less than 12 months. The RPG definition differs slightly in that it is not limited to foster care re-entries in a given time period. Rather, it encompasses all foster care re-entries during the grant period.

¹⁰⁷ Source: Child Welfare Outcomes Report Data Site. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. <http://cwoutcomes.acf.hhs.gov/data/overview>; accessed March 15, 2013.

- The percentage of children in the RPG program who re-entered foster care significantly decreased over the course of the grant period ($p < .001$). The proportion re-entering foster care decreased from 12.0 percent in year one ($n=859$ reunifications) to 8.7 percent in year two ($n=1,211$ reunifications). It then remained somewhat stable at 8.4 percent in year three ($n=1,006$ reunifications) before decreasing further to 5.1 percent in year four ($n=692$ reunifications); see Figure 20.¹⁰⁸

Figure 20: Of Children Reunified, Percentage Who Re-entered Foster Care, by RPG Program Year

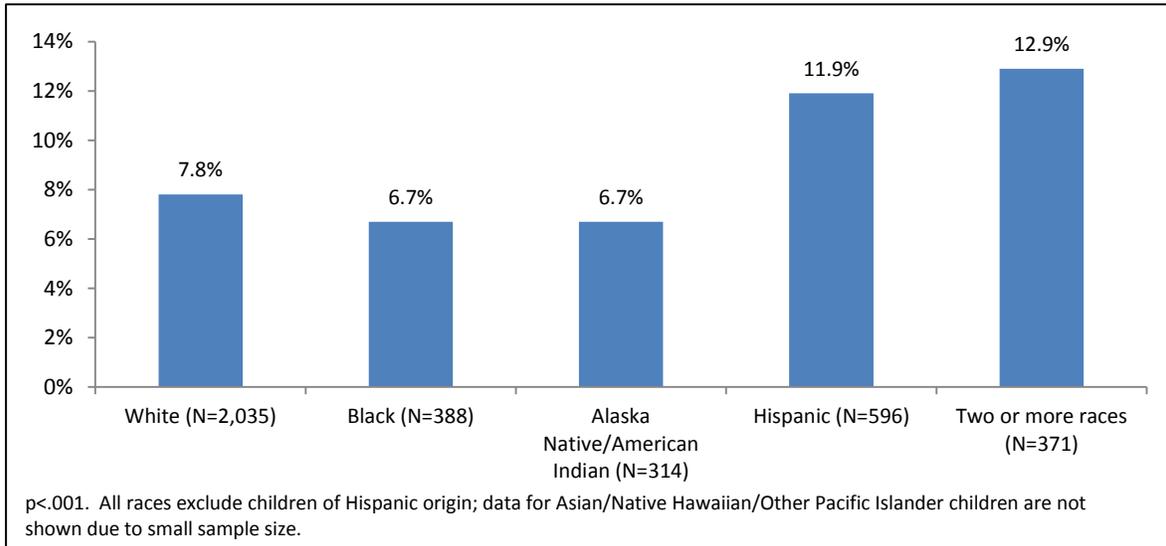


- Re-entry to foster care after reunification was not associated with child's gender.
- Children who re-entered foster care were significantly younger (Mean=4.4 years) than children who did not re-enter foster care (Mean=5.4 years; $p < .001$).

¹⁰⁸ Program year indicates when a child enrolled in the RPG Program. The trend analysis does not include program year five due to a smaller number of reunification ($n=91$). Information on foster care status may not have been available by the reporting period cutoff date for children enrolled in the last year of the program.

- The race/ethnicity of children in the RPG program was significantly associated with re-entries to foster care ($p < .001$). Among children who were reunified, lower proportions of Alaska Native/American Indian ($n=314$; 6.7 percent), Black ($n=388$; 6.7 percent), and White ($n=2,035$, 7.8 percent) children re-entered foster care than did Hispanic ($n=596$, 11.9 percent) and multiracial ($n=371$, 12.9 percent) children (see Figure 21).

Figure 21: Of Children Reunified, Percentage Who Re-entered Foster Care, by Race/Ethnicity



CHAPTER VIII: PROMOTE AND SUSTAIN RECOVERY

INTRODUCTION

This chapter presents results for the six RPG performance measures that reflect grantees' progress in promoting and sustaining adults' recovery from substance use disorders:

- Timely access to substance abuse treatment
- Retention in substance abuse treatment
- Reduced substance use
- Adults connected to supportive services
- Employment status
- Decreased criminal behavior

Overall, adults participating in the RPG Program accessed substance abuse treatment quickly, on average, within 13 days of entering the RPG program. Well over one-third (36.4 percent) entered substance abuse treatment within 3 days. Once engaged in substance abuse treatment, adult participants remained in treatment a median of 4.8 months and nearly two-thirds (65.2 percent) stayed in treatment more than 90 days. Treatment completion rates¹⁰⁹ (45.0 percent) were substantially higher than dropout rates (36.8 percent).

From substance abuse treatment admission to discharge, the majority of adults (between 61.1 and 76.2 percent, depending on the substance) participating in the RPG Program reduced their use of alcohol, marijuana, cocaine, methamphetamine, and heroin. In addition, among adults with any recent arrests prior to treatment admission, 80.0 percent reported decreased criminal behavior.¹¹⁰ Further, the percentage of adults employed (full or part time) increased significantly from 22.8 percent at treatment admission to 41.3 percent at discharge, an 81.1 percent rate of change.¹¹¹

Grantees have stressed the importance of key supportive services to help parents achieve sustained recovery and to reunify with their children (see Chapters II and III). Analysis of key services that support positive treatment outcomes found that about 9 in every 10 adults in the RPG Program received needed continuing care (87.1 percent), transportation (86.8 percent),

¹⁰⁹ Includes discharges for treatment completion (all parts of treatment plan or program were completed) and transfers to another facility when the individual was known to report and expected to continue further treatment. Federal treatment outcome reporting also considers such transfers a successful discharge.

¹¹⁰ As measured by the number of subsequent arrests. Nearly all (19.3 percent) of remaining adults reported no change in criminal behavior, while 0.7 percent reported an increase in the number of arrests. As noted in the detailed findings, these data represent a small number (n=695) of all adults served by the larger RPG Program. They should be interpreted with caution and cannot be generalized to the entire RPG Program adult population.

¹¹¹ Percent change is calculated by subtracting "old" data from "new" data, dividing that result by old data, and multiplying it by 100; for example, $[(41.3-22.8)/22.8] \times 100 = 81.1$ percent change. As noted in the detailed findings, these data represent a small number (n=2,701) of all adults served by the larger RPG Program. These results should be interpreted with caution and cannot be generalized to the entire RPG Program adult population.

parenting training and education (85.9 percent), and mental health services (84.4 percent). In addition, more than three-fourths of adults received needed primary medical care (78.7 percent), while about 7 in every 10 received dental care (70.1 percent), employment or vocational training/education (69.4 percent), housing assistance (69.2 percent), and domestic violence services (68.7 percent).

A brief descriptive profile of the adults receiving substance abuse treatment is provided below, followed by a more detailed discussion of each of the six recovery performance measures.

DESCRIPTIVE PROFILE OF ADULTS IN SUBSTANCE ABUSE TREATMENT

Fifty grantees reported on 11,748 adults who received substance abuse treatment over the course of the grant.¹¹² Grantees reported data on clients' overall treatment episodes, which may have involved treatment in multiple service types and settings. Grantees did not record data on each placement or transition from one level of care to another that may have occurred within a client's single treatment episode.¹¹³

The majority (85.5 percent) of adults experienced one substance abuse treatment episode and 8.9 percent experienced two treatment episodes during the course of their involvement in the RPG program. A smaller group of adults (3.3 percent) had three treatment episodes, while the remaining 2.3 percent experienced four or more episodes of substance abuse treatment. Because this introductory profile is intended to characterize unique individuals in treatment (rather than treatment episodes), the analyses are limited to consideration of the first treatment episode.

Brief Demographic Profile

As the majority of adults in the RPG program participated in substance abuse treatment, they closely resemble the demographic profile of the entire RPG adult population (see Chapter V):

- More than three in five (62.1 percent) adults in the RPG Program in substance abuse treatment were White.
- Slightly more than half (54.4 percent) were under 30 years of age.
- Women comprised more than three-fourths (76.6 percent) of all adults in substance abuse treatment.
- The majority of women in treatment were the biological mothers and primary caregivers of the children involved in the RPG Program.

¹¹² Approximately two-thirds (65.9 percent or 11,748 of the 17,820 adults served by grantees) participated in substance abuse treatment. Not all adults in the RPG programs required substance abuse treatment. For example, family members of the primary caregiver(s) in substance abuse treatment may not have needed treatment themselves, but received other RPG services.

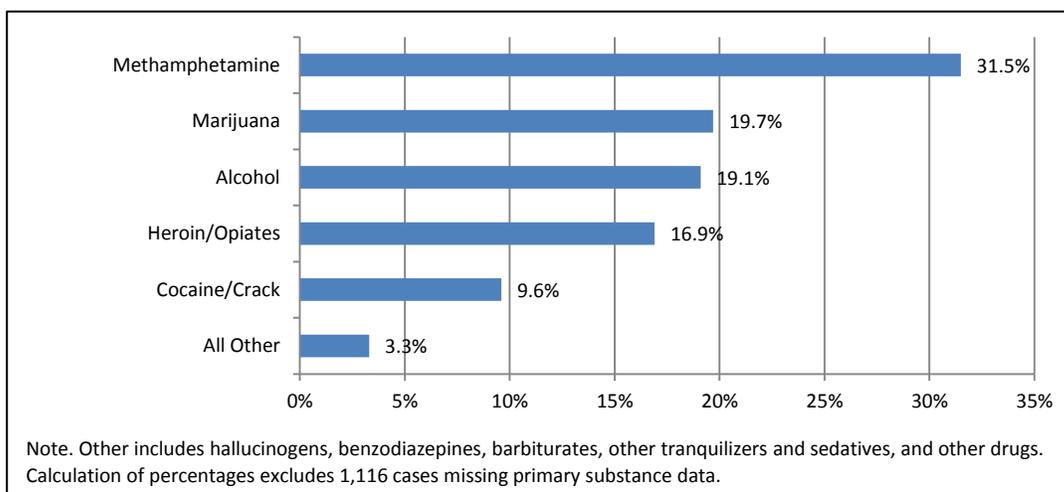
¹¹³ Multiple treatment admissions for an individual were counted as a single treatment episode if the time between two sequential admissions was 30 days or less and the discharge status for the first admission was coded as treatment completion or transferred to another program and known to report for continued treatment.

- 7.7 percent of women were pregnant at time of RPG program or substance abuse treatment admission.

Primary Substance at Admission

Nearly one-third (31.5 percent) of adults in the RPG Program admitted to substance abuse treatment reported methamphetamine¹¹⁴ as their primary substance problem. Slightly less than one-fifth reported marijuana (19.7 percent) or alcohol (19.1 percent) as their primary substance at admission, while 16.9 percent reported heroin/opiates. A smaller percentage (9.6 percent) of adults reported cocaine/crack as their primary substance problem, while the remaining 3.3 percent presented some other substance¹¹⁵ as their primary problem at first treatment admission (see Figure 22).

Figure 22: Primary Substance Problem at First Treatment Admission among Adults in the RPG Program (N=10,004)



Primary substance abuse trends for adults participating in the RPG Program differed from those of the overall adult treatment population in the grantees' states.¹¹⁶ Adults in the RPG Program were much more likely to report methamphetamine as their primary substance problem at admission than the 28-state contextual subgroup (31.5 percent compared to 7.1 percent). A slightly larger proportion of adults in the RPG Program than in the state contextual subgroup reported marijuana (19.7 percent versus 18.3 percent) and cocaine (9.6 percent compared to 7.8 percent) as their primary substance at admission. Conversely, alcohol accounted for 40.0 percent of the statewide admissions compared to 19.1 percent among adults in the RPG Program. The

¹¹⁴ Includes methamphetamine, amphetamines, or other stimulants; 98.6 percent was methamphetamine.

¹¹⁵ Includes hallucinogens, benzodiazepines, barbiturates, other tranquilizers and sedatives, and other drugs.

¹¹⁶ State contextual data represent the Treatment Episode Data Set (TEDS) 2011 admissions data for 26 of the RPG states and TEDS 2010 admissions for two of the states (2011 data were not available for Arizona and Illinois). Treatment Episode Data Set – Accessed May 6, 2013 at SAMHSA Drug and Alcohol Services Information System (DASIS) <http://www.dasis.samhsa.gov/webt/NewMapv1.htm>. Data represent 1,424,483 treatment admissions for 28 states in which RPGs are located. Aggregated state contextual data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants. Methamphetamine includes amphetamine and other stimulants.

percentage of statewide admissions for heroin/other opiates (23.0 percent) also was higher than among adults in the RPG Program (16.9 percent).

Persons with substance use disorders commonly report the use of multiple substances. Over one half (54.9 percent) of the adults in the RPG Program reported some combination of methamphetamine, marijuana, and alcohol as their primary and secondary substance problems at first treatment admission.

Primary Substance Problem by Demographics of Adults in the RPG Program

Primary substance problem was significantly associated with adult gender and race/ethnicity ($p < .001$). Larger proportions of women than men reported methamphetamine (33.3 percent), heroin/other opiates (18.3 percent), and cocaine (11.5 percent) as their primary substance problem at treatment admission. Conversely, a larger proportion of men reported marijuana (26.0 percent) and alcohol (25.2 percent) as their primary substance problem (see Table 24).

Table 24: Primary Substance Problem at First Treatment Admission by Gender		
	Female (N=7,355)	Male (N=2,257)
Alcohol	18.2%	25.2%
Cocaine	11.5%	4.6%
Heroin/Other Opiates	18.3%	15.0%
Marijuana	18.7%	26.0%
Methamphetamine	33.3%	29.2%

$p < .001$. Note: Calculation of percentages excludes 326 adults reporting other primary substances at admission and 1,055 adults missing primary substance information.

Primary substance problem at first treatment admission also differed significantly ($p < .001$) by the participating adults' race/ethnicity (see Table 25):

- A larger proportion of Whites reported heroin/other opiates as their primary substance problem at first treatment admission.
- Larger proportions of Blacks reported cocaine or marijuana as their primary substance problem.
- Alaska Native/American Indians represented the largest proportion of adults who reported alcohol as their primary substance problem.
- The largest proportions reporting methamphetamine as their primary substance problem were Asian/Native Hawaiian/Other Pacific Islander and Hispanic adults.

Table 25: Primary Substance Problem at First Treatment Admission by Race/Ethnicity					
	<u>Alcohol</u>	<u>Cocaine</u>	<u>Heroin/Other Opiates</u>	<u>Marijuana</u>	<u>Metham- phetamine</u>
Alaska Native/American Indian (N=542)	36.7%	10.9%	11.3%	15.7%	25.5%
Asian (N=104)	22.1%	8.7%	1.9%	10.6%	56.7%
Black (N=1,155)	16.4%	32.8%	6.3%	31.0%	13.5%
Hispanic (N=1,625)	18.5%	9.1%	8.9%	17.1%	46.4%
Two or more races (N=194)	27.8%	8.8%	9.8%	26.8%	26.8%
White (N=5,594)	19.1%	5.7%	24.0%	19.4%	31.8%

p<.001. Note: All races exclude adults of Hispanic origin; Asian includes Native Hawaiian/Other Pacific Islander. Calculation of percentages excludes 321 adults reporting other primary substances at admission and 998 for whom primary substance was unknown.

Access To Substance Abuse Treatment¹¹⁷

Percentage of parents or caregivers who were able to access timely and appropriate substance abuse treatment; number of days between program entry and treatment entry

Summary of Findings

- Among the 10,512 adults in the RPG Program who received substance abuse treatment, 19.7 percent were already participating in substance abuse treatment prior to entering the RPG program and 80.3 percent were admitted to treatment on or after their RPG program entry date.
- The median time to treatment from RPG program entry for the 8,441 adults who were not already in substance abuse treatment at the time of program enrollment was 13 days. However, over one-third of adults (36.4 percent) accessed treatment within 3 days. Median time to substance abuse treatment entry from the child welfare file open date was 37 days, while median time to treatment from the substance abuse assessment date was 0 days (i.e., same-day access to treatment).¹¹⁸
- Median time to treatment was relatively consistent during the first four years of the RPG Program. It started at 12 days in program year one before increasing slightly to 13 days in program year two through four. However, in program year five, the median length of time to treatment decreased to 11 days.

¹¹⁷ Forty-six grantees reported on this performance measure for their RPG participant groups. Analysis excludes cases with missing data needed to compute time to treatment.

¹¹⁸ Time to treatment is measured from these three different time points given the diversity in grantees' program models and variability in their client referral and engagement processes.

- More than 9 in every 10 (91.6 percent) adults in the RPG Program who entered substance abuse treatment received the level of care for which they were assessed.¹¹⁹
- Nine grantees reported median time to treatment for their own comparison groups.¹²⁰ Among eight of these grantees, adults in their RPG program accessed substance abuse treatment more quickly than did adults in their comparison groups. For the remaining grantee, median time to treatment was the same among participant and comparison group adults. Collectively, the adults in these nine grantees' comparison groups who received services as usual waited a median of 22 days to enter treatment.

Important Explanatory Notes Regarding the Access to Treatment Measure and Results

- The intent of this indicator is to measure how long it takes a parent or caregiver to access treatment once they have entered the child welfare system (or the RPG program, if the grantee is focused on preventing child welfare involvement). How adults enter the RPG Program and are admitted to substance abuse treatment differs between grantees, depending on their target population, lead agency, local referral, admission procedures, and other factors. Therefore, time to treatment is measured from three different time points: 1) when the family enters the child welfare system, 2) when the family enters the RPG program, and 3) when a client receives a substance abuse assessment.
- Grantees may operationalize timely access to treatment differently depending on the pathways by which a family enters the child welfare system and the RPG program, is assessed for substance abuse, and enters treatment. If a client was already involved with the child welfare system and this involvement led to RPG referral and program enrollment, the child welfare file open date more accurately assesses larger systems impact. However, a more valid measure of grantees' performance is based on the time between the adult's RPG program entry and treatment admission, thus reflecting the effectiveness of the partnership in providing timely access to treatment. Time from substance abuse assessment to treatment entry also provides a good indication of timely access to treatment.
- The median number of days is presented (rather than the mean) as it is a better measure of the typical time to treatment for adults in the treatment sample; it is less sensitive to and less affected by outlier values.
- There is no agreed-upon standardized definition of "appropriate" treatment at this time. This was an optional data component collected by grantees using the American Society of Addiction Medicine Uniform Patient Placement Criteria (ASAM PPC) or a similar standardized assessment process that determines the level of care needed by a client (e.g., residential, outpatient, day treatment). Among RPG grantees collecting this data, appropriate

¹¹⁹ This is an optional data component for grantees using the American Society of Addiction Medicine Uniform Patient Placement Criteria (ASAM PPC) or similar standardized assessment process. Thirty-five grantees reported these data for 7,124 adults in the RPG program; percentages exclude missing data.

¹²⁰ This analysis is limited to grantees with sample sizes of 35 or more adults in both their participant and comparison groups.

was defined as receiving the recommended level of care as determined by the ASAM PPC or a similar assessment process.

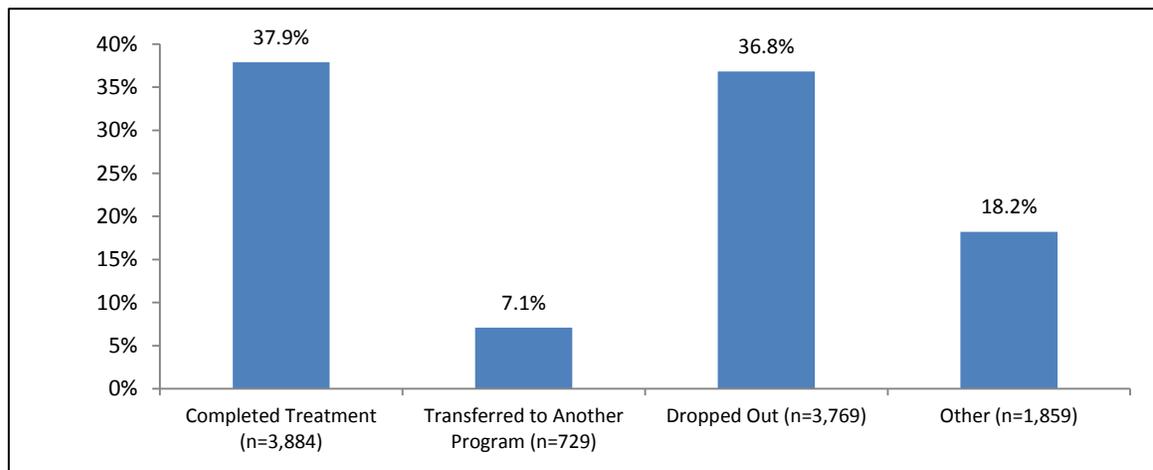
Retention In Substance Abuse Treatment¹²¹

Percentage of parents/caregivers referred to substance abuse treatment who remained until treatment completion; average length of stay in treatment for referred parents/caregivers

Summary of Findings

- Grantees reported on 10,241 substance abuse treatment discharges among the adults in their RPG programs. As noted previously, an adult may have multiple treatment episodes. Figure 23 shows that 37.9 percent of all discharges (n=3,884) completed treatment, while an additional 7.1 percent of discharges (n=729) were transferred to another program or facility for further treatment and known to report (considered a positive treatment outcome per federal treatment episode reporting). A total of 36.8 percent of discharges (n=3,769) dropped out of treatment, while the remaining 18.2 percent (n=1,859) occurred for other reasons.¹²²

Figure 23: Substance Abuse Treatment Discharges, Percentage by Discharge Status (N=10,241)



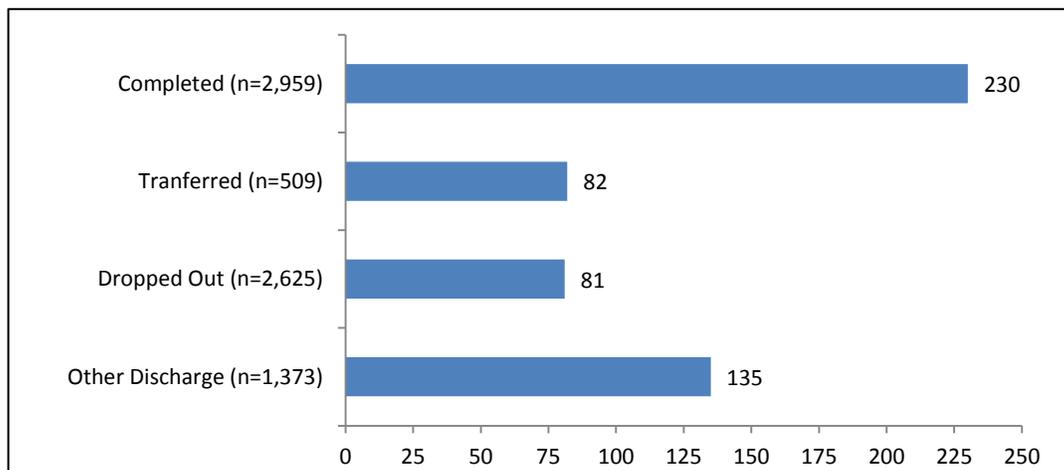
¹²¹ Forty-nine grantees reported on this measure for their RPG participant groups.

¹²² Excludes adults discharged from treatment whose discharge status was unknown. Numbers are based on total discharges; an adult may have multiple discharges from treatment. Of the 10,241 total discharges, 7,915 were single treatment episodes, 1,404 were second treatment episodes, and 922 were third or subsequent treatment episodes. Grantees reported discharge status consistent with federal Treatment Episode Data Set (TEDS) coding. Dropped out includes clients who chose not to complete the treatment program and those transferred to another facility but did not report to the next program. Other discharge status includes treatment terminated by action of facility or because the client was incarcerated, client left treatment for other specified reasons unrelated to treatment compliance, and death.

The additional treatment retention results that follow are based on the number of unique adults in treatment rather than the total number of discharges. As noted previously, the majority of adults experienced one episode of substance abuse treatment. Analysis was limited to information from the first treatment episode for the small group of adults who had multiple episodes.

- Overall, adults in the RPG Program had a median length of stay in substance abuse treatment of 146 days (4.8 months).¹²³ More than 8 in every 10 adults (84.8 percent) stayed in treatment more than 30 days and nearly two-thirds (65.2 percent) remained in treatment more than 90 days.
- As expected, adults who completed treatment had the longest median lengths of stay in treatment: 230 days (7.6 months). However, even those that dropped out of treatment received treatment for a median of 81 days (2.7 months). In addition, those who transferred received treatment for a median of 82 days (2.7 months), while those discharged for other reasons stayed in treatment a median of 135 days (4.4 months); see Figure 24.

Figure 24: Median Number of Days in Substance Abuse Treatment, by Treatment Discharge Status



- Twelve grantees reported comparison group data on this measure.¹²⁴ For 10 grantees, adults in their RPG program had longer median lengths of stay in substance abuse treatment than their own comparison group adults. Two grantees' comparison group adults had longer median lengths of stay in treatment than adults in their RPG programs. Collectively among the 12 grantees, adults receiving services as usual (the comparison group) had a median length of stay in substance abuse treatment of 91 days (3.0 months), compared to 156 days

¹²³ N=8,725 adults and excludes cases with missing information needed to compute length of time in treatment. For adults with multiple treatment discharges, length of time reflects their first treatment episode. The statistical analyses and key findings presented reflect the median (rather than the mean) number of days, as the median is considered a better measure of the typical length of stay for adults in the treatment sample.

¹²⁴ This analysis is limited to grantees with sample sizes of 35 or more adults in both their participant and comparison groups.

(5.1 months) for adults in their RPG programs. Of these grantees' comparison adults, 51.6 percent completed treatment, compared to 48.0 percent of adults in their RPG programs.¹²⁵

Discharge status was significantly different between racial/ethnic subgroups, as shown in Table 26 below:

- Higher percentages of Asian/Native Hawaiian/Other Pacific Islander, Alaska Native/American Indian, and Hispanic adults completed substance abuse treatment, and smaller percentages dropped out of treatment compared to adults in other racial/ethnic groups.
- Larger proportions of Hispanic and Black adults transferred to another substance abuse treatment program or facility (and were known to report) for further treatment.
- Compared to all other racial/ethnic groups, multiracial adults had lower rates of treatment completion and transfers for further treatment and higher treatment dropout rates.

	<u>Completed</u>	<u>Transferred to Another Program</u>	<u>Dropped Out</u>	<u>Other Discharge</u>
Alaska Native/American Indian (n=468)	47.4%	5.6%	31.6%	15.4%
Asian (n=82)	51.2%	3.7%	25.6%	19.5%
Black (n=937)	41.6%	7.4%	35.0%	16.0%
Hispanic (n=1,206)	47.5%	8.4%	30.9%	13.2%
Two or more races (n=175)	29.7%	4.0%	48.0%	18.3%
White (n=4,720)	38.0%	6.6%	34.9%	20.6%

p<.001. All races exclude adults of Hispanic origin; Asian includes Native Hawaiian/Other Pacific Islander.

Discharge status also was significantly related to the adult's primary substance problem at admission, as shown in Table 27:

- Treatment completion rates were generally highest among adults who reported cocaine (44.2 percent), methamphetamine (43.7 percent), or alcohol (43.6 percent) as their primary substance problem. In contrast, a much lower proportion of adults reporting heroin or other opiates (30.3 percent) as their primary substance at admission completed treatment.
- A larger proportion of adults who reported methamphetamine as their primary substance at admission transferred to another substance abuse treatment program or facility for further treatment.

¹²⁵ It is important to note that the transfer rate (also considered a positive treatment outcome) was higher (8.6 percent) among participant adults in these 12 RPG programs than among the grantees' own comparison groups (3.5%). Further, the median length of stay for grantees' comparison adults who completed treatment (116 days) was substantially shorter than among their RPG participant adults who completed treatment (215 days).

- Treatment drop-out rates were generally highest among adults who reported heroin or other opiates (39.6 percent) or marijuana (37.2 percent) as their primary substance problem.

Table 27: Substance Abuse Treatment Discharge Category by Primary Substance at Admission, First Treatment Episode

	<u>Completed</u>	<u>Transferred</u>	<u>Dropped Out</u>	<u>Other Discharge</u>
Alcohol (n=1,457)	43.6%	7.0%	31.9%	17.5%
Cocaine (n=730)	44.2%	7.3%	32.7%	15.8%
Heroin/Other Opiates (n=1,259)	30.3%	5.8%	39.6%	24.4%
Marijuana (n=1,447)	38.5%	7.2%	37.2%	17.1%
Methamphetamine (n=2,202)	43.7%	8.3%	34.7%	13.3%

p<.001. Excludes those whose primary substance at admission was unknown (n=1,116) or other type of drug (n=328).

Reduced Substance Use¹²⁶

Percentage of parents or caregivers who report a reduction in substance use, as measured by number of days of use in past 30 days at treatment intake and discharge¹²⁷

Summary of Findings

The results of this outcome measure can be reported in two different and equally informative ways. One way is the percentage of adults who reported any reductions in substance use. The other is changes in adults' frequency of use (i.e., the number of days use). The analyses below provide both perspectives.

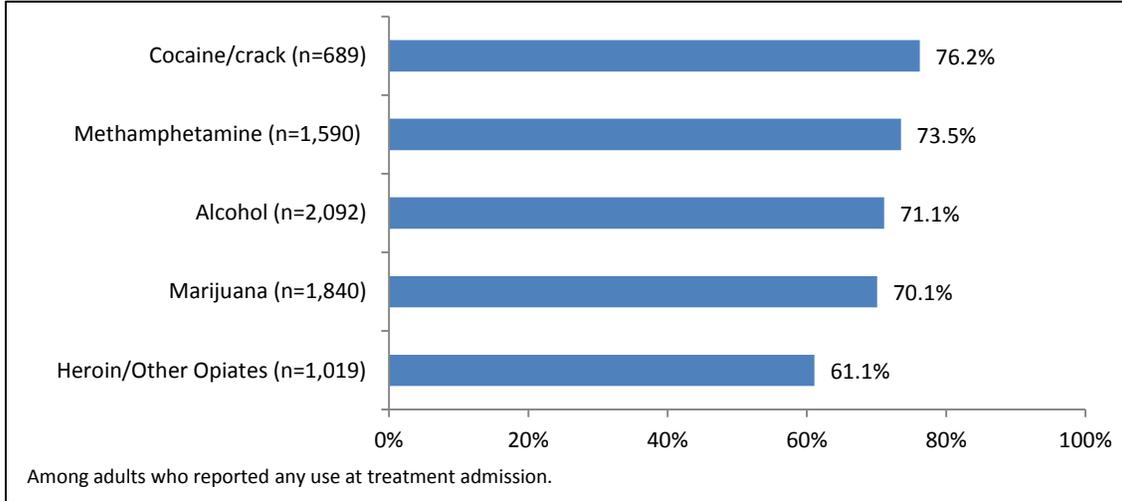
- Among adults who reported any substance use in the past 30 days at treatment admission, the largest proportion who reduced their use were those who used cocaine (76.2 percent), followed by adults who used methamphetamine (73.5 percent), alcohol (71.1 percent), and marijuana (70.1 percent). About three in every five (61.1 percent) adults who used heroin/other opiates reported reduced use from admission to discharge (see Figure 25).¹²⁸

¹²⁶ Forty-seven grantees reported on this measure for their RPG participant groups.

¹²⁷ Analysis excludes the substantial number of adults who reported no use in the 30 days prior to treatment intake and discharge. For incarcerated adults, grantees recorded use during the most recent 30-day period prior to incarceration.

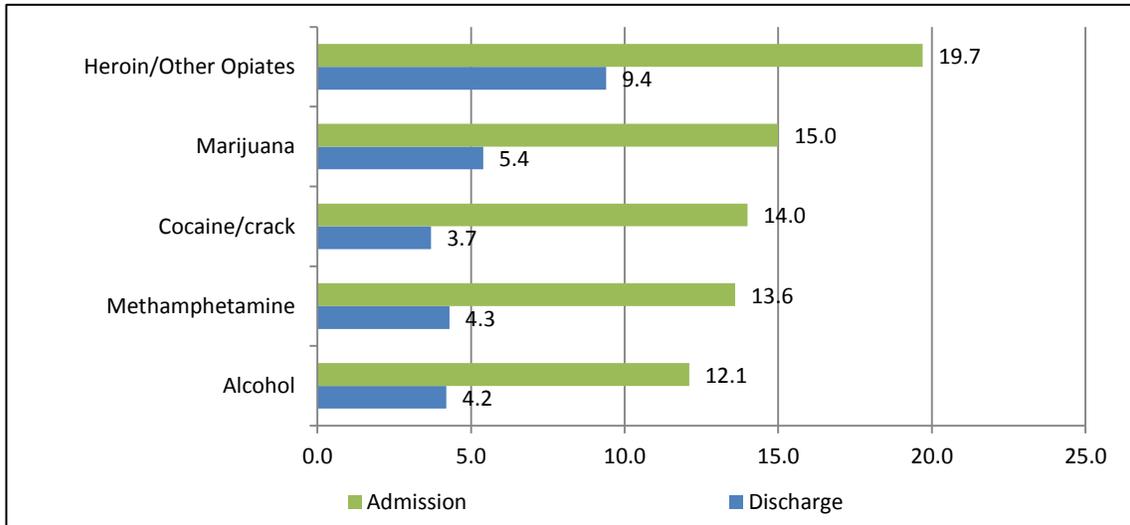
¹²⁸ The analyses focused on the five major substances used by 98.1 percent of RPG adults discharged from treatment: 1) alcohol, 2) cocaine/crack, 3) marijuana, 4) heroin/other opiates, and 5) methamphetamine. While grantees collected data on use of other substances (e.g., various subcategories of opiates, hallucinogens, benzodiazepines, barbiturates, tranquilizers, and inhalants), the number of adults reporting use of these substances was too small to conduct meaningful analyses.

Figure 25: Percentage of Adults Reporting Reduction in Use from Treatment Admission to Discharge, by Type of Substance



- Figure 26 illustrates reductions in the mean number of days of use in the 30 days prior to treatment admission compared to the 30 days preceding discharge. Heroin/other opiate use decreased from a mean of 19.7 days to 9.4 days, marijuana use decreased from 15.0 days to 5.4 days, cocaine/crack use declined from 14.0 days to 3.7 days, methamphetamine use decreased from 13.6 days to 4.3 days, and alcohol use decreased from 12.1 days to 4.2 days.

Figure 26: Mean Number of Days of Substance Use in the 30 Days Preceding Treatment Admission and Discharge, by Selected Substances



- The greatest percentage change¹²⁹ in mean days of use from substance abuse treatment admission to discharge was for cocaine/crack (73.6 percent), followed by methamphetamine (68.4 percent), alcohol (65.3 percent), marijuana (64.0 percent), and heroin/other opiates (52.3 percent).

¹²⁹ Percent change is calculated as $((\text{Admission Mean} - \text{Discharge Mean}) / \text{Admission Mean}) * 100$.

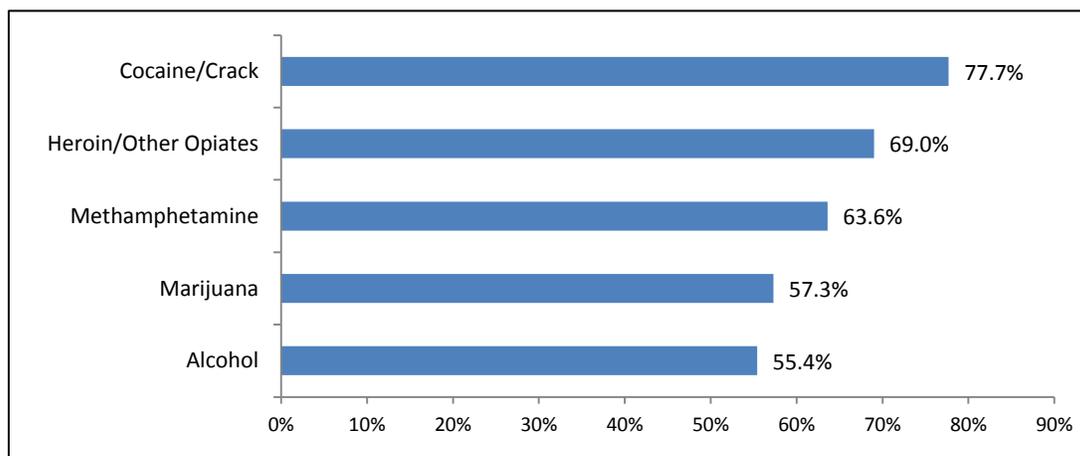
- The percentage of adults in the RPG Program who reported abstinence from alcohol use at treatment admission (60.3 percent) was slightly higher than the latest NOMs data¹³⁰ for the 25 states in which the grantees operated (58.6 percent). The percentages reporting abstinence at treatment discharge were roughly comparable among adults in the RPG Program (83.7 percent) and the 25-state contextual subgroup (84.0 percent); Table 28 below.

Table 28: Percentage of Adults Abstinent from Alcohol in 30 Days Prior to Treatment Admission and Discharge (Median Performance)		
	Adult RPG Participants	25-State Contextual Subgroup Data
Percentage of Adults Abstinent from Alcohol		
At Treatment Admission	60.3%	58.6%
At Treatment Discharge	83.7%	84.0%

Notes: RPG data represent 47 grantees. The state contextual subgroup data reflect the 25 states in which these RPGs were located. Data were retrieved from the states' Substance Abuse Prevention and Treatment Block Grant Application Forms T4 and T5 (FY2013) and represent either calendar or fiscal year 2011 for most states. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2012). The state contextual data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants.

- A substantial number of adults in the RPG program in substance abuse treatment reported no recent use of substances at both treatment admission and discharge (Figure 27).¹³¹ More than three-fourths (77.7 percent) reported no cocaine use during the 30 days preceding treatment admission and discharge, while more than two-thirds (69.0 percent) did not use any heroin or other opiates. Further, 63.6 percent of adults reported no recent methamphetamine use, 57.3 percent reported no marijuana use, and 55.4 percent reported abstinence from alcohol.

Figure 27: Percentage of Adults Reporting No Use (Past 30 Days) at Both Treatment Admission and Discharge, by Primary Substance



¹³⁰ Though the NOMs operational definition for reduction in substance use focuses on abstinence and does not directly align with the RPG indicator measure, it still provides instructive context for understanding grantees' performance.

¹³¹ The large percentage of adults reporting no recent substance use could be due to factors such as clients having already been under court supervision and undergoing regular drug testing, parents' unwillingness to disclose use for fear of repercussions from child welfare or other adverse consequences, or other factors related to type of drug and treatment modality.

Parents or Caregivers Connected to Supportive Services

Percentage of parents or caregivers who were assessed for and received supportive services that include: a) primary medical care, b) dental care, c) mental health, d) child care, e) transportation, f) housing assistance, g) parenting training/child development education, h) domestic violence services, i) employment or vocational training/education, j) continuing care/recovery support services, k) alternative therapies/natural healing practices, and l) other support services¹³²

Important Explanatory Notes Regarding the Adult Supportive Services Measure and Results

- This measure is intended to reflect whether adults received the supportive services they needed to facilitate positive recovery and child welfare outcomes. In certain cases, a grantee may have determined that a given support service was not needed or pertinent to a particular individual's situation (e.g., an adult who is already employed probably does not need employment services or a parent whose children are in kinship or foster care may not have a current need for child care). The findings presented here focus upon the parents and adults known to be in need of a given supportive service. However, to provide a fuller understanding of the most predominant needs of families served by the RPG program, information regarding whether individuals were assessed for and identified as needing a given service are summarized below and presented in more detail in Appendix H.
- The 45 grantees that reported supportive services data did not necessarily provide information regarding all 11 supportive services outlined in the measure. Grantees only collected data on the supportive services that were part of their overall program model and provided to clients either directly or through their community partners. Of the 45 grantees, the majority reported on parenting training (41), domestic violence services (41), mental health services (40), housing assistance (40), transportation (39), continuing care/recovery support services (38), child care (37), employment or vocational training/education (37), primary medical care (33), and dental care (30). Sixteen grantees collected data on alternative therapies/natural healing practices.

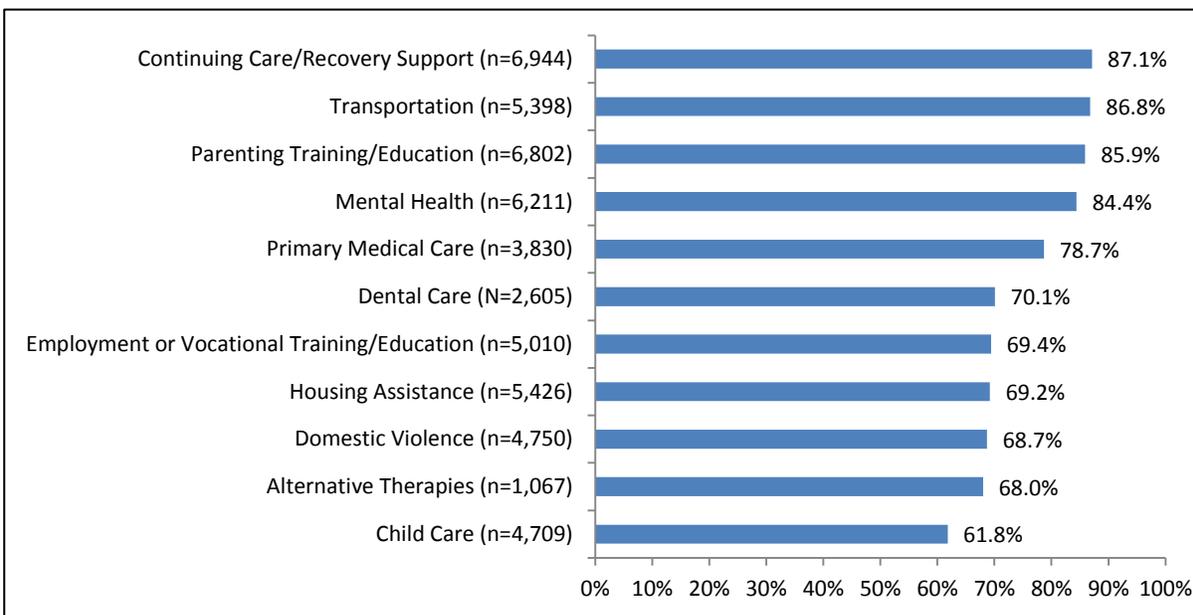
Summary of Findings

- **Assessed.** The majority of adults in the RPG programs received assessments to identify key supportive service needs. More than 90 percent of adults were assessed for mental health, continuing care, and parenting training and education needs. Between 84 percent and 88 percent of adults were assessed to determine their needs for domestic violence services, housing assistance, transportation, child care, employment and vocational training or education, and primary medical care. In addition, 77.4 percent of adults were assessed for dental care and 72.5 percent for alternative therapies/natural healing practice needs. (Data not shown; see Appendix H).

¹³² Grantees collecting data on "other support services" report those data in their local evaluation and/or Semi-Annual Progress Reports.

- Needed Service.** Among adults assessed, nearly all were identified as needing parenting training and education (96.0 percent) and continuing care/recovery support services (91.2 percent). The vast majority assessed also needed mental health services (88.6 percent), employment and vocational training services (85.2 percent), transportation (84.5 percent), primary medical care (83.5 percent), and housing assistance (83.2 percent). Further, more than three-fourths were identified as needing child care (79.3 percent) and domestic violence services (76.2 percent). Finally, more than two-thirds of adults assessed needed dental care (70.6 percent) and alternative therapies (67.1 percent). (Data not shown; see Appendix H.)
- Received Needed Service.** The majority of adults assessed and identified as needing a given service, subsequently received it. As Figure 28 below shows, almost 9 in every 10 adults received needed continuing care/recovery support services (87.1 percent, n=6,944), transportation services (86.8 percent; n=5,398), and parenting training and education (85.9 percent; n=6,802). A high percentage of adults also received needed mental health services (84.4 percent; n=6,211) and primary medical care (78.7 percent; n=3,830). Further, about 7 in every 10 adults identified as in need of the following services, received them: dental care (70.1 percent; n=2,605), employment or vocational training/education (69.4 percent; n=5,010), housing assistance (69.2 percent; 5,426), domestic violence services (68.7 percent; n=4,750), and alternative therapies (68.0 percent; n=1,067). Finally, more than three-fifths of adults (61.8 percent; n=4,709) received needed child care.

Figure 28: Percentage of Adults who Received Selected Supportive Services (of those Assessed and for whom a Given Service was Identified as a Need)



- Eight grantees reported comparison group data on the provision of needed mental health services. Of these, five grantees reported that a higher percentage of adults in their RPG programs received mental health services than did adults in their comparison groups. Only one grantee reported that a higher percentage of their comparison group adults received mental health services than their participant adults. The remaining two grantees reported that 100 percent of both their participant and comparison group adults identified as needing

mental health services received them. Overall, 73.4 percent of adults in the comparison conditions received needed mental health services.

- Ten grantees provided comparison group data on adults connected to needed parenting training and education. Six of the 10 grantees reported a higher percentage of adults in their RPG programs received parenting training and education than did adults in their comparison groups. Three grantees reported that 100 percent of both their participant and comparison group adults received needed parenting training and education. The remaining grantee indicated a higher proportion of their comparison adults received parenting training than adults in their RPG program. Among these 10 grantees, 68.6 percent of their comparison group adults received parenting training and education.
- Eight grantees reported comparison group data on the provision of continuing care/recovery support services. Five of these grantees reported a higher percentage of adults in their RPG programs received needed continuing care than did their comparison group adults, while one grantee reported a higher percentage of their comparison adults received these services. The remaining two grantees reported 100 percent of adults in both groups received needed continuing care. Overall, 75.3 percent of comparison group adults received continuing care/recovery support services.
- Eight grantees also provided comparison group data on the provision of housing assistance. Three of the grantees reported a higher percentage of adults in their RPG programs received needed housing assistance than did their comparison group adults. Conversely, three other grantees indicated a higher proportion of their comparison group adults received such services than their participant adults. The remaining two grantees reported that 100 percent of adults in both their participant and comparison groups received needed housing services. Overall, 66.2 percent of the eight grantees' comparison adults received housing services.

Employment

Percentage of parents or caregivers participating in substance abuse treatment who are: a) employed full time, b) employed part time, and c) currently enrolled in an educational or vocational training program

Summary of Findings—Employment

- Thirty-eight grantees reported the data necessary to compute employment outcomes for 2,701 adults in their RPG programs. As these data represent a small number of all adults served by the larger RPG Program, results should be interpreted with caution and cannot be generalized with confidence to the entire population of adults served by the RPG Program.¹³³

¹³³ These analyses were limited to 2,701 adults discharged from substance abuse treatment with valid employment data at both treatment admission and discharge. Analyses exclude a substantial number of adults (n=2,192) missing employment information for one or both time points, as well as adults who were not in the labor force at both substance abuse treatment admission and discharge (n=1,103) or at discharge alone (n=373).

- Among this subset of adults, the percentage who were employed *full time* increased significantly from 13.1 percent at substance abuse treatment admission to 25.1 percent at treatment discharge (Table 29). This represents a 91.6 percent rate of change from admission to discharge.¹³⁴
- The percentage of adults who were employed *part time* increased significantly from 9.7 percent at substance abuse treatment admission to 16.2 percent at discharge (Table 29), a 67.0 percent rate of change from admission to discharge.
- The percentage of adults who were employed *full or part time* increased significantly from 22.8 percent at substance abuse treatment admission to 41.3 percent at treatment discharge (Table 29), an 81.1 percent rate of change.

Table 29: Percentage of Adults Employed at Substance Abuse Treatment Admission and Discharge (N=2,701)		
	<u>Admission</u>	<u>Discharge</u>
Part Time	9.7%	16.2%
Full Time	13.1%	25.1%
Full or Part Time	22.8%	41.3%

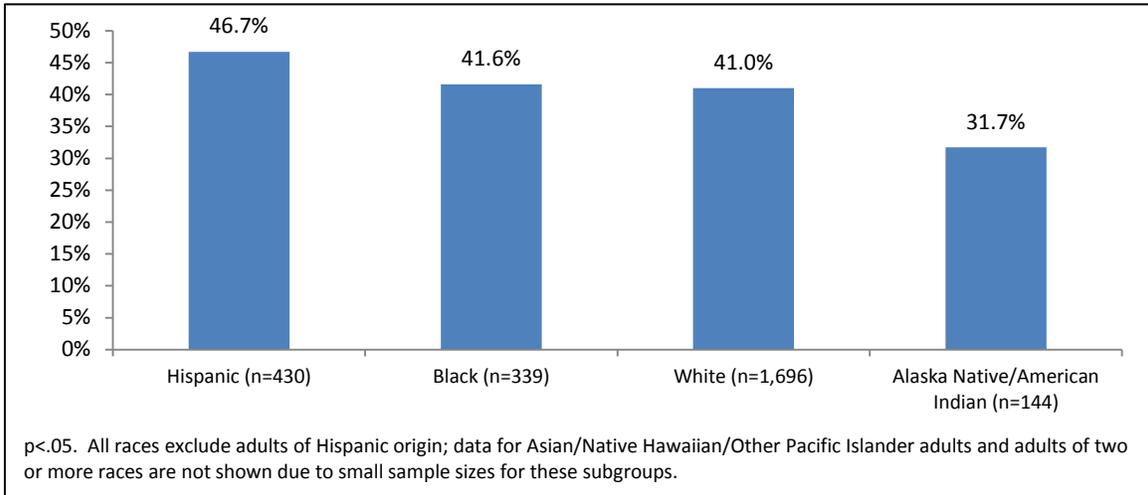
p<.001 for all items

- A total of 41.3 percent of participating adults increased or retained employment (full or part time) from treatment admission to discharge.¹³⁵
- Adults who increased or retained employment (n=1,113; Mean=30.9 years) from admission to discharge were slightly but significantly (p<.001) older than adults who remained unemployed or whose status decreased from employed to unemployed (n=1,585; Mean=29.9 years).
- Race/ethnicity was significantly associated with change in employment status from substance abuse treatment admission to discharge (p<.05). Larger proportions of Hispanics (46.7 percent), Blacks (41.6 percent), and Whites (41.0 percent) increased or retained employment than Alaska Native/American Indian adults (31.7 percent); see Figure 29.

¹³⁴ Percent change is calculated by subtracting “old” data from “new” data, dividing that result by old data, and multiplying it by 100. For example, $[(25.1-13.1)/13.1] \times 100 = 91.6$ percent change.

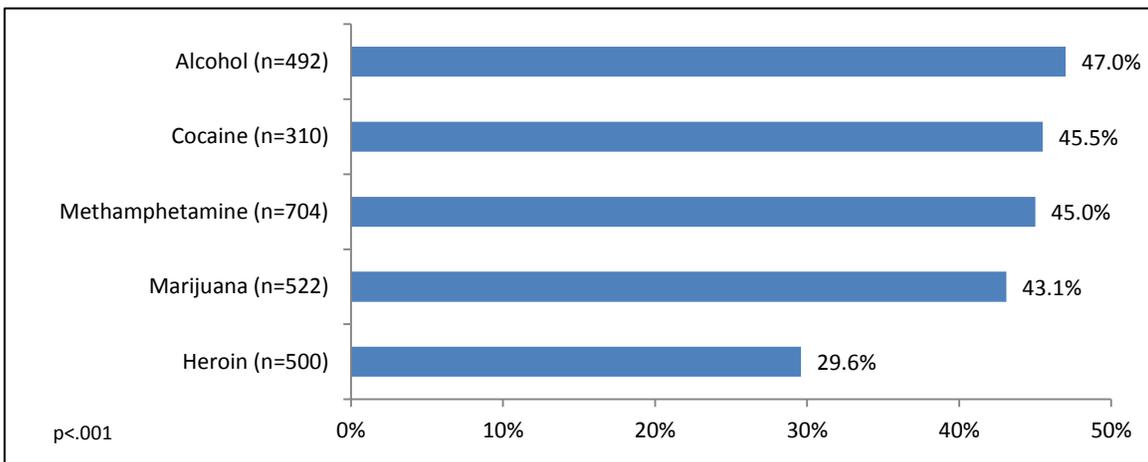
¹³⁵ Increased or retained employment is calculated based on the change from employment status at intake to employment status at discharge. That this figure (41.3 percent) is equal to the proportion of adults employed part-time or full-time at discharge from substance abuse treatment is entirely coincidental.

Figure 29: Percentage of Adults who Increased or Retained Employment (Full or Part Time) from Substance Abuse Treatment Admission to Discharge, by Race/Ethnicity



- Adults' primary substance was significantly associated with change in employment status from treatment admission to discharge (p<.001). The largest percentage of adults who increased or retained employment (47.0 percent) reported alcohol as their primary substance, followed by adults reporting cocaine (45.5 percent), methamphetamine (45.0 percent), and marijuana (43.1 percent). A substantially lower percentage of adults reporting heroin as their primary substance increased or retained employment (29.6 percent); see Figure 30.

Figure 30: Percentage of Adults who Increased or Retained Employment (Full or Part Time) from Substance Abuse Treatment Admission to Discharge, by Primary Substance Problem at Admission



Summary of Findings—Enrollment in Educational or Vocational Training Program

- The percentage of adults in the RPG Program who were enrolled in an educational or vocational training program increased significantly from 7.3 percent at treatment admission to 15.0 percent at discharge, a 105.5 percent rate of change (p<.001).
- Fifteen percent of adults in the RPG Program increased or retained enrollment in an educational or vocational training program from treatment admission to discharge.

Reduced Criminal Behavior¹³⁶

Percentage of parents or caregivers participating in substance abuse treatment who show a decrease in criminal behavior, as measured by the number of arrests in the 30 days prior to treatment intake and discharge

Summary of Findings

- Thirty-three grantees reported the data necessary to compute reduced criminal behavior for 5,195 adults. As these data represent a small number of all adults served by the larger RPG Program, results for this measure should be interpreted with caution and cannot be generalized with confidence to the entire population of adults served by the RPG Program.
- Among 695 adults with any arrests in the 30 days prior to treatment admission, 80.0 percent showed a decrease in criminal behavior at treatment discharge (as measured by number of subsequent arrests). Nearly all (19.3 percent) of remaining adults with any recent arrests at admission reported no change in criminal behavior, while 0.7 percent reported an increase in the number of arrests.¹³⁷
- Adults who showed a decrease in criminal behavior (n=555, Mean=30.8 years) were significantly younger than adults who had the same or an increased number of arrests from intake to discharge (n=139, Mean=36.2 years; p<.001).
- Most adults in the RPG Program (84.8 percent) did not have any arrests in the prior 30 days at substance abuse treatment admission and/or discharge. Still, the total percentage of RPG adults with no arrests increased significantly from 86.6 percent at treatment admission to 95.4 percent at treatment discharge (p<.001). This rate of change is greater than the latest NOMs data for the RPG states (Table 30).¹³⁸

¹³⁶ Thirty-three grantees reported complete data on this performance measure for adults in their RPG program. Analyses include adults discharged from substance abuse treatment and for whom arrest data were reported at both treatment admission and discharge.

¹³⁷ Due to delays in enforcing warrants or administrative processes, it is possible that an arrest reported for the 30 days preceding substance abuse treatment discharge could reflect a prior crime committed rather than a new law violation that occurred while the individual was participating in treatment services.

¹³⁸ The RPG performance measure differs somewhat from NOMs in that the percentage of clients with no arrests in the 30 days prior to treatment admission and discharge are not part of the RPG operational definition. However, these data are available for RPG adults and thus provided as additional contextual data. The national data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants.

Table 30: Percentage of Adults with No Arrests in the Prior 30 Days at Treatment Admission and Discharge (Median Performance)		
	<u>RPG Adults</u>	<u>21-State Contextual Subgroup Data</u>
Percentage of Adults with No Arrests in Past 30 Days		
At Treatment Admission	86.6%	91.2%
At Treatment Discharge	95.4%	95.5%

Notes: RPG data represent 35 grantees. The state contextual subgroup data reflect the 21 states in which these RPGs are located. Data were retrieved from the states' Substance Abuse Prevention and Treatment Block Grant Application Forms T3 (FY2013) and represent either calendar or fiscal year 2011 for most states. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2013). The state contextual data are not intended to serve as a comparison group for the RPG Program and do not support statistical comparisons to RPG participants.

CHAPTER IX: CHILD, ADULT, AND FAMILY WELL-BEING

CHAPTER OVERVIEW

This chapter discusses seven RPG performance measures designed to measure child, adult, and family well-being. It is informed by ACYF's recent adoption (April 2012) of a child well-being framework to promote and strengthen children's social and emotional well-being, and the field's larger shift towards a more comprehensive view of family well-being.

The beginning of this chapter provides important background and context for reviewing the well-being data. It outlines the RPG Program's approach to measuring well-being within the original grant program design: HHS did not require grantees to use specific clinical instruments or assessments, or to use the same instruments to measure the well-being indicators. Grantees had discretion to choose the instrument best suited for their overall program model and target population.

Among the more than 50 different instruments grantees selected to measure the various well-being concepts, HHS identified nine most commonly used valid and reliable instruments. The well-being measure analyses were limited to data from these nine instruments. Thus, the data presented represent only subgroups of grantees (ranging from 4 to 10 grantees) that used any of these nine instruments. As such, these data represent a small percentage of all children, adults, and families served by the larger RPG Program.

During the initial five-year grant period, the larger field of well-being measurement has advanced—and it continues to evolve. The grantees' experiences in measuring well-being reflect a field in development and the inherent challenges associated with assessing change in child, parent, and family well-being. Several important lessons learned over the course of the RPG Program for strengthening future measurement of this critical outcome area also are highlighted.

INTRODUCTION: THE WELL-BEING FRAMEWORK

When the RPG Program was implemented in September 2007, the general concept of “well-being” was recognized, together with child safety and permanency in caregiving relationships, as the primary outcomes of child welfare services. The federal Child and Family Services Review (CFSR) process operationally defined well-being as parents having enhanced capacity to care for the health and educational needs of their children. Over the past decade, measurement of well-being continues to be discussed and more clearly defined.¹³⁹

Since the implementation of the RPG Program and during the last several years in particular, there has been increased attention on ensuring services are delivered to meet children's additional needs, including their social and emotional needs, and a broader operational definition

¹³⁹ Lou, C., Anthony, E.K., Stone, S., Vu, C.M. & Austin, M.J. (2008). Assessing child and youth well-being: Implications for child welfare practice. *Journal of Evidence-Based Social Work*. 5:1-2, 91-133

of child well-being was sought. Various national and federal efforts are evidence of this change.¹⁴⁰

In April 2012, ACYF issued an Information Memorandum (IM) outlining its priority to promote and strengthen children’s social and emotional well-being, noting that ensuring safety and achieving permanency are necessary but not sufficient to improving well-being.¹⁴¹ The IM provides a child well-being framework focused on four outcome domains: cognitive functioning, physical health and development, behavioral/emotional functioning, and social functioning. Environmental supports and personal characteristics are viewed as intermediate outcome domains that influence the four child well-being domains. This framework helped inform the organization of this chapter and presentation of the RPG data.

Interest in well-being has focused largely on the individual child or adult and often centers on a single aspect of functioning. The recent ACYF IM acknowledges the inherent complexities of adequately capturing well-being noting, “ACYF is not de-emphasizing other aspects of well-being. Rather, ACYF is prioritizing social and emotional well-being.” Moreover, as the ACYF IM notes, many of the evidence-based interventions that improve child functioning require the involvement of caregivers and specifically target their behaviors for change as well; this addresses the importance of measuring overall family well-being.

With guidance from the field,¹⁴² progress in understanding and measuring well-being continues. However, “ACYF recognizes that it is not simple to transform a system in this way and that these processes take time.” The experiences of the RPG Program exemplify this recognition, as grantees’ encountered challenges in their efforts to measure child, adult, and family well-being. Yet grantees also gained important lessons over the course of the RPG Program for strengthening future measurement of this critical outcome area throughout the child welfare system.

¹⁴⁰ Other efforts focused on child and family well-being include, for example, the Strengthening Families approach and Protective Factors Framework that more than 30 states have adopted; the National Child Welfare Resource Center on Legal and Judicial Issues’ proposed well-being measures for the courts; the KIDS COUNT Data Book (which includes 16 child well-being indicators in the domains of economic well-being, education, health, and family and community); the National Study on Child and Adolescent Well-Being; and the development of a National Child Well-Being Index. ACYF also has incorporated a more explicit focus on child well-being in recent grant programs such as the Maternal, Infant, and Early Childhood Home Visiting Program and the Child Welfare – Early Education Partnerships to Expand Protective Factors for Children with Child Welfare Involvement Program. In addition, the federal government is currently exploring how three different frameworks for protecting children and preventing child maltreatment (the Centers for Disease Control and Prevention’s Essentials for Childhood, the Strengthening Families Protective Factors Framework, and the ACYF Protective Factor Framework) complement each other to form a system of protective factors.

¹⁴¹ Information Memorandum ACYF-CB-IM-12-04 issued April 17, 2012; available at: http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2012/im1204.pdf.

¹⁴² Within the field, there tends to be general agreement on some basic guiding principles for measuring well-being. See, for example: Center for the Study of Social Policy (2012). *Results-Based Public Policy Strategies for Promoting Children’s Social, Emotional, and Behavioral Health*. Washington, DC: author; O’Hare, W., Mather, M. & Dupuis, G. (2012). *Analyzing State Differences in Child Well-Being*. New York, NY: Foundation for Child Development; Fernandez, E. (2011). Conceptualizing indicators for children in diverse contexts and particular circumstances, challenges, and constraints. *Child Ind Research*. 4 (547-553); and Wollny, I., Apps, J. & Henricson, C. (2010). *Can Government Measure Family Wellbeing?* London, England: Family and Parenting Institute.

MEASURING WELL-BEING: OVERVIEW OF THE RPG PROGRAM APPROACH

This chapter discusses seven RPG performance measures that reflect grantees' progress in improving child, adult, and family well-being. The RPG Program defined these measures as follows:

- **Prevention of substance-exposed newborns:** Percentage of pregnant women who had a substance exposed newborn (first or subsequent), as detected at birth.
- **Children connected to supportive services:** Percentage of children who were assessed for and received the following supportive services: developmental services, mental health or counseling, primary pediatric care, substance abuse prevention and education, substance abuse treatment, educational services, and other supportive services.
- **Child well-being:** Percentage of children who show an increase in socio-emotional, behavioral, developmental, and/or cognitive functioning.
- **Adult mental health:** Percentage of parents or caregivers who show an improvement in mental health functioning.
- **Parenting capacity:** Percentage of caregivers who demonstrate increased parental capacity to provide for their children's needs and family's well-being. Parenting capacity is operationalized as the ability of parents/caregivers to understand and give priority to their child's basic needs (e.g., health, educational, developmental, safety, social, housing), to adapt to the child's changing needs over time, and to address any challenges posed by their child's temperament and development.
- **Family relationships and functioning:** The percentage of parents or caregivers who show improved parent-child and other family interactions. Family functioning refers to how family members communicate, relate to one another, and maintain relationships, as well as how they make decisions and solve problems.
- **Risk and protective factors:** The percentage of parents or caregivers who show a decrease in risk factors associated with reasons for service and/or an increase in protective factors to prevent child maltreatment. Risk factors may include problems such as acute life stress or everyday stress, physical and mental health crises, acute school problems, family relationship conflict, social isolation, child behavior/mental health/physical health problems, caregiver mental or physical health problems, impaired caregiver-child relationship, poverty, violence in the community, or caregiver childhood adversity. Protective factors may include elements such as family systems strengths, coping strategies, social support, spirituality, community connections, housing stability, and safe neighborhoods.

As briefly stated in Chapter IV, data collection for the first two measures (prevention of substance-exposed newborns and children connected to supportive services) is similar to that of the safety, permanency, and recovery outcome measures. They are standardized across grantees and grantees submit common data elements to calculate these measures.

For the other five measures, state and county data systems do not include standardized data elements. Grantees thus measured 1) child well-being, 2) adult mental health, 3) parenting capacity, 4) family relationships and functioning, and 5) risk and protective factors using valid and reliable instruments they selected for their specific program model and target population. HHS did not require grantees to use specific clinical instruments or the same instruments to measure the well-being indicators. Therefore, specific data elements vary across grantees.

Nearly all grantees reported on at least one of these five measures. Across all of these grantees, more than 50 different instruments were used to measure these well-being concepts. In addition, grantees often used more than one instrument or method to measure a child's, adult's, or family's progress. Further, given the interrelated nature of these five measures, grantees often assessed multiple measures with the same instrument (though they may have used a specific subscale or domain for a given well-being measure). Thus, a particular instrument may cut across multiple well-being measures.

Among the myriad of instruments grantees used, HHS identified nine of the most commonly selected valid and reliable instruments expected to yield sufficient sample sizes over the course of the RPG Program for analysis:

- Addiction Severity Index (ASI)
- Adult-Adolescent Parenting Inventory-2 (AAPI-2)
- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Social-Emotional (ASQ-SE)
- Beck Depression Inventory
- Child Behavior Checklist (CBCL)
- North Carolina Family Assessment Scales (NCFAS, NCFAS-G, NCFAS-R, and NCFAS G+R)
- Parenting Stress Index (PSI)
- Protective Factors Survey

A subset of 35 grantees that used any of these nine instruments submitted their instrument-specific data to HHS for analysis. Appendix F provides a brief description of each instrument, how it is scored, the number of grantees that used that instrument, and sample sizes. Grantees that used other instruments or methods to measure these particular well-being indicators reported their findings in their Semi-Annual Progress Reports, local evaluation reports, and/or Final Progress Report. This Fourth Report to Congress focuses primarily on grantees' data for the above nine instruments but also includes selected results from grantees using other information sources and or measures.

It is important to keep in mind that these final data encompass a small subset of all grantees and represent a small percentage of all children, adults, and families served by the larger RPG Program. For example, a subset of only seven grantees reported ASQ-SE data to HHS and a subset of only six grantees reported CBCL data.

THE RPG PROGRAM WELL-BEING DATA

All of the RPG well-being measures are clearly interdependent and closely connected. For example, improvement in a parent's mental health functioning or strengthening a family's interactions and relationships translates to an increase in protective factors. Considering the overlap between the RPG well-being measures, grantees' use of a particular instrument to measure multiple well-being indicators, and larger contextual events in the field (see above), grantees' data from the nine selected instruments were organized by the following functional well-being domains:

- Child Well-Being—which includes a child's cognitive functioning, physical health and development, and child's social-emotional and behavioral functioning
- Adult Well-Being—which focuses on a parent's or caregiver's mental health functioning and parenting capacities (e.g., parenting attitudes and behaviors)
- Family Well-Being—which includes family relationships and interactions as well as family and community supports

As previously noted, challenges remain in adequately defining and measuring the concept of well-being. Yet many advances have been made since the RPG Program was implemented. While this expanded knowledge base will be valuable in informing future endeavors in this area, the efforts and experiences of the grantees to measure well-being are perhaps best viewed as an important and ongoing learning process.

HIGHLIGHTS: WELL-BEING DATA FINDINGS AND LESSONS LEARNED

Selected child, adult, and family well-being results are summarized below. A more extensive discussion of each well-being domain and detailed data findings are included later in the chapter.

Child Well-Being

Baseline results¹⁴³ indicate that at RPG program entry:

- Approximately one-third of young children aged 0 to 5 years were identified as at risk of developmental delay and requiring a more in-depth evaluation or further monitoring in the areas of physical development (33.8 percent) or cognitive functioning (31.0 percent).
- Between 19.6 percent and 22.4 percent of young children aged 0 to 5 years were identified as having or at risk of social or emotional behavioral difficulties.
- Nearly half (49.1 percent) of school-aged children 6 to 18 years old were identified as having clinical or borderline clinical behavioral issues.

During RPG program participation, the majority of all children and youth with an identified need received supportive services to help strengthen well-being that included:¹⁴⁴

¹⁴³ Data represent the subset of grantees using the ASQ, ASQ-SE, and CBCL.

- Substance abuse prevention and education (91.1 percent)
- Primary pediatric care (85.3 percent)
- Educational services (82.3 percent)
- Mental health or counseling services (80.0 percent)
- Developmental services (75.0 percent)
- Substance abuse treatment (69.2 percent)

From RPG program entry to discharge:¹⁴⁵

- The percentage of children for whom overall child well-being was rated a strength significantly increased from 24.8 percent to 53.0 percent.
- Children made the greatest gains in the areas of mental health, behavior, and parent relations.

Adult Well-Being

At RPG program entry, 37.2 percent of adults exhibited mild to severe depressive symptoms.¹⁴⁶ Overall, the various data suggest that parents' (or caregivers') well-being improved from RPG program admission to discharge:

- The percentage of parents experiencing clinical levels of stress significantly decreased from 34.0 percent to 21.3 percent.¹⁴⁷
- Participating parents showed significant reductions in severity levels of unemployment, alcohol and drug use, legal issues, family conflict, medical issues, and psychiatric symptoms.¹⁴⁸
- The percentage of parents for whom overall parental capabilities was rated a strength significantly increased from 14.9 percent to 46.5 percent. Parents showed the most progress in the areas of substance use (e.g., no or decreased substance use, or use that does not impair their ability to parent) and age-appropriate supervision of children.¹⁴⁹

¹⁴⁴ Percentages are of children assessed and for whom a given service was identified as a need.

¹⁴⁵ Data represent the subset of grantees using the NCFAS (Child Well-Being subscale).

¹⁴⁶ Baseline data represent the subset of grantees using the Beck Depression Inventory.

¹⁴⁷ Data represent the subset of grantees using the PSI Short Form (Total Stress scale).

¹⁴⁸ Data represent the subset of grantees using the ASI.

¹⁴⁹ Data represent the subset of grantees using the NCFAS (Parental Capabilities subscale).

Family Well-Being

From RPG program admission to discharge, families showed statistically significant improvements in their overall family interactions, environment, and family safety:¹⁵⁰

- The percentage of parents for whom overall family interactions was rated a strength significantly increased from 21.8 percent to 47.0 percent. Parents made the greatest gains in age-appropriate expectations for and bonding with children, as well as mutual emotional and physical support within the family.
- The percentage of parents for whom their overall environment (e.g., a family's overall stability and safety in their home and community) was rated a strength significantly increased from 18.4 percent to 41.5 percent. Parents showed the greatest progress in the areas of safety in the community, housing stability and habitability, and creating a positive learning environment for their children.
- The percentage of parents for whom overall family safety was rated a strength significantly increased from 17.2 percent to 41.0 percent. Parents made the greatest gains in reducing occurrence or risk of child neglect, emotional child abuse, and physical child abuse, as well as reducing or successfully addressing domestic violence between parents or caregivers.

Measuring Well-Being: Key Lessons Learned

During the course of their programs, the regional partnership grantees' also identified several important lessons for continued and future cross-systems efforts to measure well-being. These lessons are discussed further in the chapter's last section and briefly highlighted below.

- *Obtaining a comprehensive picture is important.* The instrument-specific data are best viewed in combination with other measures and available information to develop a more complete picture of well-being.
- *Adequate time is needed to measure change.* Child, adult, and family well-being are multifaceted constructs and families' problems complex and severe. The recovery and family healing process are not subject to a precise timetable.
- *The instruments used to measure well-being need to align with a program's available human and financial resources.* Large-scale, in-depth evaluations intended to measure well-being require sufficient time, planning, training, and resources.
- *The provision of expert technical assistance is needed early in the planning process.* Both programmatic and evaluation technical expertise are needed to help programs select the most appropriate well-being measurement instruments that align with their program model and target population.

¹⁵⁰ Data represent the subset of grantees using the NCFAS (Family Interactions, Environment, and Family Safety subscales).

- *Appropriately trained and qualified staff are needed to administer the instruments.* Different instruments may serve different purposes and as such, require different types of staff to administer, score, and interpret.
- *Baseline self-report assessments may not accurately reflect the severity of a parent's or family's situation.* Upon initial program entry, clients may lack a clear understanding of the issues or behaviors that led to their program involvement. As a result, baseline self-assessments may not accurately depict the family's actual state.
- *Program and evaluation staff need to communicate effectively about data collection and reporting roles and responsibilities.* Clear, agreed-upon procedures regarding instrument administration and data collection and reporting should be implemented.

ANALYSIS AND INTERPRETATION OF THE RPG WELL-BEING MEASURES

The results in this report reflect grantee data submitted through the end of the grant period (September 30, 2012). Data analyses for the two standardized measures regarding substance-exposed newborns and children's supportive services included basic descriptive statistics for the grantees' participant groups.

Analyses for the other five measures (measured with one or more of the instruments identified above) also were limited to participants in grantees' RPG programs¹⁵¹ and included:

- Descriptive baseline statistics that, depending on the instrument, may include the percentage of children or adults categorized at a particular level of functioning or their mean well-being score at RPG program admission.
- Statistical analyses of change in well-being from RPG program admission to program discharge.¹⁵² Results of these pre-post analyses are presented in summary graphs, with accompanying explanatory narrative.

Grantees' initial program and evaluation designs typically included administration of their selected instrument(s) at a minimum of two time periods to measure a client's change over time (e.g., at program or treatment entry for the baseline and at program or treatment discharge for the

¹⁵¹ Due to insufficient comparison group sample sizes, analyses for this report were limited to the RPG participant group data. Grantees' ability to collect and report comparison group data for the well-being indicators was more limited because it required significant primary data collection efforts. In contrast, grantees largely obtained comparison data on the standardized child and adult performance indicators through existing administrative data sets. Where available, norm data or empirical research on use of an instrument in the general population is included in Appendix G for comparative context.

¹⁵² In general, categorical chi-square analyses or paired t-tests were conducted to test for improvements from baseline to discharge. This type of analysis is appropriate and aligns with the overall performance measurement approach HHS used to review grantees' progress. As described in Chapter IV, assessment of the overall RPG Program's progress (for this initial grant period) was not designed as or intended to be a cross-site evaluation. As such, attempts to define and control for site variability at the grantee level were not required and not appropriate for the analyses. However, where appropriate, repeated measures multivariate analyses of variance (MANOVAs) were conducted to test whether the results varied by individual grantee. This provides supplemental confirmatory tests of baseline-discharge change. These more detailed statistical results are included in Appendix F.

follow-up). As grantees' programs progressed, however, several grantees encountered difficulties with obtaining follow-up or discharge data due to various reasons (e.g., turnover or changes in staff that administer instruments, clients exiting treatment without a planned discharge, incomplete or inconsistent instrument administration, general attrition in program participants).

Table 31 below summarizes important data caveats and considerations in interpreting these data. (Refer to Appendix F for more information on methods.) A more detailed discussion of the child, adult, and well-being results follows the table.

Table 31: Key Issues to Consider in Interpreting the Well-Being Data

- ***The data represent a small subset of all grantees reporting these measures.*** The well-being data presented encompass a limited number of grantees that used one or more of the nine identified instruments. Additional grantees used other clinical instruments and methods to measure these indicators and reported their findings in their Semi-Annual Progress Reports, local evaluation reports, and/or their Final Progress Reports. Because the subset of grantees using the identified instruments represents a small percentage of all children, adults, and families served by the larger RPG Program, these data must be interpreted with caution and cannot be generalized to the whole RPG population.
- ***The data analyses align with HHS’s overall performance measurement approach, which does not control for site variability at the individual grantee level.*** As outlined in Chapter IV, HHS used a performance measurement approach to review grantees’ progress. HHS did not design or intend to conduct a cross-site evaluation of the overall RPG Program (for this initial grant period). As such, attempts to define and control for site variability at the grantee level were not required and were beyond the scope of the analyses. The well-being data analyses presented here are appropriate and align with HHS’s overall performance measurement approach. Appendix F provides supplementary statistics showing whether certain results varied by individual grantee.
- ***Differences in intended use of instruments.*** HHS did not require grantees to use specific clinical instruments or the same instruments to measure the well-being indicators. Thus, there was variability among grantees in which instruments they used and how they used them. Some grantees reported using their instruments for evaluative purposes (i.e., to provide data for the performance measure), while others used their selected instruments (e.g., the ASQ and ASQ-SE) more as a screening or assessment tool to help inform treatment and service provision.
- ***Limitations in measuring complex constructs with a single instrument.*** Many grantees indicated they did not rely on only one instrument to assess such complex constructs as child well-being, mental health, parenting, family relationships and functioning, and risk and protective factors. Rather, they used a given instrument in combination with other instruments or methods to provide a more comprehensive measure of a given well-being construct.
- ***Capacity of instruments to measure change given variation in duration and intensity of individual services and overall RPG program duration.*** Not all instruments grantees selected may be sensitive enough to detect change given the variation across grantee programs in length and intensity of services. As such, administration of the instruments, in particular at discharge or interim follow-up points, likely differed for clients, depending on the grantee, duration of specific RPG interventions, and program model. Further, some constructs such as adult depression or child developmental status may be harder to affect than other constructs such as social support or parenting behaviors. In such cases, the duration of the intervention needs to be sufficient for the instrument to detect change.
- ***Severity and complexity of RPG clients’ needs and variation in target populations.*** Grantees targeted at-risk populations with many co-occurring issues and complex needs. The clinical severity of their populations is evident in many of the baseline instrument scores presented. Grantees noted that some clients’ behaviors or problems may be so complex or severe that the instrument may not capture change or significant progress in the timeframe that they received RPG services, even though the client showed signs of improvement while in the RPG program. In addition, the target populations served and complexity of client needs may have dramatically differed among grantees that used the same instrument. This may reduce the effects of targeted program services on these measures across grantees and can affect interpretation of baseline and change scores.

Child Well-Being—Detailed Analysis

As noted in this chapter's introduction, child well-being encompasses multiple aspects of a child's overall development. This report, in keeping with ACYF's child well-being framework, focuses on a child's social-emotional/behavioral, cognitive, and physical functioning. Each domain plays an important part of a child's functioning throughout their development; together they provide a comprehensive picture of a child's well-being.

This section provides more detailed data results for the subset of grantees that used the ASQ, ASQ-SE, CBCL, and NCFAS (Child Well-Being subscale) to measure these domains. It also presents results for those grantees reporting on the prevention of substance-exposed newborns and children connected to supportive services.

Social-Emotional and Behavioral Functioning—Summary Findings

Grantees are using several instruments to measure the various domains of a child's social-emotional and behavioral functioning (e.g., self-control, self-esteem, self-efficacy, emotional management and expression, internalizing and externalizing behaviors, pro-social behavior, coping, social competencies, social connections and relationships). This section provides selected baseline descriptive data regarding children's social-emotional and behavioral functioning at RPG program admission as well as data highlighting change over time.

In addition to the cognitive and physical health and development domains discussed in the subsections further below, the ASQ also includes a personal-social domain that assesses young children's solitary and social play skills. At RPG program admission:

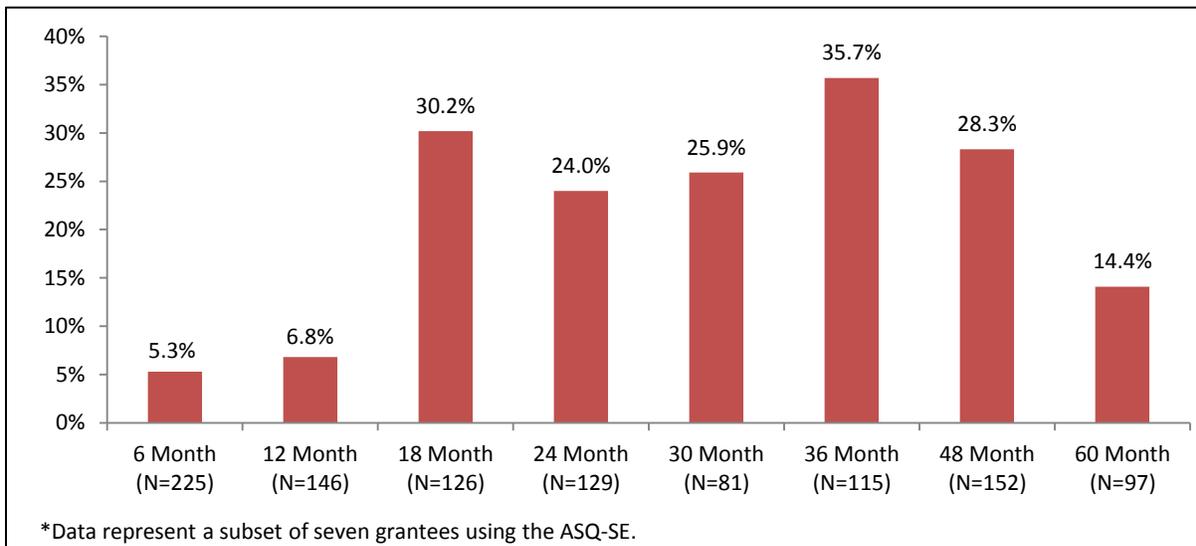
- A total of 17.1 percent of children were identified as needing a more in-depth assessment (7.3 percent) or further monitoring (9.8 percent) in this area.
- Among different age groups, children less than 1 year old had the highest rates of potential delay (20.3 percent), compared to children aged 1 to 3 years (13.2 percent) and children aged 4 to 5 years (11.8 percent) (data not shown).

The ASQ-SE, which is often used in conjunction with the ASQ, addresses social and emotional behavior in seven areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. Among the subset of RPG children five years and under assessed with the ASQ-SE:

- Nearly one-fifth (19.6 percent) were identified as at risk of social or emotional behavioral difficulties at RPG program admission.

- As Figure 31 below shows, results differed by age group, ranging from a low of 5.3 percent for children 6 months old to a high of approximately 35.7 percent for those 36 months old.

Figure 31: Percentage of Children Screened with the ASQ-SE and Identified as At Risk of Social or Behavioral Problems at RPG Program Admission, by ASQ-SE Age Interval



- Overall, the subsample of children participating in these RPG programs were somewhat more likely to be identified as at risk of social or emotional difficulties than a general population of children with one or no identified environmental or medical risk factors. However, children participating in the RPG programs were less likely to be identified as having social or emotional problems compared to a population of children with two or more risk factors; a population that likely shares similar characteristics to the RPG program population. The degree to which children in the RPG programs were more or less likely to be at risk than the two normative groups varied by age group—for example, the 6-month-old RPG participant children had mean scores that indicated lower risk of social or emotional problems than the general population.¹⁵³

The CBCL addresses internalizing and externalizing behavioral problems in young children aged 1.5 to 5 years and school-aged children 6 to 18 years old. Internalizing behaviors mainly reflect problems within the self, such as emotional reactivity, anxiety, depression, somatic complaints without known medical cause, and withdrawal from social contacts. Externalizing behaviors represent attention problems and conflicts with other people, such as aggressive behavior.

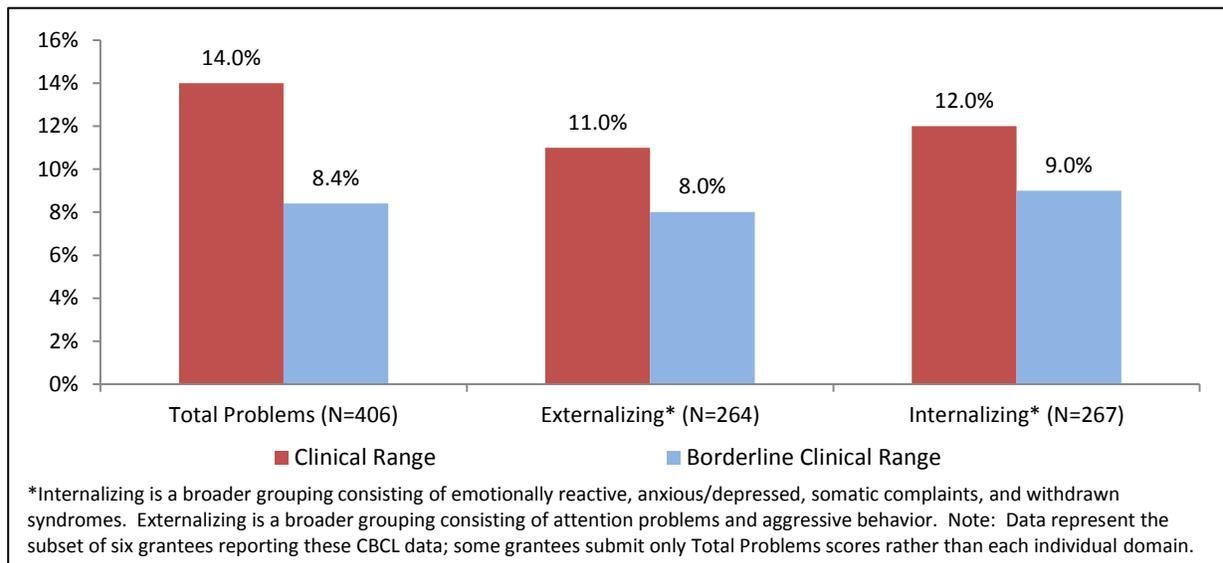
- Overall, in this grantee subsample, a greater percentage of school-aged children 6 to 18 years old were identified in the borderline or clinical range compared to young children aged 1.5 to

¹⁵³ Variables used to determine level of risk in the normative sample included: 1) family income of less than \$12,000, 2) mother younger than 18 years old when child was born, 3) mother has less than high school graduation education level, 4) family is involved with child protective services, 5) child is in foster care, and 6) child's birth weight was less than 3 pounds, 5 ounces. Source: ASQ-SE Technical Report (no date); accessed January 17, 2011 from <http://archive.brookespublishing.com/documents/asq-se-technical-report.pdf>. See Appendix G for more detailed data on RPG children compared to a no risk and at risk normative population.

5 years. This finding is consistent with recent results from a longitudinal study of children exposed to methamphetamine.¹⁵⁴

- Among children aged 1.5 to 5 years, 14.0 percent were found to be within the clinical range for total problems, requiring further assessment or intervention. An additional 8.4 percent were in the borderline clinical range, indicating that they may benefit from modified services tailored to their needs. A roughly equal percentage (11.0 and 12.0 percent) of young children were identified in the clinical range for externalizing and internalizing behaviors (see Figure 32 below).

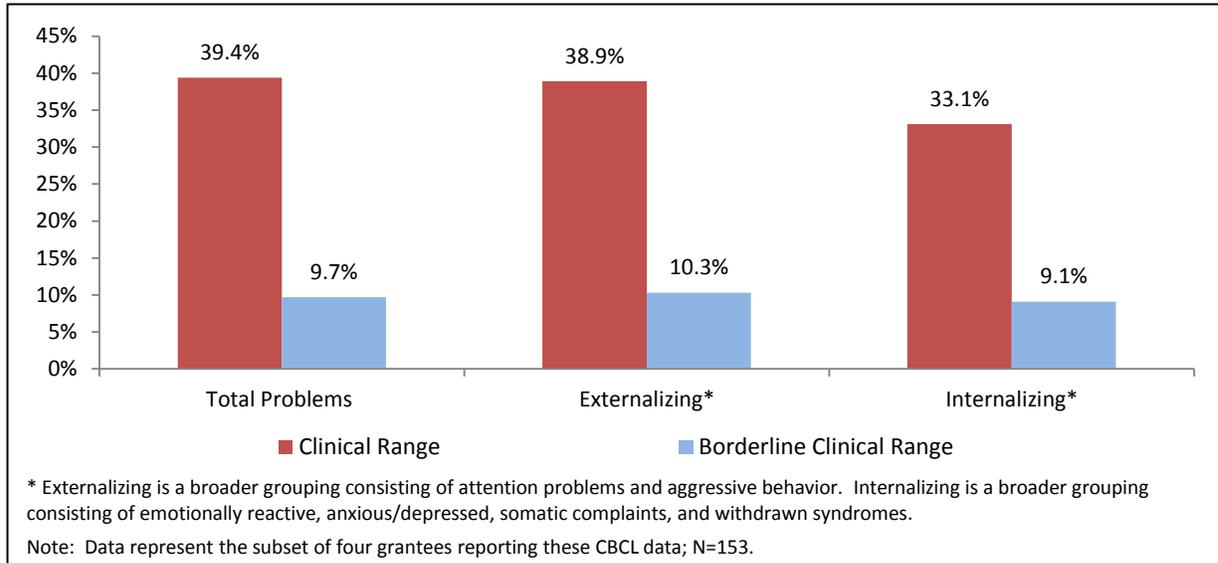
Figure 32: Percentage of Children Aged 1.5 to 5 Years Identified as in the Clinical Range for Behavioral Problems at RPG Program Admission, by Overall CBCL Areas



- Among school-aged children 6 to 18 years old, 39.4 percent were identified within the clinical range for total problems, requiring further assessment or intervention. An additional 9.7 percent were identified in the borderline clinical range. A greater percentage of school-aged children exhibited externalizing behaviors in the clinical range than internalizing behaviors (38.9 percent and 33.1 percent, respectively). See Figure 33 below.

¹⁵⁴ LaGasse, et al., (2012). Prenatal methamphetamine exposure and childhood behavior problems at 3 and 5 years of age. *Pediatrics*. 129(4): 681-8.

Figure 33: Percentage of Children Aged 6 to 18 Years Identified as in the Clinical Range for Behavioral Problems at RPG Program Admission, by Overall CBCL Areas



The NCFAS Child Well-Being subscale includes items that address a child’s overall well-being and social-emotional and behavioral functioning. It assesses if a child is experiencing any problems in the following areas: mental health, behavior or discipline problems, school performance, relationship with parents/caregivers, relationship with siblings, relationship with peers, and cooperation or motivation to maintain the family. The subscale also includes an overall child well-being item intended to summarize a child’s ratings across these areas.

Among the subsample of grantee children assessed with the NCFAS:

- The percentage for whom the overall child well-being item was rated as a mild or clear strength significantly increased from 24.8 percent at program admission to 53.0 percent at program discharge ($p < .001$; data not shown).
- Similarly, the percentage for whom overall well-being was rated as a mild to serious problem significantly declined from almost one-third (31.9 percent) to 12.7 percent ($p < .001$; data not shown).¹⁵⁵
- The percentage of children for whom specific areas of well-being were rated as a mild or clear strength significantly increased from RPG program admission to program discharge in all areas. Ratings for children increased most in the areas of relationships with their parents/caregivers, mental health, and behavior. These improvements indicate improved emotional stability, better behavior, less discipline and supervision problems, and better communication with their parents (see Table 32 below).
- Children also showed significant improvements in ratings for increased motivation to behave and cooperate with their parents and family, improved relationships with their siblings,

¹⁵⁵ Statistically significant improvements in the overall child well-being item were consistent across grantees reporting these data.

school attendance and behavior, and better and more frequent interactions with their peers (see Table 32).¹⁵⁶

Table 32: Percentage of Children for Whom Selected NCFAS Child Well-Being Areas were Rated a Mild/Clear Strength at RPG Program Admission and Discharge		
	RPG Program Admission	RPG Program Discharge
Relationship with Parents (N=724)	32.5%	56.8%
Mental Health (N=558)	27.9%	52.1%
Behavior (N=714)	26.9%	49.1%
Cooperation (N=703)	45.5%	66.0%
Relationship with Siblings (N=532)	40.9%	59.4%
School Performance (N=523)	21.2%	39.6%
Relationship with Peers (N=486)	28.9%	45.7%

p<.001 for all items

Notes: Data represent the subset of eight grantees reporting these NCFAS data.

Cognitive Functioning—Summary Findings

The ASQ includes two domains that address the cognitive development of children five years and younger. The communication domain assesses developmental skills such as babbling, vocalizing, listening, and understanding, while the problem solving domain addresses learning and playing with toys.

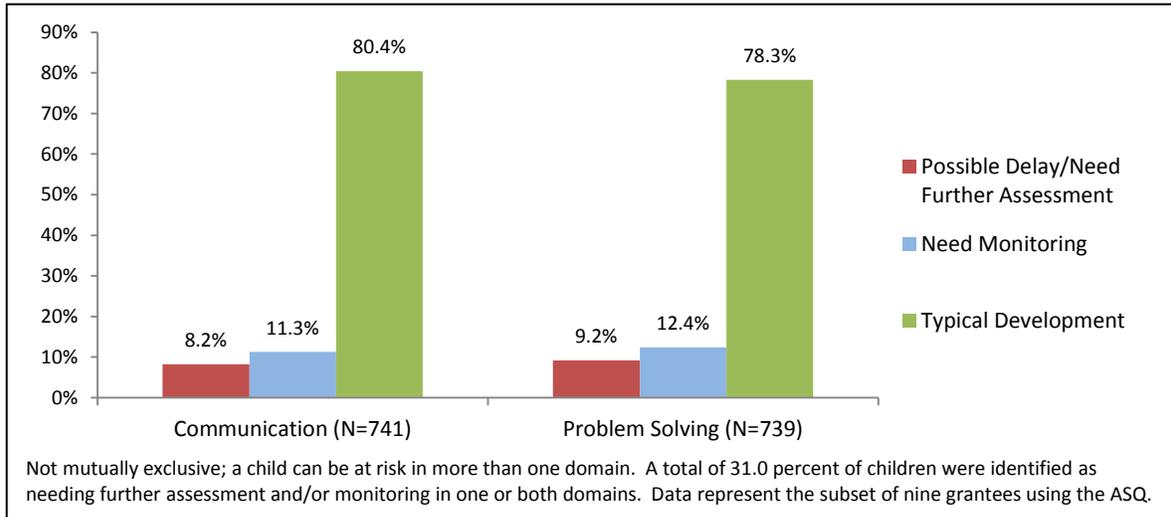
At RPG program admission, among the subset of children assessed with the ASQ:

- More than one-fifth (21.6 percent) of children required either a more in-depth evaluation (9.2 percent) or further monitoring¹⁵⁷ (12.4 percent) in the problem solving domain (Figure 34).
- Slightly less than a total of one-fifth (19.5 percent) required either a more in-depth evaluation (8.2 percent) or further monitoring (11.3 percent) in the communication domain (Figure 34).
- Overall, approximately one-third (31.0 percent) were identified as requiring a more in-depth evaluation and/or further monitoring in one or both of these cognitive development domains (data not shown).
- The percentage identified as at risk of delay was similar across different age groups: 32.9 percent for children less than 1 year old, 31.3 percent among children aged 1 to 3 years, and 35.4 percent among children aged 4 to 5 years (data not shown).

¹⁵⁶ Statistically significant improvements in all items, except for relationship with siblings, were consistent across grantees reporting these data. For that item, findings of statistical significance varied across grantees; see Appendix F for additional detail.

¹⁵⁷ Children whose scores indicate a need for further assessment or continued monitoring require additional diagnostic assessment, more frequent screenings, closer monitoring, or specialized activities and interventions to further support their development.

Figure 34: Percentage of Children Identified as At Risk of Delay in Cognitive Development at RPG Program Admission, by Selected ASQ Domains



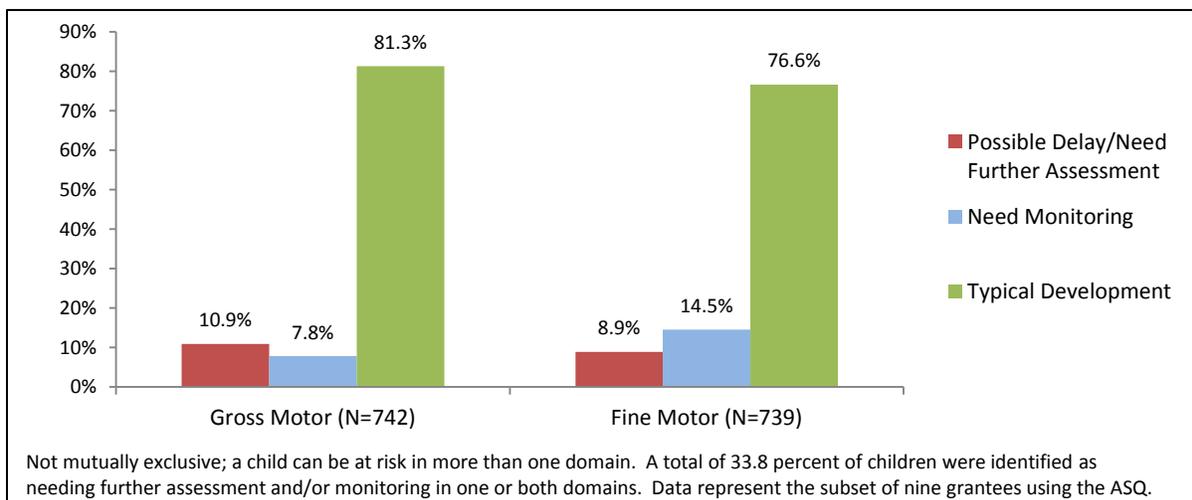
Physical Health and Development—Summary Findings

The ASQ also includes two domains that address the physical development of children aged five years and under. The gross motor domain assesses the use and coordination of arm, body, and leg movements; the fine motor domain assesses hand and finger movement and coordination.

At RPG program admission, among the subset of children assessed with the ASQ:

- Nearly one-fourth (23.4 percent) of children required either a more in-depth evaluation (8.9 percent) or further monitoring (14.5 percent) in the fine motor domain (Figure 35).
- Fewer total children (18.7 percent) required a more in-depth evaluation (10.9 percent) or further monitoring (7.8 percent) in the gross motor domain (Figure 35).

Figure 35: Percentage of Children Identified as At Risk of Delay in Physical Development at RPG Program Admission, by Selected ASQ Domains



- Overall, approximately one-third (33.8 percent) were identified as requiring a more in-depth evaluation and/or further monitoring in one or both of these physical development domains (data not shown).
- Overall results varied by age group: A higher percentage of children aged 4 to 5 years (43.8 percent) were identified as at risk of delay compared to children less than 1 year old (34.1 percent) or aged 1 to 3 years (30.6 percent) (data not shown).

In addition to all of the results presented above, there are two other RPG performance measures related to overall child well-being: prevention of substance exposed newborns and children connected to supported services. As stated in the introduction, grantees reported data for these two measures in a standardized format similar to the safety, permanency, and recovery measures presented in the preceding chapters. Results for these two measures follow.

Prevention of Substance-Exposed Newborns

Prenatal substance exposure may cause a wide spectrum of both immediate and longer-term physical, emotional, and developmental problems for infants and children. The harm caused to the child can be significant and long lasting, especially if the exposure is not detected and early intervention and needed services are not provided.

This RPG performance measure examines the percentage of pregnant women who had a substance-exposed newborn, as detected at birth. While identification of a substance-exposed newborn is to come from a doctor or other health care professional assessing the newborn's health, it is not limited to a positive toxicology test. Grantees may use other clinical indicators to determine substance exposure, including maternal and newborn presentation, history of mother's substance use or abuse, or other medical history.

In reviewing these data, it is important to note the sample size of children born after families became involved in RPG services was extremely low. These data should be interpreted with caution and generalizations to the larger RPG population cannot be made.

- Eighteen grantees provided data on 122 children born after their mother's entry into the RPG program.¹⁵⁸ Overall, 27 children (22.1 percent) were identified as experiencing prenatal substance exposure.
- Seven of the 18 grantees, however, reported no substance exposure among 38 children born after the mother's RPG program entry.
- Further, it is important to note the data suggest the vast majority (88.9 percent) of women giving birth to substance-exposed newborns were already in their second or third trimester of pregnancy at time of RPG enrollment. For example, among the 27 children identified with prenatal substance exposure, 25.9 percent were born less than one month after their mother entered the RPG program, while 29.6 percent were born one to three months after RPG entry, and 33.3 percent were born four to six months after RPG entry. Only one baby (3.7 percent)

¹⁵⁸ Among these 18 grantees, the number of births reported ranged from 1 to 25, with a median of 5.

was born 7 to 12 months after the mother's RPG program entry, while the remaining two babies (7.4 percent) were born more than 12 months following their mother's RPG program entry. Thus, prenatal exposure is likely to have occurred prior to the woman's admission to the RPG program.

These limited data suggest the majority of woman who gave birth to a substance-exposed newborn likely used substances during their pregnancy before they received RPG services. As a result, these grantees did not have the opportunity to prevent a woman's substance use during pre-pregnancy or intervene early in the prenatal period. In general, however, a woman's participation in substance abuse treatment provided through the RPG Program is likely to result in early identification and disruption of prenatal substance use and improve the likelihood of a healthy birth outcome.

Supportive Services to Help Strengthen Child Well-Being

This RPG performance measure examines the percentage of children who were assessed for and received the following supportive services: developmental services, mental health or counseling, primary pediatric care, educational services, substance abuse prevention and education, and substance abuse treatment.¹⁵⁹ It is intended to capture whether children are receiving the key supportive services they need to help facilitate positive outcomes and strengthen a child's cognitive functioning, physical health and development, and social-emotional and behavioral functioning.

The findings presented here focus primarily on the children known to be in need of a given supportive service. In certain cases, a grantee may find that a given support service is not needed or pertinent to a particular individual's situation (e.g., a child is already receiving developmental services). However, to provide a fuller understanding of the most predominant needs of families served by the RPG programs, summary information on the number of children assessed for and identified as needing a given service are presented below (and in more detail in Appendix H).

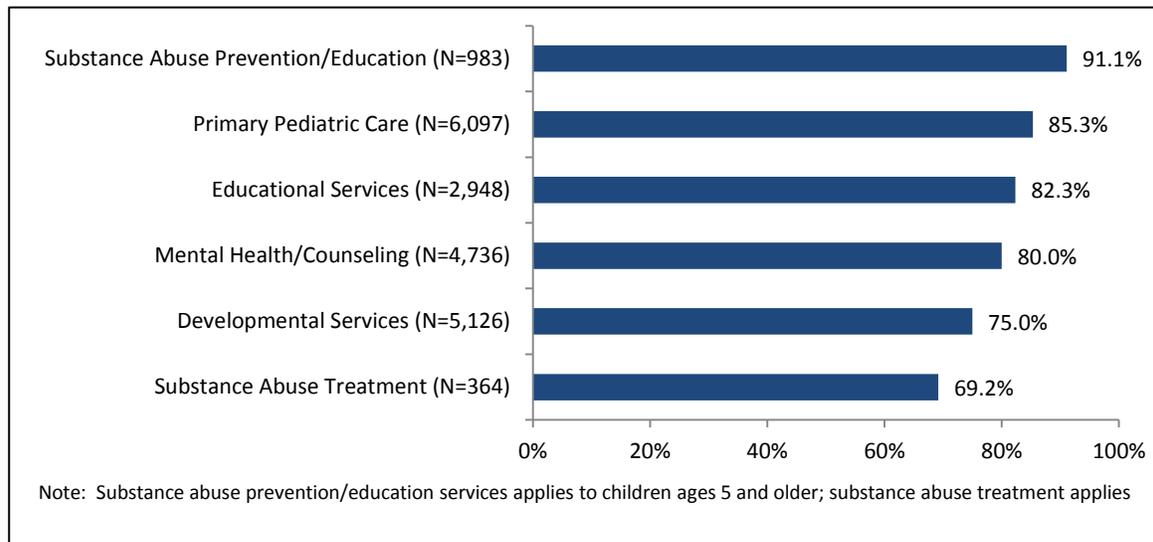
- **Assessed.** Overall, the majority of children in the RPG programs received the necessary assessments to identify key supportive service needs. More than three-fourths were assessed for primary pediatric care (84.0 percent), substance abuse prevention (78.2 percent), and educational service (77.1 percent) needs. More than two-thirds were assessed for mental health or counseling (69.3 percent) and developmental (68.1 percent) needs, while more than half (55.6 percent) received needed substance abuse treatment assessments. (Data not shown; see Appendix H).
- **Needed Given Service.** Among children assessed, the vast majority were identified as needing primary pediatric care (86.9 percent), while more than three-fourths needed developmental services (76.2 percent) and mental health or counseling services (75.5

¹⁵⁹ Each of the 41 grantees that reported supportive services data did not necessarily provide information on all six supportive services. A grantee only collected data on those supportive services that were part of their overall program model and provided to clients either directly or through linkages to their community partners. Of the 41 grantees, 40 reported on developmental services, 39 reported on mental health or counseling services, 34 on educational services, and 34 on primary pediatric care. A smaller number of grantees reported data on substance abuse prevention (25) and substance abuse treatment services (24).

percent). In addition, 70.3 percent of children assessed needed educational services. Fewer children were identified as needing substance abuse prevention (62.8 percent) and substance abuse treatment for their own substance use disorder (57.1 percent). (Data not shown; see Appendix H.)

- Received Needed Services.** The majority of those children assessed and identified as needing a given supportive service were connected to such services. As Figure 36 shows, nearly all children (91.1 percent) received needed substance abuse prevention and education, while 85.3 percent received primary pediatric care. Further, 82.3 percent of children received educational services and 80.0 percent were connected to mental health or counseling services. Three-fourths (75.0 percent) of children received developmental services and more than two-thirds (69.2 percent) received substance abuse treatment, as needed.¹⁶⁰

Figure 36: Percentage of Children who Received Selected Supportive Services (of those Assessed and for whom a Given Service was Identified as a Need)



- Only a small number of grantees provided sufficient comparison group data on children connected to supportive services; these data are not provided. However, the percentage of children in the RPG Program receiving needed mental health services was higher than rates identified in a recent study of children in the child welfare system. Findings from the National Survey of Child and Adolescent Well-Being indicated that among children 1.5 to 10 years old identified as at risk for a behavioral or emotional problem, 42.5 percent received some kind of mental health services. Among children 11 to 17 years old, just over half (51.9 percent) received needed mental health services.¹⁶¹

¹⁶⁰ One reason children may not receive needed supportive services is if their families left the RPG program early and they did not have adequate time to access services or chose not to engage in them. Analysis for substance abuse prevention and education was limited to children aged 5 and older; analysis for substance abuse treatment was limited to children aged 12 and older.

¹⁶¹ Ringeisen, H., Casanueva, C., Smith, K. & Dolan, M. (2011). *NSCAW II Baseline Report: Children's Services*. OPRE Report #2011-27f, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Adult Well-Being—Detailed Analysis

Parents¹⁶² play an active role in a child’s life—particularly during early childhood—and can have a positive influence on their child’s development. A supportive, stable, secure, responsive, reciprocal, and loving parent-child relationship is essential to a child’s healthy development and overall well-being.¹⁶³ Yet a positive parent-child relationship is dependent on the overall health and well-being of the parent. The quality of the relationship may be affected by various parent characteristics, including a parent’s mental health, physical health, self-confidence, knowledge, experience, and employment.

As described in Chapter II, grantees implemented a wide array of substance abuse and mental health treatment services, family-strengthening programs, and clinical and community support services to improve parent well-being and promote strong parent-child relationships.

Two particular aspects of adult well-being are addressed here: mental health functioning and parenting capacity. The latter is a multidimensional concept affected by individual parent characteristics as well as broader family relationships and larger community and contextual characteristics. The following discussion focuses primarily on individual parent characteristics (e.g., parental stress, parenting and child-rearing attitudes).

The next section in this chapter on family well-being addresses broader family relationships and interactions and outside environmental and community supports. However, as the introduction noted, because the concepts of child, adult, and family well-being are interdependent, certain instruments may measure multiple concepts that span both adult and family well-being.

Parent/Caregiver Mental Health and Related Functioning—Summary Findings

Understanding parental stress is important for families who have experienced traumatic events and may be an important focus for effective trauma-focused interventions. High levels of stress in the parenting relationship have been associated with problems in parenting behavior, impaired parent-child behavior, and child psychopathology.

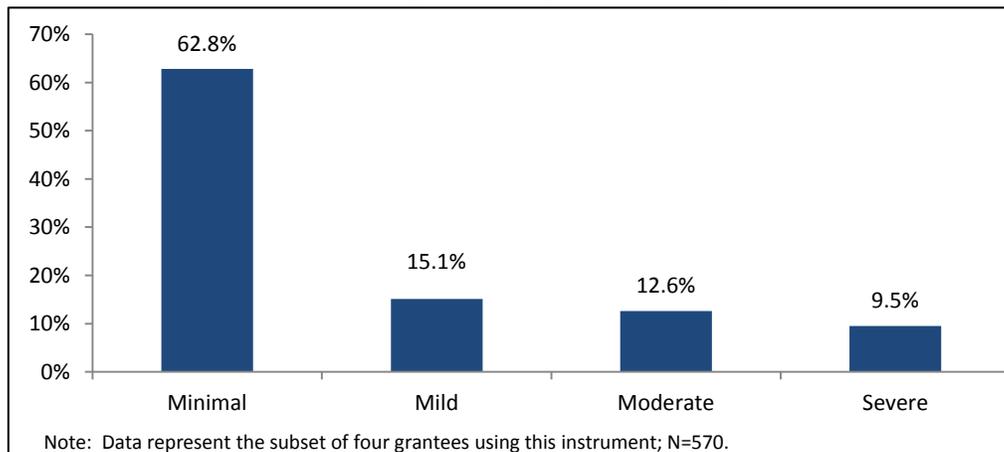
As one grantee noted, “While the program has continued to see improvements in mental health for parents successfully engaging in service, mental health risks were among the greatest challenges facing those who were more intermittently involved in the program. The number of demands on parents and day-to-day crises also has challenged staff’s ability to work on the more deep-seated trauma that is often at the root of the parent’s substance abuse and corresponding mental health. . . . Hiring staff with specialized experience in mental health treatment setting has strengthened the project’s capacity to provide these services.”

¹⁶² The term “parent” typically refers to the birth parent, but also may be an adoptive parent, foster parent, grandparent, or other primary caregiver for the child.

¹⁶³ National Research Council and Institute of Medicine (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Committee on Integrating the Science of Early Childhood Development. Jack P. Shonkoff and Deborah A. Phillips, eds. Board on Children, Youth, and Families, Commission on Behavioral Sciences and Education. Washington, D.C.: National Academy Press.

The Beck Depression Inventory identifies the presence and severity of depressive symptoms. Among a subset of 570 parents screened with the Beck Depression Inventory, 22.1 percent reported moderate to severe depression at RPG program admission and an additional 15.1 percent of parents reported mild depression (see Figure 37). Grantees' sample sizes for matched baseline-discharge data were not sufficient to analyze change over time.

Figure 37: Percentage of Adults with Depressive Symptoms at RPG Program Admission, as Measured by the Beck Depression Inventory



Data are not available for a normative population. Yet a recent study found that 41 percent of 9-month-old infants live with a mother who suffers from some form of depression, 7 percent of whom suffer from severe depression. Depression can compromise a parent's ability to provide consistent care in a safe environment and interfere with parenting, potentially leading to poor child development.¹⁶⁴

The PSI Short Form includes a total stress score that measures the overall level of parenting stress an individual is experiencing. The total stress score reflects stresses reported in the three subscales: parental distress, parent-child dysfunctional interaction and difficult child. The parental distress subscale assesses certain parent characteristics (e.g., competence, depression, lack of social support). The parent-child dysfunctional interaction subscale examines the parent-child bond and the parent's expectations of his or her child. The difficult child subscale focuses on the child's behavior and the parent's ability to manage the child's behavior.

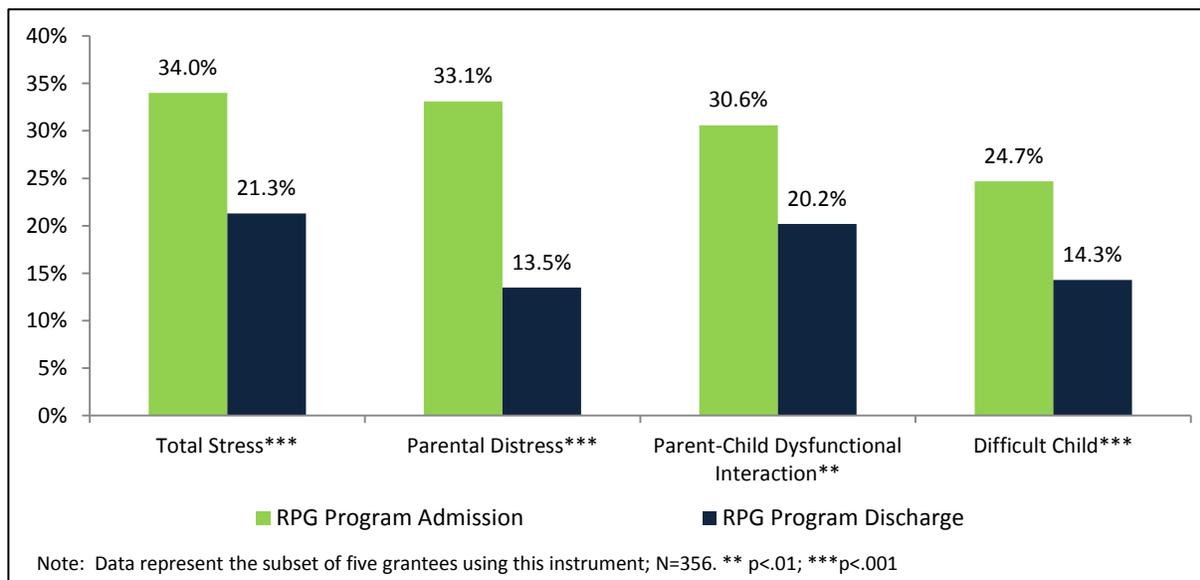
As Figure 38 below shows, among the subset of 356 parents assessed with the PSI Short Form, the percentage of parents experiencing clinically significant levels of stress decreased significantly from RPG program admission to discharge as follows:

- From 34.0 percent to 21.3 percent for total stress

¹⁶⁴ Vericker, T., Macomber, J. & Golden, O. (2010). *Infants of depressed mothers living in poverty: Opportunities to identify and serve*. Washington, DC: The Urban Institute.

- From 33.1 percent to 13.5 percent in the parental distress domain¹⁶⁵
- From 30.6 percent to 20.2 percent in the parent-child dysfunctional interaction domain

Figure 38: Percentage of Adults Experiencing Clinically Significant Levels of Stress at RPG Program Admission and Discharge, as Measured by the PSI Short Form



- From 24.7 percent to 14.3 percent in the difficult child domain

As noted previously, many different issues may impact a parent’s overall functioning. The Addiction Severity Index (ASI) assesses seven of these domains: alcohol use, drug use, medical issues, psychiatric symptoms,¹⁶⁶ legal issues, employment status, and family/social issues.

Among the subset of RPG adults assessed with the ASI:

- Across all ASI domains, adults showed significant improvements in addressing the various issues that impair functioning and reported less severe problems at program discharge (see Table 33 below).¹⁶⁷

¹⁶⁵ Statistically significant improvements in the Parental Distress domain varied slightly across grantees with all but one grantee showing improvements from admission to discharge; see Appendix F for additional detail.

¹⁶⁶ Though the psychiatric problem section is perhaps the most reliable and validated of the ASI domains, the instrument developers note that it does not yet adequately address trauma and its consequences. McLellan, A., Cacciola, J., Alterman, A., Rikoon, S. & Carise, D. (2006). The Addiction Severity Index at 25: Origins, contributions and transitions. *American Journal of Addiction*, 15 (2): 113-24.

¹⁶⁷ Statistically significant improvements were mostly consistent across grantees, though not all grantees showed improvement or the same relative level of change over time on all domains. See Appendix D for additional detail.

- Given the impact of the current economic environment and the difficulty that grantees say many participating families experienced in finding jobs, it is not surprising that the employment domain showed the highest severity levels. As described in Chapter III, grantees are continually seeking new ways to help clients obtain employment and maintain self-sufficiency.
- At baseline, females in this RPG subgroup showed greater severity in the medical and employment domains than the general population, but less severity in the alcohol use, drug use, and legal domains. Psychiatric symptom severity levels were roughly the same (see Appendix G). Norm data on changes in pre/post scores is not available.

Table 33: ASI Domain Mean Composite Scores for Subset of RPG Adults, Change from RPG Program Admission to Discharge		
	<u>RPG Program Admission</u>	<u>RPG Program Discharge</u>
Legal (N=171)**	0.13	0.06
Employment (N=161)*	0.71	0.67
Alcohol Use (N=162)**	0.11	0.03
Drug Use (N=118)**	0.06	0.02
Psychiatric (N=170)**	0.25	0.12
Family/Social (N=168)**	0.24	0.11
Medical (N=169)*	0.22	0.14

*p<.05 **p<.005

Notes: Data represent the subset of four grantees using this instrument. The higher the composite score the greater the severity.

One grantee, using an adapted Post-Traumatic Stress Scale, found that parents experienced a significant decrease in trauma symptoms over the course of the program. The mean score for a subsample of their parents decreased significantly from 35.9 at baseline to 31.3 at discharge. (Higher scores indicate more trauma symptoms; highest possible score is 68.)

Another grantee used the Trauma Symptom Checklist-40 to assess parents' stress and anxiety related to trauma they experienced as a child and/or adult. This grantee found that parents who completed the RPG program showed a significant decrease in trauma-related stress and anxiety from program admission to discharge.

Selected Aspects of Parenting Capacity—Summary Findings

This section presents data highlighting changes over time in caregivers' parenting behaviors and attitudes, as measured by the NCFAS Parental Capabilities subscale and the AAPI.

The NCFAS Parental Capabilities subscale assesses if parents are experiencing problems with supervision of children, disciplinary practices, control and monitoring of children's media access and content, provision of developmental/enrichment opportunities (e.g., sports, music), promotion of and involvement in child's education, literacy skills (e.g., integrating reading and writing into the family's everyday life), and alcohol and drug use that impacts their ability to

parent children. The subscale also includes an overall parental capabilities item intended to summarize a parent’s ratings across these areas.

- The percentage of caregivers for whom the overall parental capabilities item was rated as a mild or clear strength significantly increased from 14.9 percent at program admission to 46.5 percent at program discharge ($p<.001$; data not shown).
- Similarly, the percentage for whom overall parental capabilities was rated as a mild to serious problem significantly declined from 51.0 percent to 20.4 percent ($p<.001$; data not shown).
- In six of the seven specific parental capability areas, parents showed significant improvement (see Table 34). The greatest progress was made regarding no or decreased substance use and appropriate supervision of children.¹⁶⁸ The percentage of parents in the strength range for no or decreased substance use significantly increased from only 11.1 percent at program admission to 44.7 percent at discharge. While supervision was a strength for almost one-fourth (24.0 percent) of parents at program admission, this significantly increased to well over half (54.2 percent) by program discharge. Parents also showed significant improvements in appropriate disciplinary practices and increased support of enrichment opportunities for their children.

	<u>RPG Program Admission</u>	<u>RPG Program Discharge</u>
Use of Drug/Alcohol (N=747)***	11.1%	44.7%
Supervision of Children (N=716)***	24.0%	54.2%
Disciplinary Practices (N=701)***	20.0%	44.9%
Developmental/Enrichment Opportunities (N=697)***	23.1%	44.6%
Promotes Education (N=143)*	21.7%	33.6%
Controls Access to Media (N=121)*	12.4%	22.3%
Parent's Literacy (N=184)	27.2%	35.3%

* $p<.05$; *** $p<.001$

Note: Data represent a subset of 8 to 10 grantees reporting these NCFAS data; not all grantees report on all individual items.

One grantee who was successful in strengthening parents’ relationships with their children and enhancing their parenting skills noted, “It is likely that using an evidence-based curriculum developed specifically for use with parents in recovery, and having a staff position dedicated to parent education, contributed to these outcomes.” The grantee explained their use of a team approach in which a parent educator works closely with other RPG project staff. In addition, the team includes a nurse, who worked with parents on their own health issues and the health and developmental needs of their children.

¹⁶⁸ Statistically significant improvements in parent’s literacy, controls access to media, and use of drugs and alcohol was consistent across grantees. For the other items, findings of statistical significance and the relative change in admission to discharge varied across grantees; see Appendix F for additional detail.

The AAPI assesses parenting and child rearing attitudes in five areas and provides an index of risk for parenting behaviors known to be attributable to child maltreatment. Those five areas address: inappropriate expectations of children (e.g., understanding of normal child growth and development), empathy towards children's needs and nurturing skills, corporal punishment and discipline, role reversal (e.g., parent uses child to meet their own needs, treats child as peer or confidant), and restricting a child's power and independence (e.g., extent to which parent supports a child's ability to problem solve, make decisions, and think independently).

A subset of 280 adults were assessed with the AAPI at RPG program admission and discharge. Results should be interpreted with caution given the small sample size. As Table 35 shows:

- Parents' mean scores in the areas of inappropriate expectations and corporal punishment showed significant improvement from program admission to discharge, though parents (on average) remained in the moderate risk category for behaviors associated with potential maltreatment.
- Scores in the role reversal and empathy domains showed relatively little change in either direction, with parents again remaining in the moderate risk category.
- Scores in the power/independence domain showed no change; parents showed the highest potential risk in this area.¹⁶⁹
- It is worth noting that research has shown it is relatively difficult to change individual's general attitudes with conventional attitude change manipulations.¹⁷⁰ More specifically, results on parenting interventions and attitude change tend to be equivocal and may vary depending on culture, age, race, gender, and other factors.¹⁷¹

¹⁶⁹ Overall, at RPG program admission, the percentage of RPG female parents at high risk was much greater than the general female parent population, particularly in the areas of power and independence and empathy; see Appendix E for normative data.

¹⁷⁰ Gregg, A.P., Seibt, B. & Banaji, M.H. (2006). Easier done than undone: Asymmetries in the malleability of implicit preferences. *Journal of Personality and Social Psychology*, 90: 1–20; and Petty, R.E., Tormala, Z.L., Brinol, P. & Jarvis, W.B.G. (2006). Implicit ambivalence from attitude change: An exploration of the PAST model. *Journal of Personality and Social Psychology*, 90: 21–41.

¹⁷¹ Sources include: Bavolek, S.J. (1989). Assessing and treating high-risk parenting attitudes. In J.T. Pardeck (Ed.), *Child Abuse and Neglect Theory, Research and Practice*, New York, NY: Gordon and Breach; Budd, K.S., Behling, S., Li, Y., Parikshak, S., Gershenson, R.A., Feuer, R., and Danko, C.M. (2012). Measuring attitudes toward acceptable and unacceptable parenting practices. *Journal of Child Family Studies*, 21: 247-261; and Crouch, J.L. and Behl, L.E. (2001). Relationships among parental beliefs in corporal punishment, reported stress, and physical child abuse potential. *Child Abuse and Neglect*, 25(3): 413-419.

Table 35: Change in Caregivers' Parenting Attitudes and Behaviors from RPG Program Admission to Discharge, as Measured by the AAPI—Mean Sten Scores

	<u>RPG Program Admission</u>	<u>RPG Program Discharge</u>
Inappropriate Expectations*	5.4	5.7
Corporal Punishment*	4.8	5.1
Role Reversal	5.3	5.5
Empathy	4.2	4.1
Power/Independence	3.6	3.6

Notes: Mean sten scores range from 1 to 10 and provide index of risk for practicing parenting behaviors associated with child maltreatment: high risk (1-3), moderate risk (4-7), and low risk (8-10). Data represent a subset of six grantees reporting these AAPI data (N=280). Results should be interpreted with caution given the small sample size.

*p<.05

One grantee commented how the RPG substance abuse treatment recovery staff observed that parents' AAPI results were often high at RPG program admission, when parents felt positive about their parenting skills and practices. However, after parents had received parenting education, staff noted that the parents would reevaluate their skills, which resulted in lower AAPI scores at follow-up administration.

Family Well-Being—Detailed Analysis

This section addresses the broader family relationships and interactions and outside environmental and community supports that help increase parental capacity, strengthen families, and promote overall child, adult, and family well-being. Data presented represent the subset of grantees that used the NCFAS (various subscales) and Protective Factors Survey to measure these constructs. As previously stated, these two areas of family well-being are closely intertwined and the measurement of these conceptual domains may overlap across instruments or subscales.

Family Relationships and Interactions—Summary Findings

The NCFAS Family Interactions subscale measures the quality and strength of relationships within the family unit. Items in this subscale focus on parents' closeness with their child, use of effective communication with the child, age-appropriate and clear expectations for children, physical (e.g., transportation, child care) and emotional (e.g., encouragement) support within the family, healthy relationships between parents, the presence of established and regular family routines and rituals (e.g., holiday celebrations), and regular time for family recreation and play activities. The subscale also includes an overall family interactions item intended to summarize a parent's ratings across these areas.

- The percentage of RPG adults for whom the overall family interactions item was rated as a mild or clear strength significantly increased from slightly more than one-fifth (21.8 percent) at program admission to nearly half (47.0 percent) at program discharge (p<.001; data not shown).

- Similarly, the percentage for whom overall family interactions was rated as a mild to serious problem significantly declined from 42.5 percent to 19.5 percent ($p < .001$; data not shown).
- In six of the seven specific family interactions areas, RPG parents showed significant improvement (see Table 36 below). Families made the greatest progress in the areas of appropriate expectations for and bonding with children as well as mutual support within the family. The percentage of RPG families in the strength range for age-appropriate expectations significantly increased from 27.8 percent at program admission to 57.6 percent at discharge, indicating parents' increased understanding of children's cognitive, physical, social, and emotional development.
- In addition, though parent-child bonding was a strength for 44.6 percent of parents upon RPG program admission, this figure significantly increased to 70.6 percent by program discharge. The percentage of families for whom mutual support was rated a strength increased from 34.2 percent to 58.4 percent. Families also showed significant improvements in relationships between parents, regular family routines, and family recreation and playtime.¹⁷²

Table 36: Percentage of Families for Whom Selected Areas of NCFAS Family Interactions Subscale were Rated a Mild/Clear Strength at RPG Program Admission and Discharge

	<u>RPG Program Admission</u>	<u>RPG Program Discharge</u>
Expectations of Children (N=519)***	27.8%	57.6%
Bonding with Children (N=535)***	44.6%	70.6%
Mutual Support Within Family (N=550)***	34.2%	58.4%
Relationship Between Parents (N=467)***	24.4%	43.7%
Family Recreation (N=145)**	12.4%	28.3%
Family Routines (N=157)**	14.0%	26.1%
Communication with Children (N=167)	25.2%	34.8%

** $p < .01$; *** $p < .001$

Note: Data represent a subset of 8 to 10 grantees reporting these NCFAS data; not all grantees report on all individual items.

Environmental and Community Factors and Supports—Summary Findings

Numerous environmental factors (e.g., poverty, unemployment, community violence, lack of social supports and connections) can adversely impact a family's ability to provide for their children's needs and promote child safety, permanency, and well-being, as well as adult well-being and recovery. Research has found that when a family's stressful living conditions persist over time, the risk for child neglect increases.¹⁷³

¹⁷² Statistically significant improvement in all areas was consistent across grantees reporting these data; see Appendix F for more detail.

¹⁷³ Child Welfare Information Gateway (2006). *Child Neglect: A Guide for Prevention, Assessment and Intervention*. Chapter 4 Risk and Protective Factors. Washington, DC: Office on Child Abuse and Neglect, Children's Bureau.

To measure how environmental and community factors and supports are influencing overall family well-being, a subset of grantees used the Protective Factors Survey and the NCFAS (three specific subscales). This section provides selected baseline descriptive data regarding family well-being at RPG program admission and data highlighting change over time in a family's overall living situation and ability to maintain a safe environment for their children.

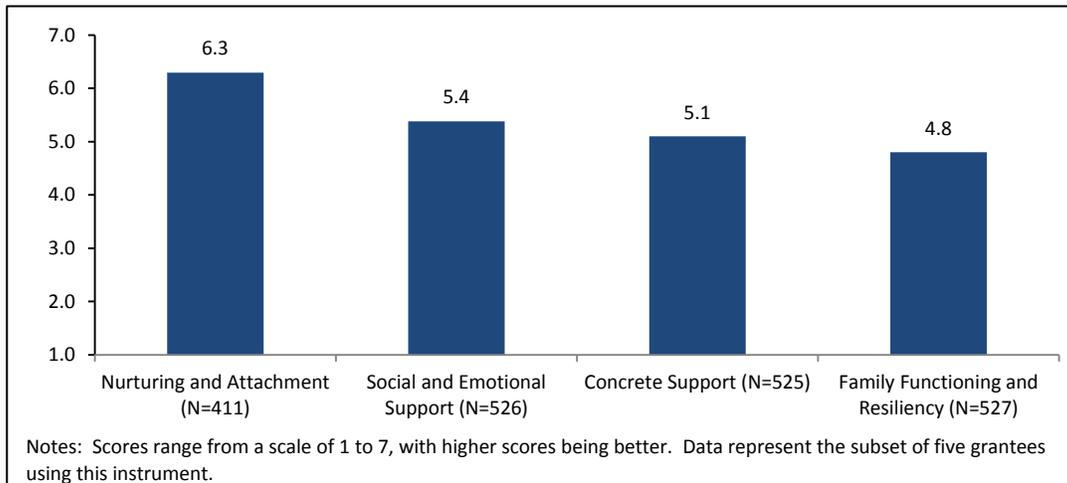
The Protective Factors Survey assesses multiple protective factors against child maltreatment in five areas: family functioning and resiliency, social emotional support, concrete support, nurturing and attachment, and knowledge of parenting and child development. Though the mean domain scores are designed to be used in a pre/post manner to assess improvements over time, the baseline results provide a snapshot of RPG families at program admission and the protective factor areas in which families appear to be doing well and those requiring improvements.

As Figure 39 shows,¹⁷⁴ at RPG program admission, this subset of families:

- Scored highest in the area of nurturing and attachment (6.3 out of possible 7.0), meaning they reported positive parent-child interaction and nearly always are able to soothe their child when upset, feel close to their child, spend time doing activities their child likes to do, and enjoy being with their child.
- Reported they slightly or mostly agree (with a mean score of 5.4) that they have adequate informal support from family, friends, and neighbors that helps provide for their family's emotional needs (e.g., have someone to talk to about their problems or concerns).
- Indicated that when it comes to concrete support (e.g., health care, child care, transportation, food, and clothing) they only slightly agree that they are aware of and have access to such goods and services. The baseline mean score of 5.1 identifies a need to strengthen community supports and resources that can help families cope with stress and lower child maltreatment risk factors.
- Reported that when it comes to family functioning and resiliency, they frequently or at least half the time, are able to accept and manage stressful situations or problems. The baseline mean score of 4.8 suggests that families need additional assistance in developing skills and strategies to communicate, work through, and adapt to crises.

¹⁷⁴ Calculation of a subscale score for the knowledge of parenting and child development domain is not recommended and therefore not presented.

Figure 39: Families' Mean Subscale Scores in Selected Protective Factor Domains at RPG Program Admission, as Measured by the Protective Factors Survey



The NCFAS includes three subscales that help assess a family’s broader living situation and the extent of social and community supports that contribute to family well-being: Environment (e.g., a family’s overall stability and safety in their home and community), Family Safety (e.g., absence of domestic violence and child abuse or neglect), and Social/Community Life (e.g. interactions with family and friends and connection to the community). Findings for each subscale are discussed below for the subset of grantees using the NCFAS.

- The percentage of families for whom the overall environment item was rated as a mild or clear strength significantly increased from 18.4 percent at program admission to 41.5 percent at program discharge ($p < .001$; data not shown).
- Similarly, the percentage for whom their overall environment was rated as a mild to serious problem significantly declined from 46.3 percent to 19.4 percent ($p < .001$; data not shown).¹⁷⁵
- In all six specific environment areas, families showed significant improvement from admission to discharge (see Table 37 below).¹⁷⁶ At program admission, approximately one-fourth of families had a strength rating in the areas of housing stability (e.g., able to occupy the same residence and make rent or mortgage payments with no or minimal problems), learning environment (e.g., parents have established routine and time for play and study, and are actively involved with the child’s school), safety in the community (e.g., providing a safe and secure neighborhood for their children), and housing habitability (e.g., home is clean, safe, not in need of major repairs). By program discharge, this had increased to a range of 42.3 percent to 49.3 percent of families (depending on the area). Though personal hygiene (e.g., children and parents are well groomed, have appropriate clothes) was a strength area for a substantial percentage of parents upon RPG program admission, the findings still showed significant increases by program discharge.

¹⁷⁵ Statistically significant improvement in the overall environment item varied by grantee, though all means were in the same direction; see Appendix F for more details.

¹⁷⁶ Statistically significant improvements in environmental risks, housing habitability, and learning environment were consistent across grantees that reported these data. For the other items, findings of statistical significance varied across grantees with most means by grantee in the expected direction; see Appendix F for additional detail.

Table 37: Percentage of Families for Whom Selected Areas of NCFAS Environment Subscale were Rated a Mild/Clear Strength at RPG Program Admission and Discharge

	<u>RPG Program Admission</u>	<u>RPG Program Discharge</u>
Housing Stability(N=507)***	22.5%	49.1%
Learning Environment (N=459)***	22.5%	48.8%
Safety in the Community (N=498)***	22.9%	42.3%
Habitability of Housing (N=489)***	29.6%	49.3%
Personal Hygiene (N=503)***	39.0%	55.9%
Environmental Risks (N=170)*	10.5%	19.4%

*P<.05; ***p<.001

Note: Data represent a subset of 8 to 10 grantees reporting these NCFAS data; not all grantees report on all individual items.

- The percentage of families for whom the overall family safety item was a mild or clear strength significantly increased from 17.2 percent at program admission to 41.0 percent at program discharge (data not shown; p<.001).
- Similarly, the percentage for whom their overall family safety was rated as a mild to serious problem significantly declined from 45.4 percent to 19.0 percent (data not shown; p<.001).¹⁷⁷
- In all of the specific family safety areas, parents showed significant improvement (see Table 38 below). They made the greatest change in the areas of child neglect, emotional child abuse, physical child abuse, and domestic violence. The percentage of families in the strength range significantly increased from 18.0 percent at program admission to 41.5 percent at discharge for child neglect, from 27.7 percent to 44.4 percent for physical child abuse, and from 22.2 percent to 39.2 percent for emotional child abuse. This indicates the absence of such maltreatment, or if it occurred, the family has successfully been involved in services to address the problem.
- Significant differences from admission to discharge also occurred with regard to absence of resolution of domestic violence between parents; the percentage of families in the strength range increased from 17.6 percent to 36.6 percent. Families also showed significant improvements in the areas of conflict and sexual child abuse.¹⁷⁸

¹⁷⁷ Statistically significant improvement in the overall family safety item varied across grantees, though all means were in the same direction; see Appendix F for additional detail.

¹⁷⁸ Statistically significant improvement for the child sexual abuse item was consistent across grantees reporting these data. For the other items, findings of statistical significance varied across grantees, though most means were in the expected direction; see Appendix F for additional detail.

Table 38: Percentage of Families for Whom Selected Areas of NCFAS Family Safety were Rated a Mild/Clear Strength at RPG Program Admission and Discharge

	<u>RPG Program Admission</u>	<u>RPG Program Discharge</u>
Child Neglect (N=672)***	18.0%	41.5%
Physical Child Abuse (N=553)***	27.7%	44.4%
Domestic Violence (N=585)***	17.6%	36.6%
Emotional Child Abuse (N=640)***	22.2%	39.2%
Sexual Child Abuse (N=610)***	32.8%	42.9%
Family Conflict (N=160)*	5.6%	13.8%

p<.01; *p<.001

Note: Data represent a subset of 8 to 10 grantees reporting these NCFAS data; not all grantees report on all individual items.

LESSONS LEARNED ABOUT MEASURING WELL-BEING

Over the course of the five-year grant period, the regional partnerships made progress in measuring well-being. Yet they also encountered several major challenges. These challenges, in combination with the data caveats and limitations outlined previously in Table 31, translate into important lessons for continued and future cross-systems collaborative efforts to measure child, adult, and family well-being. The overarching theme that emerged from these lessons is the need for ample support and an adequate infrastructure to implement well-being measurement tools as intended, consistently, and with fidelity.

- *Obtaining a comprehensive picture is important.* While these instrument-specific data provide a useful snapshot of child, adult, and family well-being, the data should not be considered in isolation. As previously stated, well-being is not always conceptually distinct from other measures of improvement. Thus, these data are best viewed in combination with other measures and available information to develop a fuller understanding of how RPG participants are functioning in these well-being areas.

Further, other factors that may affect the results need to be considered. These factors include whether the data reflect a parent or practitioner report, the influence of cultural factors on child, parent, and family functioning, and the impact of situational or contextual factors (in particular, the economic environment) on a child’s, parent’s, or family’s well-being.

After a review of assessments, charts, and staff and client interviews, one grantee concluded that their parents’ family bonds and functioning improved by at least 70 percent from program enrollment to completion. The grantee said parents reported an increased sense of competence, bonding, and social connection, which positively impacts their parenting ability. In addition, children received support services such as mental health services, developmental services, food, housing, and social support, in addition to being in the custody of a sober parent. As a result, the grantee reported children were thriving by the end of treatment.

- *Adequate time is needed to measure change.* Child, adult, and family well-being are multifaceted constructs. In addition, many RPG families’ problems are complex, severe, and intergenerational in nature. Yet the recovery and family healing processes are not subject to

a precise timetable. As such, the duration of some RPG program interventions may only be sufficient to affect marginal (but critical) change from program admission to discharge. As one grantee noted, “Within the context of the Strengthening Families Program change measures, the most difficult impact within a 4-month (14-week) time period to measure are children’s behaviors.”

- *The instruments used to measure well-being need to align with a program’s available human and financial resources.* Sufficient time, planning, training, and resources are needed to assess the multiple dimensions of child, parent, and family well-being using valid and reliable methods. Programs must balance the need for comprehensive well-being assessments with available organizational resources and capacity, as well as families’ needs.

The length of time it takes to administer, score, and interpret an instrument, and the associated costs need to fit within a program’s service delivery structure and budget. These considerations will likely drive (and may limit) the parameters of a feasible measurement approach. In short, large-scale, in-depth evaluations intended to measure well-being require substantial investment upfront.

- *The provision of expert technical assistance is needed early in the planning process.* Technical assistance during the evaluation and program planning stage is needed to help programs select the most appropriate well-being measurement instruments that align with their program model and target population. After implementation, some grantees found their services and interventions were not designed to impact the type of change measured by the selected instrument, or a given measurement tool was not sensitive enough to detect their intervention effect. Other grantees found their selected instrument was best suited for screening and to inform treatment planning, rather than to evaluate program service delivery.
- *Appropriately trained and qualified staff are needed to administer the instruments.* Different instruments may serve different purposes (e.g., screening, assessment, treatment planning, evaluation) and thus require different types of staff to administer, score, and interpret them. For instance, while basic screening may be done by a front-line worker, a more in-depth assessment may require the knowledge of a licensed or certified service provider. Further, a more extensive evaluation may need to be conducted by an experienced clinical psychologist that specializes in given subject matter.

The type of staff or professional needed to administer a chosen instrument must be practical given a program’s existing staffing. In addition to staff training on how to administer an instrument, adequate cross-systems clinical training is needed to enhance staff’s knowledge about the complexity of the issues being measured (e.g., trauma, mental disorders, children’s social-emotional and cognitive development).

- *Baseline self-report assessments may not accurately reflect the severity of a parent’s or family’s situation.* Upon initial program entry, clients may lack a clear understanding of the issues or behaviors that led to their program involvement. As a result, baseline self-assessments may not accurately depict the family’s actual state. Individuals may overestimate their own or their child’s strengths or abilities in a given area, or underestimate the severity of their problems. Over the course of program participation, clients typically

obtain skills and knowledge that provides them with a more accurate understanding of the extent of their problems. They begin to modify their frame of reference, which is known as response bias shift.^{179, 180} If a client's initial baseline self-assessment is skewed, it may be difficult to objectively and accurately measure progress from baseline to program discharge.

- *Program and evaluation staff need to communicate effectively about data collection and reporting roles and responsibilities.* During the course of the grant, the partnerships experienced challenges with quality, consistency, and timeliness of various data, including administering standardized instruments to measure well-being (see also Chapter XI). A key contributing factor to this problem is difficulty fully engaging clinical and other front-line staff to participate in accurate data collection and reporting, due in part to lack of a shared understanding regarding the purpose and importance of the evaluation.

Clear, agreed-upon procedures are needed regarding frequency of instrument administration and subsequent reporting of data. This is particularly important given the challenges with program participant attrition that often occur when working with vulnerable populations and in community or treatment (rather than research) settings.¹⁸¹ At the same time, evaluators need to communicate clearly and regularly with program staff responsible for collecting and maintaining the data to identify and address any data problems, and convey the usefulness of the data to all positions (e.g., administrators, supervisors, clinicians).

SUMMARY

As discussed in the next chapter, grantees reported the families they served faced complex challenges (see capacity to serve families measure). These included significant co-occurring substance use and mental health disorders (including trauma), long-standing and severe substance use disorders, prior child welfare and/or criminal justice system involvement, a long history of unemployment or related employment issues, and other compounding risk factors.

Within the identified data limitations, these findings show that grantees measuring well-being with these selected instruments had a positive impact on various aspects of child, adult, and family well-being, despite clients' challenges. These results, together with the above measurement lessons provide an important foundation to inform future programmatic and evaluation efforts in the well-being area.

¹⁷⁹ Pratt, C.C., McGuigan, W.M. & Katzev, A.R. (2000). Measuring program outcomes: Using retrospective pretest methodology. *American Journal of Evaluation*, 21, 341-349.

¹⁸⁰ Howard, G.S. and Dailey, P. R. (1979). Response-shift bias: A source of contamination of self-report measures. *Journal of Applied Psychology*, 64, 144-150.

¹⁸¹ National Research Council (2001). *Evaluating Welfare in an Era of Transition*. Panel on Data and Methods for Measuring the Effects of Changes in Social Welfare Programs. Robert A. Moffitt and Michele Ver Polog, Editors. Committee on National Statistics, Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.

CHAPTER X: IMPROVE SYSTEMS COLLABORATION

INTRODUCTION

This chapter focuses on four service capacity measures that reflect grantees' efforts to strengthen collaborative practice among the substance abuse treatment, child welfare, court, and other key service systems and increase their capacity to serve families.

- Coordinated case management
- Substance abuse education and training for foster parents and other substitute caregivers
- Regional partnerships' collaborative capacity
- Regional partnerships' capacity to serve families

Grantees indicate that nearly all (94 percent or more) of participant families received cross-systems coordinated case management services and regular cross-agency assessments, and reported active involvement in their case planning process. Further, over the course of the grant, more than 1,900 foster care parents and other substitute caregivers received training and education on addiction and substance abuse treatment, issues related to family recovery, and the special needs of children whose parents have a substance use disorder.

The regional partnerships showed significant improvement in all key areas of collaborative practice over the five-year grant period. Their greatest strengths were consistently in the underlying values and principles of their collaborative relationships, screening and assessment, and client engagement and retention. The partnerships showed the most amount of improvement in the areas of children's services and cross-systems information sharing and data systems.

Most grantees also demonstrated progress regarding their total number of children and families served. At the end of their grant, 27 grantees (52.9 percent) had reached 90 percent or more of their cumulative projected number of *children* to be served, while 29 grantees (54.7 percent) had reached 90 percent or more of their projected number of *adults* to be served. The majority of these grantees exceeded 100 percent of their projected child and adult targets. The median percentage met across all grantees was 97.6 percent for children and 92.9 percent for adults.

Coordinated Case Management¹⁸²

Percentage of families that receive appropriate coordinated case management services.

Percentage of families who: a) report active involvement in various aspects of the case planning process, including identifying strengths, needs and needed services, and establishing and evaluating progress toward goals, b) received joint case management services coordinated between a substance abuse treatment provider and a child welfare agency, and c) received joint case management services who received a cross-agency assessment conference every 90 days or less

Important Background Regarding the Coordinated Case Management Measure

- This measure is intended to determine whether families receive coordinated case management services across multiple service systems that facilitate children’s safety, permanency, and well-being, as well as parents’ recovery, self-sufficiency, well-being, and ability to provide for their children’s needs. The 33 grantees that reported data on all or selected aspects of this measure obtained the information from program or case records and/or client satisfaction surveys or similar questionnaires.

Summary Findings

- Overall, the majority of families in the RPG programs received coordinated case management services. More specifically, an average of 94.1 percent of all families served reported active involvement in various aspects of the case planning process. Sixteen of the 27 grantees submitting these data reported that 100 percent of their families were actively involved in coordinated case planning.¹⁸³
- Of those families served who had open cases in both the child welfare and substance abuse treatment systems, an average of 94.4 percent received joint case management services coordinated between the systems. Twenty of the 27 grantees providing these data reported that 100 percent of their families received joint case management services.
- Grantees reported that of those families receiving joint case management services, an average of 95.6 percent received a cross-agency assessment conference every 90 days or less. Twenty-one of the 25 grantees providing these data indicated that 100 percent of their families received such a cross-agency assessment conference.

¹⁸² Thirty-three grantees reported on all or some aspect of this indicator for their RPG participant groups. Only a small number of grantees (one to five, depending on the particular indicator component) reported these data for their own comparison groups; as such, summary comparison data group are not presented.

¹⁸³ There is no uniform or standardized definition for what it means for a family to have active involvement in case planning. Grantees had the flexibility to define and operationalize “active involvement in case planning” at the local level, as they deemed appropriate.

Substance Abuse Education and Training for Foster Care Parents and Other Substitute Caregivers

Percentage of foster parents or substitute caregivers who received education and training about: a) addiction and substance abuse treatment, b) special needs of children who have experienced maltreatment and whose parents have a substance use disorder, and c) family recovery

Important Background Regarding the Training for Foster Parents Measure

- As previously established in this and prior RPG reports to Congress, there was variance and diversity in the 53 grantees' program-specific strategies and target populations. Grantees only reported on the RPG measures that aligned with their project's goals, activities, and intended outcomes. Only a small number of grantees had an overall program model that warranted regular reporting on this measure. More often, grantees provided substance abuse education and training for foster care parents or other substitute care providers as needed or on an ad-hoc basis.

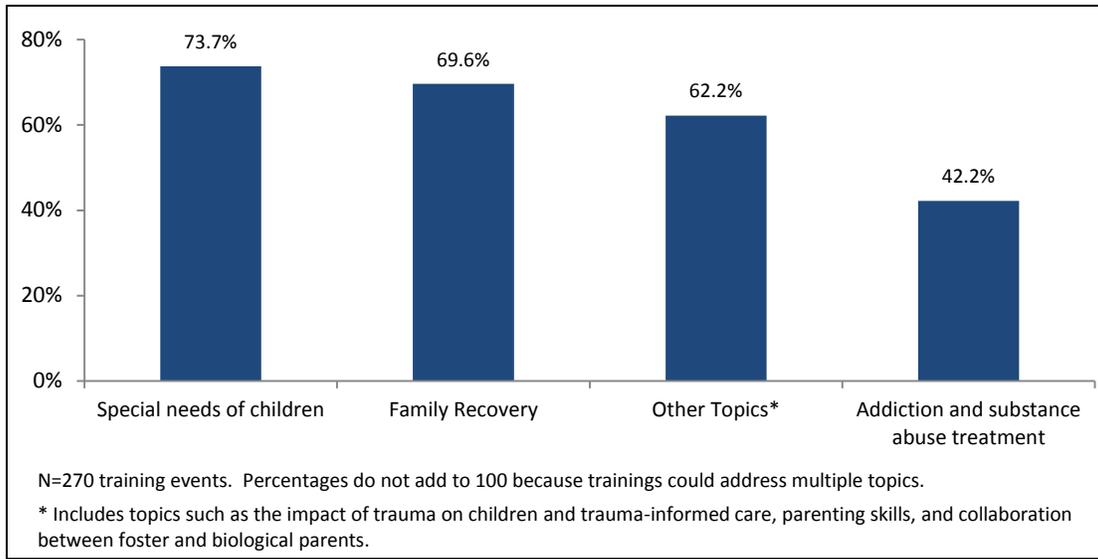
One site trained all foster parents on the Nurturing Parent program to ensure better consistency across partners and between foster and biological parents. The grantee noted the foster parents recognize most children will return to their parents and as such, want to strengthen families and help parents deliver consistent parenting practices. Further, the foster parents often remain connected to the biological families after the children and their parents reunify, helping to reduce any further trauma children may experience when leaving their foster parents to return home.

Summary Findings

- Over the course of the grant period, 12 regional partnerships provided 270 substance abuse education and training events in which 1,901 foster care parents and other substitute caregivers participated. Four grantees accounted for approximately three-fourths (75.6 percent) of all such training events.
- Nearly three-fourths (73.7 percent) of all trainings addressed issues related to the special needs of children who have been maltreated and are impacted by their parent's substance use. More than two-thirds (69.6 percent) of trainings covered family recovery, while 42.2 percent covered issues regarding addiction and substance abuse treatment. Finally, more than three-fifths (62.2 percent) of trainings addressed other related topics, such as the impact of trauma on children and trauma-informed care, parenting skills, and collaboration between foster parents and biological parents (see Figure 40).¹⁸⁴

¹⁸⁴ Percentages do not add to 100 because a given training could cover more than one topic.

Figure 40: Substance Abuse Education and Training Events Provided to Foster Care Parents and Other Substitute Caregivers, Percentage by Topic Area



“The majority of the families coming to [the RPG program] had little understanding of what was driving their [foster] child’s behavior. They merely saw a child who was out of control, violent, aggressive, or oppositional. What the [foster] families did not understand was the *why* behind their child’s behavior. For most of our families, it was the first opportunity they had to understand what was going on with their child and to understand that their child could get better. . . . Helping the parent to understand their child’s unique needs and the biologically-based source of the behavioral difficulties became an important part of the therapy program, even when the child was the identified patient and treatment focused primarily on him or her.”

Regional Partnership Grantee

Collaborative Capacity

Regions have new or increased ability to address parental or caregiver substance abuse and its effect on children, as measured by increased cross-systems understanding and collaborative activities

Important Background Regarding the Collaborative Capacity Measure

All 53 grantees used the Collaborative Capacity Instrument (CCI) to inform their efforts to improve cross-systems collaboration. The CCI is a reliable and valid self-assessment tool used by state or local substance abuse and child welfare service agencies and dependency courts

seeking to strengthen their collaborative relationships and capacity to provide comprehensive services to and improve outcomes for children and families.¹⁸⁵

The CCI addresses the 10 key elements or domains of cross-systems linkages (outlined in Chapter III) that substance abuse treatment, child welfare, and court systems must be engaged in to be effective and sustainable:¹⁸⁶

- Underlying Values, Principles, and Priorities of Collaborative Relationships
- Daily Practice in Screening and Assessment
- Daily Practice in Client Engagement and Retention
- Daily Practice in Services to Children
- Information Sharing and Data Systems
- Staff Training and Development
- Budgeting and Program Sustainability
- Working with Related Agencies
- Building Community and Family Supports
- Joint Accountability and Shared Outcomes

The CCI allows individual members of a collaborative to rate their partnership's strengths in specific areas and the extent to which they think the partnership has formed effective cross-systems working relationships. The questions are designed to elicit discussion among and within substance abuse, child welfare, the courts, and other key service systems about their readiness to work together more closely and effectively. Questions are measured on a three-point Likert-type scale (1=Disagree, 2=Somewhat Agree, 3=Agree)¹⁸⁷ and include a Don't Know/Not Sure response.

The regional partnerships administered the CCI in program year one (baseline administration), year three (interim administration), and year five (final administration). All of a partnership's front-line and supervisory RPG program staff working with families, as well as the core

¹⁸⁵ Children and Family Futures developed the CCI. The tool has been tested for reliability and internal consistency for measuring improvements in these practices over time (Drabble, L., Pathways to collaboration: Exploring values and collaborative practice between child welfare and substance abuse treatment fields. *Child Maltreatment*, 2007; 12:31-42). To date, the HHS-funded NCSACW has used the CCI with approximately 38 states, 250 counties, 300 local level entities, and 9 tribes.

¹⁸⁶ More information on the 10 domains of cross-systems collaborative linkages and their development is available at: <http://www.ncsacw.samhsa.gov/>.

¹⁸⁷ There are two questions that rate selected aspects of the grantees' child welfare and substance abuse treatment services using a five-point scale, where 1=poor, 3=fair, and 5=excellent.

management team, steering committee, or other RPG advisory or oversight members were asked to complete the survey. The time between administrations allowed the partnerships to become more established and enabled a more comprehensive identification of collaborative progress and challenges.

The number of regional partnership members who completed the CCI was 862 in year one, 956 in year three, and 622 in year five.¹⁸⁸ Results were aggregated across all grantees and overall mean scores were calculated in each of the 10 domains. Percentage change was calculated to assess changes in collaborative capacity mean scores from baseline to interim administration (year one to year three), interim to final administration (year three to year five), and baseline to final administration (year one to year five).

Higher mean scores identify areas of strength and agreement and lower mean scores indicate areas with opportunity for improvement. In addition, the percentages of Don't Know/Not Sure responses are included because they provide important context to help interpret the mean scores.¹⁸⁹

A final note: While the CCI provides a standardized, quantitative measure of grantees' collaborative capacity, the qualitative review of grantees' Semi-Annual Progress Reports imparts additional insights regarding grantees' collaborative progress. These lessons, discussed in Chapter III, are useful to consider in conjunction with the CCI results to provide a more comprehensive picture of the partnerships' accomplishments and challenges in strengthening cross-systems collaboration.

Summary Findings

Overall, during the course of the RPG Program, the regional partnerships showed improvement in all 10 areas of collaborative practice. In general, grantees' showed the most rapid and greatest amount of change during the first part of the grant period. Their broader collaborative capacity continued to improve during the latter part of the grant period, yet typically at a more moderate rate. Two areas proved the exception: underlying values and principles of collaborative relationships and building community and family supports. Grantees showed greater progress in these two domains during the second (rather than first) part of the grant period.

The relative slowing down in the rate of progress likely reflects several developments. During initial program implementation, project teams were formed and enthusiasm was high. In later years, several sites experienced leadership changes and significant staff turnover; progress stalled as partnerships had to adjust to these events. Also, many sites were adversely impacted by the fiscal and economic environment. As discussed in Chapter III, budget cuts, staff and service

¹⁸⁸ Only the five-year grantees completed the final CCI administration.

¹⁸⁹ The frequency of Don't Know/Not Sure responses helps inform mean scores by serving as a way to gauge how widely and broadly knowledge and information about the partnership's functioning has spread to all members. Further, such responses provide valuable information regarding ongoing RPG program and partner staff training and development needs. Substantial percentages of Don't Know/Not Sure responses are typical when partnerships are in the early stages of collaboration. Over time, as partners increase their information sharing and develop a better understanding of each other's systems, the percentages of Don't Know/Not Sure responses are expected to decline. Refer to the Second Report to Congress for further discussion on this issue.

reductions, and other related effects hampered grantees' overall collaborative capacity. These contextual events tested the collaborative relationships of many sites, often requiring more intensive and extensive discussions as grantees worked through these issues.

In addition to higher mean scores in all areas, the percentage of Don't Know/Not Sure responses continually declined over the course of the grant period. This indicates that project staff and partners developed an increased understanding of how their partnership's various collaborative domains were functioning.

Table 39 shows overall RPG Program mean scores for each time point and the percentage change in scores in each of the 10 areas. More specifically:

- *Underlying values and principles of collaborative relationships* was rated as the strongest of the 10 areas throughout the grant period, with respective mean scores of 2.52, 2.59, and 2.71 at each administration. At all time points, regional partners were in the highest agreement that they prioritized parents in the child welfare system for substance abuse treatment services, and the child welfare system and the courts consider alcohol abuse as important as illicit drugs as a contributing factor to child maltreatment. Further, by year five, substance abuse treatment, child welfare, and court partners were much more likely to have used a formal values assessment process.
- *Screening and assessment* ranked among the top three collaborative practice areas in years one, three, and five (with mean scores of 2.44, 2.57, and 2.68, respectively). There was particularly high agreement that substance abuse assessments also ask about children and child safety issues; information systems routinely document substance use screening and assessment results; and the projects have multidisciplinary service teams that include substance abuse, child welfare services, and court workers.
- *Client engagement and retention* also was ranked consistently as one of the top three collaboration areas throughout the grant period (with mean scores of 2.41, 2.58, and 2.69 at the respective time points). Partners' knowledge about each other's systems and their ability to talk with families about substance abuse, child welfare, and court issues continued to be rated as a primary strength. By year five, partners were more apt to agree that they were using drug testing effectively to monitor clients' treatment compliance. The partnerships showed the greatest amount of progress in assessing client dropout points, training staff in approaches to improve client retention, and providing family-focused substance abuse treatment.
- *Services to children* showed the greatest amount of improvement over the course of the grant period. However, overall, this area of collaboration was consistently rated the lowest of the 10 areas. The mean score increased 17.8 percent, from 2.08 in year one to 2.45 in year five. As discussed in Chapters II and III, grantees continually strengthened and enhanced various children's services during the grant. The partnerships made the greatest gains in ensuring all children receive comprehensive mental health assessments, developing a range of programs that target children's special developmental needs, and implementing substance abuse prevention and early intervention services for children. Further, partners agreed most strongly that their projects were now familiar with national prevention and intervention

models for substance-affected children; this is likely the result of the extensive technical assistance and training HHS provided to grantees (see Chapter XII).

- The area of *information sharing and data systems* showed the second greatest amount of change from baseline to final administration. The mean score increased a total of 15.2 percent, from 2.31 in year one to 2.66 in year five, as grantees strengthened their ability to collect, report, and use their data for program improvement. In addition, the decline in Don't Know/Not Sure responses (from 46.7 percent in year one to 32.5 percent in year five) suggests project staff became more knowledgeable about their own and each other's data system capacities.
- *Staff training and development* showed a significant amount of change over time, but remained among one of the lower rated areas (with a mean score of 2.51 in year five), compared to the other practice domains. Cross-systems clinical training, in particular between substance abuse treatment and child welfare agencies, was identified as a key strength. In addition, the partners were in strong agreement that training programs are multidisciplinary in their approach and delivery.
- *Budgeting and program sustainability* showed the least amount of change over time. The mean score showed a slight increase of 7.1 percent, going from 2.38 in year one to 2.55 in year five. Further, this area had the highest percentages of Don't Know/Not Sure responses (which decreased somewhat from 53.3 percent in year one to 43.1 percent in year five). These findings may reflect the challenges grantees faced with third-party billing for RPG services and the larger fiscal environment's impact on sustainability planning (see Chapter III, Lessons 10 and 11). In addition, front-line staff (in contrast to project directors and managers) may not be as actively involved in or aware of sustainability or financial planning.¹⁹⁰
- *Working with related agencies* was a key collaborative strength throughout the grant period, with mean scores of 2.41, 2.57, and 2.68 at each CCI administration. In particular, partners indicated child welfare and substance abuse staff did extremely well in identifying and linking families with needed support services. The partnerships made the greatest amount of improvement from year one to year five in routinely assessing supportive service referral and completion rates and monitoring barriers to access needed services. In addition, by year five, partners indicated substance abuse recovery groups were more likely to include a focus on child welfare and safety issues.
- *Building community and family supports* showed significant gains, particularly in the latter half of the grant period. However, overall it was one of the lower rated collaborative areas (with a mean score of 2.49 in year five), compared to the other domains. The partnerships' greatest strengths centered on providing families with needed community-based supports and resources. Areas that showed the most progress from year one to year five, but still could be improved, involved engaging and obtaining input from the community.

¹⁹⁰ For the interim and final CCI administration, an average of 43 percent of respondents were front-line staff, while 37 percent were administrators, managers, or supervisors.

- *Joint accountability and shared outcomes* showed substantial improvement over the course of the grant period. The mean score increased 13.7 percent, from 2.27 in year one to 2.58 in year five. Within this collaborative area, partners strongly agreed that parents were referred to parenting and child development programs with demonstrated positive results. Partners also felt child welfare and substance abuse treatment agencies had established shared accountability for mutual clients (i.e., substance abuse treatment system shares accountability for positive safety outcomes for parents in treatment and child welfare shares accountability for successful substance abuse treatment outcomes).

Table 39: Collaborative Capacity Results—Changes from Baseline to Follow-Up Administrations, by Collaborative Practice Domain

Collaborative Practice Domain	Overall RPG Mean Score by Administration Time Point			Percent Change from Baseline (Year 1) to Follow-Up Administrations (Years 3 & 5)			Percent Don't Know/Not Sure		
	Year 1	Year 3	Year 5	Year 1 to Year 3	Year 3 to Year 5	Year 1 to Year 5	Year 1	Year 3	Year 5
Underlying Values and Principles of Collaborative Relationships	2.52	2.59	2.71	2.8%	4.6%	7.5%	26.7%	20.3%	14.7%
Daily Practice in Screening and Assessment	2.44	2.57	2.68	5.3%	4.3%	9.8%	30.2%	21.6%	17.2%
Daily Practice in Client Engagement and Retention	2.41	2.58	2.69	7.1%	4.3%	11.6%	29.5%	20.1%	15.5%
Daily Practice in Services to Children	2.08	2.27	2.45	9.1%	7.9%	17.8%	37.6%	31.4%	24.4%
Information Sharing and Data Systems	2.31	2.54	2.66	10.0%	4.7%	15.2%	46.7%	39.9%	32.5%
Staff Training and Development	2.19	2.36	2.51	7.8%	6.4%	14.6%	42.4%	33.6%	27.0%
Budgeting and Program Sustainability	2.38	2.48	2.55	4.2%	2.8%	7.1%	53.3%	50.3%	43.1%
Working with Related Agencies	2.41	2.57	2.68	6.6%	4.3%	11.2%	32.3%	23.3%	17.2%
Building Community and Family Supports	2.22	2.3	2.49	3.6%	8.3%	12.2%	38.0%	32.4%	25.9%
Joint Accountability and Shared Outcomes	2.27	2.44	2.58	7.5%	5.7%	13.7%	40.6%	31.7%	24.4%

As noted in Chapter III, collaboration is an iterative process and collaborative capacity is developed and acquired over time. To move relationships into true partnerships requires the active involvement of all key partners (see Lessons 1 and 2). The regional partnerships showed significant improvement in all key areas of collaborative practice over the five-year grant period, as measured by the CCI. Their progress in building collaborative capacity directly reflects the legislation's emphasis on developing and strengthening interagency collaboration and services integration.

Capacity to Serve Families

Regions have new or increased capacity to serve families in which a parent or caregiver has an identified substance use disorder and there is current or potential involvement with the child welfare system: a) percentage of regional partnership member agencies that increased the number of appropriate treatment programs for the targeted region, and b) among those partner agencies, increase in the number or percentage of families served or the number or percentage of treatment slots¹⁹¹ available in the targeted region

Important Background Regarding the Service Capacity Measure

This measure was designed to determine how access to treatment for families involved with the child welfare system had improved since implementation of the grantees' programs. As originally conceptualized, it specifically focused on the percentage change in the number of substance abuse treatment programs,¹⁹² treatment slots, adults who received substance abuse treatment, and children (of adults receiving treatment) who received services in the 12 months prior to the grantee's program implementation compared to the end of the grant.

Grantees encountered significant challenges in obtaining the data (particularly the pre-RPG baseline data) needed for this measure, as originally defined. Despite efforts to strengthen grantees' collection and reporting of these data, HHS determined that the data grantees were able to submit did not provide a valid and reliable assessment of this performance measure.

In response, approximately midway through the grant, HHS identified a viable alternative approach to help measure service capacity. HHS instead assessed the extent to which grantees met their own projections for the total number of children and adults their programs would serve. This is a suitable proxy for measuring increased capacity to serve children and families, as grantees have implemented various new, expanded, or enhanced services and collaborative activities that did not exist prior to their RPG project implementation.

This analysis used grantees' own projected totals to be served through the end of their grant period. To provide the most accurate picture of grantees' progress, the number of both children and adults served were considered. Highlighted below are key issues that are important to consider when reviewing and interpreting these results.

¹⁹¹ Treatment slots (part b) was an optional aspect of this measure that grantees could choose to report.

¹⁹² There is no standardized definition of a new treatment program. For purposes of this project, a new program was defined by the addition of new services or a new level of care that did not previously exist or was not available for families in the child welfare system (e.g., services expanded to another county or geographic area where they were not previously available, residential treatment was added).

Key Issues to Consider Regarding the Projected Targets Met Analysis

While information on projected targets met is useful, it provides only one perspective of grantees' overall efforts to improve their effectiveness and capacity to serve families. In particular, the following issues should be considered when reviewing and interpreting the results.

- This type of quantitative analysis does not take into account grantees' successes and challenges in obtaining referrals and engaging and retaining clients; their efforts to overcome identified barriers to client engagement and retention; and program enhancements made that improved their ability to meet families' needs (see Chapters II and III).

For example, a grantee may have been somewhat behind in meeting their cumulative projected targets in the first 12 to 18 months, but over the course of the grant, successfully modified their program model, increased outreach, expanded their target population, and took other actions to ensure they reached children and families in subsequent program years. It is important to recognize that when looking at the numbers from a cumulative perspective, grantees may likely never "catch up" to overcome those early deficits. Conversely, a grantee may have exceeded their projected targets, but proposed to serve a very small number of families or may have struggled with early or high client dropout rates.

- Some grantees served multiple target populations or operated different program models. These grantees may have met or exceeded their projected targets for one population or component, while experiencing challenges with another. For example, a grantee operating multiple family drug courts in different sites may have met their projected targets for some courts, but encountered challenges with others. The information presented reflects a grantee's overall status across all its programs or sites.
- This analysis does not account for differences in grantees' target populations and grantees who may have focused on "harder to serve" clients. Currently, there is no objective way to measure if a grantee targets a harder to serve population. There is no agreed-upon operational definition of what this means (e.g., clients require more intensive and/or longer duration of services, have co-occurring substance abuse and mental or other disorders, or have history of prior treatment episodes and child welfare involvement). Though grantees did not report on the "harder to serve" issue in a systematic manner, the partnerships increasingly mentioned this as a challenge over the course of the grant, noting its impact on program operations in their Semi-Annual and Final Progress Reports.
- In addition to examining the number of adults and children grantees served, there are additional quantitative and qualitative data that provide further evidence of how grantees have increased capacity to serve families. As noted in Chapter II, 81.7 percent of the various substance abuse treatment services and linkage activities that grantees implemented represented new services or an expansion/enhancement of existing services—this is a clear indication of building service capacity. It also is valuable to consider how capacity to serve families has increased due to improved cross-systems collaboration and ongoing cross-systems staff training and development to ensure a well-qualified workforce (refer to Chapters II and III).

Summary Findings—Percentage Projected Targets Met

- At the end of grant period, 27 grantees (52.9 percent) had reached 90 percent or more of their total projected number of *children* to be served, while 29 grantees (54.7 percent) reached 90 percent or more of their projected number of *adults* to be served. The median percentage met across all grantees was 97.6 percent for children and 92.9 percent for adults.

- More specifically, as Table 40 shows, most grantees actually exceeded 100 percent of their projected child and adult targets: 45.1 percent for children served and 39.6 percent for adults served. Conversely, 17.6 percent and 11.3 percent of grantees served less than 50 percent of their total projected number of children and adults, respectively.¹⁹³

Table 40: Grantee Progress in Meeting Projected Number of Children and Adults to be Served, Number and Percentage of Grantees within Given Percentage of Target Met				
Percentage of Target Met	CHILDREN		ADULTS	
	Number and Percentage of Grantees*		Number and Percentage of Grantees*	
Met More than 100% of Target	23	45.1%	21	39.6%
Met 90%–100% of Target	4	7.8%	8	15.1%
Met 70%–89% of Target	11	21.6%	11	20.8%
Met 50%–69% of Target	4	7.8%	7	13.2%
Met Less than 50% of Target	9	17.6%	6	11.3%

*For children, N=51; excludes two grantees who indicated they do not serve children as their primary client and therefore did not provide projected targets for number of children to be served; for adults, N=53.

Factors Contributing to Grantees’ Progress in Serving Families

Typically, there was not a single reason, but rather a combination of factors attributed to grantees’ success in reaching or exceeding their projected targets. Contributing factors most often included:

- *Enhancement of the RPG program model.* As discussed in Chapter II, grantees continually refined their programs to better respond to families’ needs and ensure adequate numbers of appropriate program referrals. For example, during the grant period, 81.1 percent of grantees added new services to their overall program model or enhanced existing RPG interventions (see Chapter II for additional program improvements).
- *Increased and strengthened collaboration.* As Chapter III highlights, extensive and well established collaborative relationships and networking are needed to identify and engage families in services. Grantees emphasized the importance of strengthening collaborative relationships with existing partners and establishing relationships with new partners to increase and diversify referral sources. They achieved this through co-location of staff, cross-systems training, targeted and intensive partner and community outreach, marketing and dissemination of program and client outcomes, and other means.

¹⁹³ Percentage projected met was based on the total number of unique children and adults served during the grantee’s grant period. For children, N=51 grantees; excludes two grantees who indicated they do not serve children as their primary client and therefore did not provide projected targets for number of children to be served. For adults, N=53 grantees. Several grantees, with HHS approval, revised their original projected targets during the grant. As needed, grantees’ year one annual projections were adjusted based on the month they started seeing clients to account for initial start-up and program development and implementation. Where needed, certain grantees’ year five annual projections were adjusted in a similar manner (e.g., due to the length of the RPG intervention, a grantee may have had to stop enrolling new families earlier than anticipated to ensure they were able to complete the program).

- *Specialized client outreach and engagement.* To improve identification and engagement of families in RPG treatment and services, nearly all (96 percent) of grantees had implemented new or strengthened existing specialized outreach strategies, such as peer recovery support specialists and motivational interviewing (see Chapter II).

One grantee noted they now serve families in 36 of the state’s 39 communities, and approximately 30 percent of families served since program implementation were from towns and cities the project was previously unable to serve. The partnership succeeded in expanding from a limited multi-community project (serving a predominantly inner city, urban population) to a statewide program, including other major cities and both suburban and rural populations. An outgrowth of this expansion was the ability to offer services to Native American families for the first time. The project team was able to learn about the specific needs of Native American families and the resources available within the local tribe, which further strengthened the project’s capacity.

Key Challenges in Meeting Projected Targets

Just as there were a host of factors that contributed to grantees’ success in reaching or exceeding their projected targets, so, too, were there typically multiple reasons for why some grantees had difficulty in this area. Grantees cited three leading factors in particular: complexity of families’ needs, changes in child welfare caseloads, and continued and extensive staffing challenges. These are discussed further below.

Complexity of Families’ Needs

Over the course of the grant, the partnerships increasingly expressed challenges with effectively engaging and retaining families due to the complexity of families’ needs. Grantees noted the following characteristics made their target populations harder to serve:

- Significant co-occurring substance use and other disorders—e.g., mental health, trauma, domestic violence (37 grantees)
- Multiple prior substance abuse treatment episodes (that pre-date the parent’s RPG program involvement and enrollment) and/or a long-standing substance dependence disorder (32 grantees)
- A prior history of child welfare system involvement that pre-dates the family’s RPG enrollment (31 grantees)
- A long history of unemployment, currently unemployed or under-employed and/or no history of employment (27 grantees)
- Children who already had been removed from the home and in foster care for quite some time (e.g., 12 months or more) prior to the family’s involvement in the RPG program (23 grantees)
- Prior and/or current involvement with the criminal justice system (22 grantees)

- Having experienced multiple risk factors over time (e.g., low literacy, poverty, lack of family or social connections, as well as the factors already mentioned above) that compound the difficulty of working with these families (32 grantees)

One grantee noted that among the mothers they served:

- 58% had a history of domestic violence with past or current partners
- 39% had been sexually abused as a child; 28% had been physically abused
- 55% had received mental health treatment in the past
- 44% reported a history of psychiatric illness
- 27% reported a co-occurring eating disorder
- 23% had attempted suicide
- 80% had been incarcerated
- 73% had at least one criminal conviction
- 58% were on probation or parole at time of RPG program intake

Grantees noted that due to these and other factors, families required significantly more time and effort to engage and subsequently retain in RPG services. Further, once enrolled, grantees found that families stayed in the program longer than anticipated due to the severity and complexity of their issues. Grantees said it was sometimes difficult to meet all of a family's needs and obtain desired outcomes in a timely manner. For some grantees, larger contextual factors, such as a lack of employment and housing in clients' communities, also contributed to extended program lengths of stay (see also Chapter III, Lesson 11).

As noted in Chapter V, the mean duration of services for all closed RPG cases was 8.2 months. However, 14 grantees had a mean duration of RPG services of one year or longer. While longer lengths of stay in the program positively impacted participants' ability to achieve and sustain recovery, several grantees stated it meant their programs were near, at, or beyond capacity for extended time periods. This reduced the number of available treatment slots for new admissions.

One grantee noted how, over the course of the grant, clients remained in their program for much longer than envisioned. The average length of stay was 14 months, with some clients staying as long as 2 years.

The grantee described one mother who entered the RPG program with clinical diagnoses that included methamphetamine dependence, major depression, and post-traumatic stress resulting from severe physical and sexual abuse as a child and domestic violence as an adult. She also had numerous physical health and dental problems. Further, she was the primary caregiver for her young son, who had medical issues.

The grantee recalled that this mother was frequently discouraged; she asked twice to be discharged, stating she could not cope with the program's demands and expectations. However, with the RPG project team's support and assistance to address her many needs (e.g., substance abuse treatment, safe permanent housing, parenting training, trauma-informed psychotherapy, dental reconstruction), she successfully completed all services and graduated from the family drug court in 14 months.

Changes in Child Welfare Caseloads

As discussed in Chapter III (Lesson 11), child welfare systems around the country have increased their focus on providing front-end services to help keep families together and prevent removal of children from the home. As a result, the number of children entering foster care has decreased and the number of alternative or differential response cases has increased. For several grantees, this shift and the implementation of alternative or differential response programs resulted in decreased referrals or otherwise affected client engagement.

Further, grantees noted that due to full implementation of alternative or differential response programs and their region's increased capacity to keep children safely at home without opening formal child welfare cases, only the more difficult cases remained on the child welfare caseloads. As discussed above, grantees observed that families presented with increasingly complex service needs that required more intensive services for longer duration.

One grantee that served all voluntary child welfare cases noted the families presented with much more complex needs than expected for a voluntary population. Many required residential treatment and, once engaged, remained in the program for 12 to 18 months. Because many clients had no or limited family and social supports, the RPG case managers spent an extensive amount of time helping participants establish new and healthy social support systems, develop the capacity to function independently, and be able to provide a safe and nurturing home for their children. The grantee notes it took RPG staff more than four years to really understand and respond to the complexity of the population's needs.

Staffing Challenges

As discussed in Chapter III (see Lessons 9 and 11), the vast majority (86.8 percent) of grantees reported challenges with turnover or retention in front-line or direct service staff at some point, while nearly two-thirds (62.3 percent) experienced turnover or retention difficulties with key management or administrative positions. Further, well over three-fourths (79.2 percent) of grantees also cited state, county, or other agency personnel changes or reorganizations (outside of the RPG) as an important contextual issue impacting their program's operations at some point during the grant.

Challenges regarding meeting projected targets was directly associated with these staffing reductions and changes, which were significant and ongoing for many grantees. For example, grantees cited decreased program referrals due to primary referral sources closing or reorganizing, or new partnering agency staff that lacked knowledge about the RPG services and supports.

Expanded Capacity—Looking Beyond the Numbers

As previously noted, assessing the total number of adults and children grantees served is just one facet of how grantees have increased their region's capacity to serve child welfare families affected by parental substance use. Additional markers of success include:

- *The comprehensiveness of available services.* As discussed in Chapter II, grantees implemented a comprehensive set of direct treatment and support services, many of which did not exist for children, adults, and families in their region prior to RPG Program

implementation. Over the course of the grant, the majority (75.5 percent) of grantees added new services or enhanced their existing RPG interventions to meet families' emerging needs and provide a comprehensive continuum of care. They also continually broadened their partnerships beyond their original core partners to secure other core treatment and supportive services. As noted in Chapter I, 39 grantees reported the addition of more than 430 new partners over the course of the grant.

- *The accessibility of services provided.* Not only did grantees implement a vast array of services for families, they fundamentally changed and strengthened how services were delivered by modifying protocols, procedures, or staffing (for example, see Chapter III, Lesson 4). Grantees stated that due to improved cross-systems collaboration, families now receive more timely access to a more integrated system of care. By the end of the grant, key partners and stakeholders said they had gained a much better understanding of what it really means to collaborate and the positive impact it has on child welfare families (Lesson 1).
- *The development of a well-trained and well-qualified workforce.* The regional partnerships placed a high priority on cross-systems training to enhance the skill set of the diverse set of providers and professionals that work with these families. Over the course of the grant, the 53 grantees provided or participated in more than 6,100 training events involving more than 86,400 project staff and community partners (see Chapter II). Such trainings served to build the service capacity of the grantees' regions, particularly rural areas where there tend to be significant shortages of qualified staff. Grantees then helped sustain staff expertise and knowledge by institutionalizing ongoing training into regular program and partnership operations.
- *The impact on the partners and larger service systems.* Overall, grantees succeeded in bringing their collaborative voice, accrued expertise, and collective experiences to the larger community to inform other initiatives. For several grantees, the practice approach initiated through the RPG Program resulted in added opportunities to expand the population served beyond the scope of the grant. In short, the partnerships created a collaborative model that others are interested in developing. They established a foundation, grounded in cross-systems collaboration, on which to build current and future community projects to serve families (see Chapter III, Lesson 2).

One grantee implemented six family drug courts as part of their RPG program. By the end of the grant, this grantee had used their lessons learned to implement four more family drug courts without any additional grant funding. They also developed family drug court standards, requirements, and best practices to share statewide.

CHAPTER XI: GRANTEE PERFORMANCE MONITORING AND EVALUATION IMPLEMENTATION PROGRESS

INTRODUCTION AND OVERVIEW

As Chapter II highlighted, the 53 grantees provided a comprehensive array of services for children, parents, and families (e.g., substance abuse treatment and mental health services, children's services, family-strengthening services, and other clinical and community supportive services). They also implemented various activities to strengthen cross-systems collaborative practice.

As Chapters VI through X showed, the grantees reported data on a broad set of agreed-upon performance measures to assess the collective RPG Program's progress in improving safety, permanency, recovery, well-being, and systems collaboration. In addition to the RPG Program performance measures, most grantees conducted their own local program evaluations to address site-specific implementation and effectiveness.

The capacity and capability of grantees to combine a program of comprehensive, integrated service delivery with a rigorous performance monitoring and local project evaluation approach varied across sites. Some partnerships had the benefit of extensive past research experience coupled with strong in-house or university-based evaluation teams. Other grantees, particularly the smaller community-based lead agencies, were less prepared for the level of staff and experience needed for such large scale reporting. Regardless, most all grantees agreed the RPG Program performance monitoring was the most extensive of any service grant they had previously encountered.

During the first two years of the RPG Program, grantees engaged in the initial stages of cross-systems data sharing, performance monitoring, and evaluation. They identified appropriate performance measures, developed the data collection and reporting systems to track those measures, trained staff on data collection procedures, and addressed early performance monitoring and local evaluation related problems (e.g., clarified data coding, reduced the amount of missing data).

As the grant progressed, the partnerships focused on addressing the more demanding aspects of measuring performance across child welfare, substance abuse treatment, and other applicable service systems. As one grantee stated, "We all have data systems that don't talk to each other," which complicates reporting and challenges evaluation. Over the course of the RPG Program, HHS provided evaluation technical assistance and support to grantees to address major data collection and reporting issues. HHS also provided training on key evaluation topics (e.g., designing a process evaluation component, the use of propensity scoring, how to conduct a cost-benefit analysis) to help strengthen grantees' individual program evaluation efforts.

With Progress, Comes Challenges

Though the learning curve was steep, the partnerships made substantial progress over the course of the grant. Among the 10 elements of collaborative practice, the area of information sharing

and data systems showed the second greatest amount of change from program year one to year five (see Chapter X, collaborative capacity performance measure results). Grantees strengthened their ability to collect, report, and use their data for program improvement. Project staff and partners became more knowledgeable about their own and each other's data system capacities.

However, this collaborative practice area also was the one in which the most grantees experienced significant challenges. During the course of this initial five-year grant period, nearly all grantees (94.3 percent) encountered new or ongoing issues related to data collection and reporting for their RPG participant and/or comparison groups. The extent and severity of the problems varied. Some challenges centered on the grantees' own internal program operations. Others related to broader systems and contextual factors that affected the partnerships' ability to monitor client outcomes and program effectiveness. Grantees were able to address many of these issues. However, despite ongoing technical support, some data collection challenges were never fully resolved, given the number of data sources used and the different data tracking mechanisms across providers and systems.

With Challenges, Comes Lessons

Eight key evaluation implementation lessons emerged from grantees' successes and challenges (see Table 41). These lessons reflect the partnerships' collective experiences with the RPG Program performance monitoring and their own local program evaluations.¹⁹⁴ They emphasize the inherent complexity of examining case-level child, adult, and family outcomes across multiple service systems. All of these lessons, discussed in more detail below, parallel the collaborative program implementation lessons discussed in Chapter III.

¹⁹⁴ These lessons are based on in-depth review of all grantees' Semi-Annual Progress Reports, any interim local evaluation reports that grantees may have provided during the course of the grant, and selected Final Progress Reports received prior to the writing of this report. Grantees were not required to provide local evaluation results until the end of their grant period. In their Final Progress Reports, grantees are to report on all their performance measures and include local process evaluation and qualitative data, as applicable.

**Table 41: Key Performance Monitoring and Program Evaluation Implementation Lessons—
Insights from the 53 Regional Partnership Grantees**

1. Collaboration, broad-based partner support, and shared values are prerequisites for establishing cross-systems information sharing.
2. Considerable staff and financial resources are needed to implement cross-systems information sharing and performance monitoring.
3. Program and evaluation staff must establish a close partnership and effective communication.
4. Process and outcomes evaluation data need to be communicated to partners and key stakeholders on a regular basis.
5. Data collection roles and responsibilities need to be clearly defined and agreed upon for both individual staff and partner agencies.
6. Ongoing training and monitoring are needed to ensure data quality and consistency.
7. A mixed-methods research design is needed to capture the regional partnerships' full impact on the families and communities served.
8. Program evaluation and performance monitoring in a real-world setting are inherently difficult.

Evaluation Lesson 1: Collaboration, Broad-based Support, and Shared Values are Prerequisites for Establishing Cross-Systems Information Sharing

Only through cooperative working relationships can the regional partnerships effectively track families' involvement across systems and monitor the partnership's progress in achieving its shared outcomes. Grantees stressed the importance of working jointly with partnering agencies at the outset (and reassessing as needed) to develop an evaluation plan that outlines what each agency can do to meet the proposed goals and objectives.

Grantees noted that during initial implementation, key partners supported the project and agreed, in general terms, to provide the necessary data and information. However, their follow through on those expressed commitments did not always materialize. Typically, this was due to two primary reasons: limited understanding of the purpose and complexity of the performance monitoring and program evaluation, and significant budget and staff cuts that reduced partners' data collection and reporting capacity (see next lesson).

Extensive and well-established collaborative relationships and networking are needed for a program of this scale to measure and achieve shared outcomes and systems reforms. Grantees stressed that extensive support for performance monitoring and evaluation at all levels—community partners, program staff, and agency leadership—is imperative. Regional partners must view data collection as more than just “a requirement of the grant.” They need to see it as part of standard best practice to support continuous quality improvement and program monitoring.

An ongoing challenge for grantees was fully engaging clinical and other front-line staff to participate in accurate data collection and reporting. The partnerships stated the need to establish, in advance, a shared understanding of the purpose and importance of the data at the

management and direct practice level. They noted that identifying shared goals and values during early program implementation facilitated partner engagement in sharing data. In short, collaborative partnerships create an essential infrastructure to support and maintain cross-systems data and information sharing.

Evaluation Lesson 2: Considerable Staff and Financial Resources are Needed to Implement Cross-Systems Information Sharing and Performance Monitoring

As Chapter III highlighted, collaboration to establish cross-systems service integration is developmental and iterative in nature, and takes substantial time to achieve. Similarly, cross-systems information and data sharing involving multiple agencies also progresses through specific stages over time.¹⁹⁵ Moreover, grantees conceded it took more time and resources (both human and financial) than anticipated. Grantees emphasized the need for both adequate staff time and funding to develop and sustain a data collection and reporting infrastructure that can support a comprehensive, high quality program evaluation and ongoing performance monitoring.

“It takes time, effort, and resources to ensure communication flow, data sharing, and the institutionalization of policies and procedures.”

Regional Partnership Grantee

Grantees underscored that they underestimated the amount of time, effort, and complexity involved in the beginning stages. They cited lengthy processes to establish data-sharing agreements, obtain Institutional Review Board (IRB) approval on their research designs, reach agreement on final data collection tools, and begin to obtain cross-systems data (despite having a formalized data-sharing agreement). By the end of year three, most grantees noted that routine data collection and reporting processes were relatively well established. However, they still faced various evaluation-related challenges for the remainder of the grant.

At both the state agency and local site level, grantees stressed that data collection and reporting cannot be an “add on” to someone’s current responsibilities. Sufficient resources are needed to support such endeavors, particularly in an adverse fiscal environment. This includes funding for state- or county-level data personnel who extract data for the partnerships. As one grantee commented, project team members may support the RPG project, but their primary responsibilities likely lie in other areas, funded by their own agencies.

Several grantees also noted their original grant budgets were inadequate to support the scale and scope of data collection required by the RPG Program. Grantees cited challenges in balancing the RPG Program reporting requirements with the need to focus on their local program evaluation.

¹⁹⁵ Walker, K.E., Farley, C. & Polin, M. (2012). *Using Data in Multi-Agency Collaborations: Guiding Performance to Ensure Accountability and Improve Programs*. Philadelphia, PA: Public/Private Ventures and Washington, DC: Child Trends.

In addition to adequate financial resources, successful cross-systems performance monitoring and evaluation hinges on having an evaluation team sufficient in both number and experience. Over the course of their grant, nearly three-fourths (73.6 percent) of grantees experienced challenges with various evaluation staffing issues that affected their overall program evaluation capacity. These included:

- Turnover or retention of key evaluation positions
- Lack of staff with adequate evaluation experience
- Insufficient time or resources to carry out evaluation tasks
- Turnover or cuts in state or county data personnel who extracted and provided case-level data to the grantees

Importance of State Agency Role and Active Involvement

As discussed in prior reports to Congress, the majority of the RPG performance measures aligned with existing standardized performance measures in federal child welfare and substance abuse treatment outcome reporting systems (e.g., AFCARS, TEDS). The required data elements thus exist in a state or county's automated child welfare and substance abuse treatment data systems. HHS adopted this approach expecting that grantees' ability to draw on these existing information systems would reduce primary data collection burden.

Yet a substantial number of partnerships experienced ongoing difficulties in obtaining timely or complete data from the requisite state or county agency. For example, 58.5 percent of grantees experienced difficulties obtaining or accessing needed child welfare data, while 45.3 percent encountered challenges with obtaining needed substance abuse treatment data.

Several grantees cited not having direct access to needed child welfare or substance abuse treatment data and instead relying on state or county agency staff to take on this extra responsibility as a distinct disadvantage. Despite initial data-sharing agreements, severe staffing shortages, management information system issues, and changes to state/county child welfare or substance abuse treatment data systems often prevented grantees from getting needed data (in a timely fashion or at all). RPG data retrieval was often a low priority task for state agencies, particularly those whose staff had no direct involvement in the local RPG project.

Further, grantees stated the data they did receive was frequently lacking in quality and completeness. The partnerships often had to conduct extensive reviews of the data and repeated follow-ups with agency staff to obtain missing data elements.

One grantee said a major problem encountered was not having identified early on a state-level data person to access needed data. “By not pre-establishing the time and financial resources required to do ongoing data pulls, we were understandably met with resistance and a lack of options for getting us data, due to their staffing limitations.” The grantee added that when a new evaluator came on board toward the end of the grant, she was able to reach out to her contacts and establish a relationship with the state-level data staff.

Budget cuts throughout the grant period exacerbated the problem. State or regional child welfare offices that provided data for the RPG projects closed and staff with expertise and familiarity about the RPG project were laid off, transferred, or shifted to other tasks. These unanticipated changes and problems in the larger child welfare system (and to a lesser extent, the substance abuse treatment system) were outside the RPG programs’ control, but still had significant impacts.

Importance of Qualified Program and Evaluation Staff

Beyond these larger external system capacity issues, the partnerships also experienced related challenges at their own site level. Given the nature of the RPG programs, grantees often relied on front-line staff (e.g., clinicians, caseworkers, peer recovery support specialists) to collect certain client data. Yet in many sites, program staff did not have the time or capability to collect extensive participant data.

Practitioners were focused on their immediate clinical and direct service work. They saw ongoing data collection and entry as taking valuable time away from assisting families. As one grantee recommended, each partner agency needs to ensure clinicians have “protected time” to complete required data reporting correctly and consistently.

Sufficient time was not the only barrier. Grantees stressed that front-line, direct care staff often lacked adequate evaluation experience and training. They did not have a full understanding of the role and importance of timely and accurate data documentation. As one grantee stated, the people best suited to provide the RPG treatment and supportive services may not have the skills or experience needed to carry out the required RPG program data collection and reporting.

Lack of experienced also extended to evaluation staff. Several grantees came to learn (sometimes too late) that their local evaluators did not have the depth of experience needed to monitor and evaluate this type of program. Further, many sites experienced substantial evaluation staff turnover and had difficulty finding and retaining qualified and experienced evaluation staff. One grantee summed up an important lesson expressed by others: “The importance of working with evaluators who understand both child welfare data and substance abuse data, as well as the context of the project, cannot be underestimated.”

Evaluation Lesson 3: Program and Evaluation Staff Must Establish a Close Partnership and Effective Communication

Program and evaluation staff must have a close, mutually respectful working relationship and open, two-way communication. Effective and regular communication with program staff as well as key partners and the larger community needs to include routine sharing of positive and negative data, discussion of identified data issues, refinement of data collection/reporting policies and procedures, and accurate interpretation of results.

Grantees stated both evaluation and program staff need to “speak the same language” to ensure evaluation activities reflect a thorough understanding of the project’s day-to-day practices, and evaluation results are translated into continued program improvements. To do this, grantees need to integrate the evaluators into the larger RPG project team. At the same time, the evaluators need to view program staff as members of the evaluation team.

For example, in one site, the evaluation staff frequently visited court hearings and joint staffings to observe the program. They conducted client and staff focus groups and provided useful feedback to staff. In another program, the research associate had close, regular contact with the in-home specialists and attended weekly clinical supervision meetings to discuss the challenges and progress of each case. Interdependent relationships such as these led to more open communication, increased support of evaluation processes, and agreement on shared measurable goals.

Grantees also stressed the importance of having evaluators who are proactive, timely, responsive, and actively engaged in the larger project and partnership. Someone, as one grantee said, who is “invested in telling the story of the RPG program.” Evaluators need to be effective at working with direct service providers to provide data collection and reporting support and help program staff make informed decisions based on the data.

One grantee reported the evaluators were involved as key members of the project team from the time of grant application submission throughout program implementation. As members of the project team, the evaluators were able to influence the program implementation to better meet the needs of the community, while also remaining objective in the interpretation of any data reviewed.

The Importance of Location

During the course of the grant, more than one-third (34.0 percent) grantees reported challenges with a lack of effective communication or coordination between program and evaluation staff. Several partnerships noted having the evaluation team onsite (rather than remote) was an effective way to address such barriers and strengthen overall data collection and analysis. Onsite evaluators provided close oversight during initial evaluation and program implementation and continuity as grantees modified their programs to serve families more effectively. Grantees emphasized onsite evaluation staff are more likely to have a thorough understanding of all program components and the needs of staff, partners, and the families served. In addition,

having program and evaluation staff in close proximity to each other helps facilitate regular discussion of performance monitoring and evaluation results; see next lesson.

As one grantee explained, “We wanted a local evaluator to help us ask the tough questions: Are the treatment activities being implemented as we initially intended? Are our methods achieving the results we want? Are we using our resources effectively and efficiently?” The grantee noted the placement of an onsite evaluator within the substance abuse treatment facility ensured systematic data collection and analysis, and objective recommendations regarding program effectiveness. The onsite evaluator helped create a healthy culture and attitude towards data collection and evaluation among program staff.

Evaluation Lesson 4: Process and Outcomes Evaluation Data Need to be Communicated to Partners and Key Stakeholders on a Regular Basis

Sharing data that demonstrate the RPG program benefits to families and other service systems can bolster new and continued collaboration and, as one grantee remarked, positively impact the “culture” of collaboration between partners. Beginning in program year three, most grantees reached a point where the data was useful for a variety of stakeholders and sufficient to help manage program performance.

During the course of the grant, 62.8 percent of grantees indicated they had shared data or related information with their key partners (e.g., through regular evaluation meetings with project staff, site-specific local data reports). In addition, 58.1 percent of grantee also said they had shared program data and information with leaders, policymakers, or other decision-makers outside of the regional partnership.

Beyond sharing data with partners and other interested stakeholders, grantees specifically used their data to:

- Inform or strengthen program development as it relates to services and activities provided to clients (79.1 percent)
- Inform their sustainability planning (65.1 percent)
- Inform the development of new policies and procedures or modification of existing ones for how the RPG program or larger service systems operate (48.8 percent)

Through reports and presentations, one grantee shared data with:

- The schools, courts, and other community partners to emphasize need for early identification and referrals for children with prenatal and environmental substance and trauma exposure
- The community-based health center staff and physicians to address no-show issues, increase coordination and planning, and develop single case files
- State policy makers to inform development of the state’s home visitation model

Review and Discuss the Data Regularly

Over the course of the grant, the partnerships expended a vast amount of time, effort, and resources to improve the completeness and quality of their data. However, in several cases, grantees focused almost exclusively on strengthening their data *collection* efforts and may not have concentrated sufficiently on the important next step of *analyzing* their data to use for ongoing program management and continuous quality improvement. As one RPG evaluator commented, “Reflecting back, even with limited data, the group should have been reviewing the information available on a much more frequent basis. . . . It was a mistake to focus solely on increasing data collection and entry and not to use what was available in the first four years to explore the programs potential and its unanticipated needs.”

Other grantees echoed this sentiment, acknowledging they waited until too late in the grant period to use the data to guide decision making about program components and sustainability strategies. One site noted it was only when they had a change in evaluation staff in the last year did they start to consider how the data could be used. While they did hold regular meetings throughout the grant period to share case-specific information for treatment planning purposes, they neglected to share outcomes data until the last year. The grantee deemed this “a missed opportunity.”

Given the lengthy duration of many grantee program models, it may in fact require two or more years to document longer-term outcomes and assess the project’s broader success. Still, projects such as the RPGs need to identify and use interim process and outcomes findings for ongoing program development.

Evaluation Lesson 5: Data Collection Roles and Responsibilities Need to be Clearly Defined and Agreed Upon for Both Individual Staff and Partner Agencies

The regional partnerships collected and linked data from multiple providers and systems. When dealing with such complex cross-systems data efforts, grantees stressed the importance of all partners being clear on their individual and larger agency data collection responsibilities. Lack of shared accountability and consistent, systematic guidelines impacted data quality and ultimately, grantees’ ability to use data for program improvements and sustainability. Further, evaluators need to convey to all project staff (e.g., administrators, supervisors, clinicians) the value and usefulness of the data.

Grantees stressed that agreed-upon roles, responsibilities, and processes should be in formal data-sharing agreements. Several partnerships learned informal or good faith agreements that endorsed data sharing were not adequate. Formal data-sharing arrangements, particularly with state or county agencies needed to extract case-level data, should be established during early program implementation to facilitate data collection. Such agreements need to detail expectations, matching procedures, deliverables, and funding. In addition to formalized data-sharing agreements, shared values that prioritize information sharing and project evaluation can be built into service provider contracts to enhance accountability and follow through.

One site is building on its RPG work to develop memorandums of understanding (MOU) to continue data sharing between the courts and child welfare. The MOUs will include tests of data matching between systems with the overall goal of increased capacity to do regular matches and uploads of court data into the state's automated child welfare system. This effort goes beyond the scope of the RPG to a broader systems level.

Given the changing nature of the RPG programs and the communities in which they operate, partnerships are encouraged to review data-sharing protocols and agreements periodically (e.g., annually) to ensure all data can continue to be collected and reported. This provides an opportunity for partners to adjust evaluation objectives, as needed.

Evaluation Lesson 6: Ongoing Training and Monitoring are Needed to Ensure Data Quality and Consistency

Clearly defined data collection roles and responsibilities is an essential step, but it is not the only one for program implementers. Ongoing oversight, which includes quality assurance checks and regular data monitoring, is needed to ensure data quality and consistency. During the course of the grant, nearly three-fourths of grantees (73.6 percent) encountered challenges with and worked to improve the overall quality, consistency, and timeliness of their data.

Throughout the five years, HHS worked closely with grantees to address identified data entry and coding issues and clarify interpretation of the data elements and calculation of the RPG performance measures. Some issues were outside grantees' control (e.g., quality of existing state level data). However, others were at the site level, which the partnerships could actively address. These challenges reinforced the need for project management to understand the evaluation design, conduct regular data checks and balances, and communicate regularly with program and evaluation staff responsible for data collecting and reporting. In doing so, grantees could promptly and efficiently identify and address data problems.

Data quality and consistency issues often were closely intertwined with turnover of RPG evaluation staff and state agency staff. The need for close and constant supervision of data collection processes intensified with frequent and continued program and evaluation staff changes (see also Lesson 3).

Several programs minimized the adverse impact of such staffing challenges on program evaluation by providing continued staff training. As one grantee noted, training regarding evaluation and the importance of data was crucial for newly hired staff. Yet it also served as a reminder to all partners that data provided a platform on which to show improvement, identify where to change procedures, and determine how best to serve families.

In addition to ongoing training, grantees implemented other monitoring strategies to strengthen the consistency and quality of the data collection and reporting. These strategies included:

- Regular meetings with partners and program staff to discuss evaluation implementation and identified data collection issues

- Regular (e.g., monthly, semi-annual) distribution of evaluation and data reports to clinicians and direct service staff
- Monthly reviews of client data between program and onsite data entry staff
- Co-location of a RPG clinician or staff person at partner agencies to manage all data entry
- Implementation of data “ticklers” and feedback loops in the data system
- Development of data monitoring and tracking tools to ensure completeness and accuracy of client data collection

Evaluation Lesson 7: A Mixed-Methods Research Design is Needed to Capture the Partnerships’ Full Impact on the Families and Communities Served

Grantees acknowledged the quantitative RPG Program performance measures were important to gauge their progress. Yet they emphasized process and qualitative evaluation information that described families’ and partners’ experiences were equally essential to capture the full breadth, depth, and scope of grantees’ programs and cross-systems collaborative progress.

Qualitative information provided further evidence of how grantees had increased capacity to serve families and served to reinforce the RPG mission and experience. Such information provided important, additional context for interpreting the numbers. As one grantee explained, “Often in child welfare, outcomes are not black and white, successful or unsuccessful, but various places in between.”

As one grantee explained, gathering qualitative data helped convey the unique, powerful aspects of the RPG program that are difficult to capture through quantitative data. The qualitative information enabled the partnership to better portray families’ challenges and complexities and the role the RPG project played in helping them reunify with or retain custody of their children. The grantee concluded it is necessary to share both the quantitative and qualitative data to paint a full picture of the program’s importance in the lives of children and families and further promote sustainability.

Grantees reported using various process evaluation methods, typically in combination, to gain the most comprehensive account of their efforts. In general, the most frequently used approaches involved focus groups, interviews, and/or surveys to obtain participant, program staff, and key partner feedback. Grantees stated evaluation feedback from client focus groups, in particular, resulted in some of the most meaningful and impactful program changes. Focus groups illuminated aspects of the program that otherwise would not have been captured. Hearing direct participant feedback provided validity and context for the quantitative findings. Other process evaluation methods grantees mentioned included participant observation, case reviews and/or case studies, and fidelity assessments.

Evaluation Lesson 8: Program Evaluation and Performance Monitoring in a Real-World Setting are Inherently Difficult

As Chapter IV discussed, grantees had flexibility and discretion in developing their local program evaluation designs. Their research designs thus varied, from fundamental descriptive studies focused on program implementation to more advanced randomized control trials of family and child outcomes. In general, the partnerships often struggled with how to balance the tension between implementing a rigorous program evaluation design and delivering direct services to families.

During the course of the grant, 41.5 percent of grantees encountered evaluation research design or methodology challenges. Several grantees found their original evaluation plan hampered their overall grant implementation and the community's perception of the program. These grantees discussed how their project's evaluation design created discord between the evaluation team and service providers and stakeholders.

This friction and lack of evaluation buy-in at all levels (management and workers) affected program referrals. Some grantees found aspects of their evaluation plan were too ambitious and burdensome on participants. For example, in some case, sites modified lengthy evaluation-driven screening and assessment process to overcome barriers to client engagement. This reinforces the importance of involving the evaluator early in the grant application process to ensure alignment of the service delivery approach and evaluation design.

Grantees' experiences reinforce the inherent difficulty of conducting research in an applied or real-world setting where families' complex and multiple needs require flexibility in service delivery. As one grantee explained, the RPG program was not a "one-size fits all" intervention. Further, grantees continued to modify and enhance their programs throughout the course of the grant (see Chapters II and III). While beneficial to families, program model changes can impact local evaluation plans.

One grantee, whose target population was women involved in the child welfare and criminal justice systems, did a retrospective study on their program's use of the Trauma Symptom Inventory (TSI). The evaluators concluded standardized trauma assessment measures needs to be reviewed for their appropriate use with the intended population. They identified several important considerations for selecting limitations with the TSI (for the women they served):

- Instruments need to measure the full range of experiences and persistent trauma that an individual may encounter. For example, the TSI tends to measure more sexual trauma, but does not assess stress related to living in a dangerous, violent neighborhood. Further, many assessments focus on trauma as a single event. This grantee found that the TSI's fixed-choice responses did not speak to their clients' experiences.
- Standardized instruments must be appropriate for a client's literacy level. This grantee found their clients had difficulty responding to certain types of questions that required higher levels of thinking.
- Programs need to consider the conditions under which the assessment takes place and clients' perceptions of services. This grantee found that mandated or court-ordered services negatively affected clients' willingness to disclose their traumatic experiences.

The Challenge of Comparison Groups

Grantees' predominant evaluation design challenges centered on comparison group issues such as selecting an appropriate and feasible comparison group, recruiting an adequate number of comparison group participants, difficulties achieving random assignment to groups, and unintended variations in service intensity. Grantees identified various reasons why they had difficulty obtaining comparison group data. These included, but were not limited to:

- Capacity and resource issues, including agency budget cuts and staff turnover (primarily within child welfare). For example, new staff had to learn the comparison group recruitment and matching process. Further, they often did not have time to pull case-level comparison group data given staff shortages, increased workloads, and competing priorities.
- Lack of buy-in from program staff and partners who either obtained referrals for the comparison groups or provided comparison data. As previously noted, this lack of buy-in may have resulted from little or no direct involvement in the project. However, staff may also have been reluctant to refer their clients to a comparison condition in which families would not receive the full intervention.
- Difficulty with matching despite a systematic sampling approach. Grantees cited difficulties in securing an appropriate comparison group matched on key demographics relevant to their target participant population. Grantees noted it was particularly challenging to identify cases documenting substance abuse as a contributing factor to child welfare involvement. The problem, according to grantees, is part access and confidentiality, but more often the quality of existing data in state systems.
- Concerns about how the comparison group data would be used, particularly for grantees who sought to use a similar community-based program as a comparison site. For example, one grantee was unable to get comparison data from another substance abuse treatment provider because the provider was concerned their data would be used to make unfavorable comparisons. Despite many discussions and assurances, the grantee was not able to overcome this mistrust to share information.

One grantee used a dosage specific design to assess the benefits of services for children and families, based on their level of program involvement. The design involved comparisons between groups that had different levels of treatment or intervention. The grantee typically defined client involvement as the amount of contact families had with the program. Project staff developed quantitative indicators associated with different levels of involvement. They documented contacts in clients' records, which they then used to classify each client at case closing.

The Difficulty of Obtaining Follow-up Data

To assess clients' progress over time, grantees measured change in certain areas from program admission to discharge. Yet, collecting follow-up client data at either discharge or post-discharge has been and will continue to be a long-standing challenge for researchers. The regional partnerships are no exception: 37.7 percent of grantees reported challenges in obtaining follow-up data on their clients. Grantees cited several reasons, including:

- Difficulty locating and then establishing contact with families. Even when staff knew where clients resided, it required substantial time and repeated attempts before they successfully reached them.
- Complex scheduling or timing issues. Follow-up interviews were sometimes delayed due to difficulty coordinating schedules among clients and staff. Further, the assessment process may be time consuming to administer.
- Attrition of program participants that often occurs when working with specific at-risk or vulnerable populations in a natural community or treatment setting.
- Client reluctance or unwillingness to participate. For example, one site reported that although program participants initially consented to a pre and post interview, 45 percent of those individuals later withdrew their consent when it was time for the follow-up interview. Families may have various reasons for not wanting to participate including: negative repercussions from child welfare or the courts, no longer feeling connected to the program, or distrust and wariness of external research staff.

Grantees' experiences suggest programs with a strong continuing care component were more apt to have success with follow-up. These programs had maintained a relationship with and access to clients after they left the RPG program and returned to the community. For example, one grantee that strives to provide aftercare services and track families for at least two years following program discharge, reported obtaining follow-up evaluation information on 70 percent of clients that had completed the program.

Related to the overall challenge of obtaining follow-up data was difficulty collecting data and administering standardized instruments to measure child, adult, and family well-being adequately: 43.4 percent of grantees reported this was a challenge at some point during the grant. See Chapter IX for further discussion on grantees' challenges with measuring well-being over time and lessons learned for strengthening future measurement in this critical area.

The Promise—and Challenge—of Conducting a Cost Study

Grantees increasingly recognized the importance of conducting a cost study (i.e., cost determination, cost-effectiveness analysis, or cost-offset analysis) as part of their overall program evaluation and sustainability efforts. Yet many partnerships found they lacked the knowledge, capacity, collaborative relationships (particularly among budget staff), and financial and human resources to develop and complete such an analysis. As discussed above in Evaluation Lesson 2, most grantees underestimated the amount of resources needed to support a full-scale program evaluation, and particularly one that included a cost study. A few grantees brought in outside consultants to assist with this aspect of their evaluation.

Producing a detailed cost study is a significant challenge due to the complexity of documenting all costs and benefits across multiple systems. The local RPG programs included service providers from many different agencies and community-based organizations, an array of integrated and specialized services, and support from several different funding streams (in addition to the RPG funding) as well as in-kind expenses and matching dollars.

Grantees also noted difficulties in obtaining partner buy-in and support for a cost analysis. This largely may have been a function of the fiscal environment during the grant period. Despite the agreed-upon importance of cost studies to facilitate sustainability, implementation of other program and evaluation tasks often took precedence in a constrained fiscal environment.

By the end of their grant, nearly one-third (32.1 percent) of grantees had either completed, were currently conducting, or were in the planning stages of a cost analysis. Grantees were in different stages of their cost studies at the writing of this report. Yet several grantees reported promising results, primarily related to cost benefits of reduced lengths of stay in foster care and increased and more timely reunification rates:

- One grantee determined their FDC program generated a savings of \$38,850 per child due to expedited reunification. The annual cost savings to the county was approximately \$1.01 million based on shorter stays in foster care.
- Another grantee reported cost avoidance of \$3.51 million to \$6.75 million in out-of-home care costs as result of their program. For every \$1.00 spent on the program, the state avoids up to \$2.52 on the cost of out-of-home care.
- One grantee completed a cost-effectiveness study of the SFP. They found the typical SFP child spent 190 fewer days in out-of-home care compared to a propensity score matched comparison group of children in out-of-home care. At an average out-of-home care state rate of \$86 per child per day, the SFP program saved approximately \$16,340 in out-of-home care costs per child. Every \$1.00 invested in the SFP program yielded an average savings of \$9.83.
- One statewide grantee found its FDC participants performed better than their comparison group in several outcome areas: higher reunification rates, fewer children removed from their parent's custody, and shorter foster care lengths of stay. The grantee estimated the RPG program saved the state more than \$2 million dollars in child welfare and substance abuse treatment cost avoidance over the course of the grant period. The grantee concluded: "There appears to be a relationship between greater resources spent on parent/caregiver substance abuse treatment and both current and future child welfare cost avoidance. . . . This [cost analysis] likely understates the cost avoidance because it focuses solely on substance abuse treatment and child welfare cost data."
- Another FDC site estimated more than \$154,000 in annual cost avoidance related to filing of fewer dependency petitions. In program year four, the grantee found 16.9 percent of children in the RPG program had petitions filed compared to 33.6 percent of comparison group children. (The site estimated a per petition cost of \$2,614.) The site is continuing to work with child welfare to obtain data to calculate out-of-home care costs.
- Still another FDC site reported children in their RPG program spent significantly fewer days in foster care and were more likely to reunify than their comparison children. The expedited reunification for participant children generated a cost savings of approximately \$251,600 due to shorter lengths of stay in foster care. The expedited adoption rate generated a savings of approximately \$438,700.

- One site calculated a total of 19,318 days in foster care were “saved” by allowing parents to reunite with their children more quickly in their supervised housing program. The grantee reported a cost savings of approximately \$313,300 to the foster care system (at their daily rate of \$16.22).

Grantees agreed cost analyses are a critical component of sustainability planning. However, conducting cost studies that require sharing cost information across multiple systems will likely remain a challenge for partnerships. To help mitigate challenges, grantees stressed the need to design a cost analysis at the project’s outset and dedicate sufficient financial and human resources to carry it out successfully. Further, grantees’ experiences suggest having an appropriate comparison group is an important first step in a strong cost study. Once grantees had established more positive outcomes for their participant groups, they could then demonstrate the cost offsets and cost savings.

SUMMARY

As previously stated (see Chapter IV), the RPG Data System is the most extensive quantitative dataset currently available to assess the progress of families affected by substance use disorders and child maltreatment. It likely represents the largest cross-systems performance measurement effort for programs serving this vulnerable population. With such a large-scale and ambitious initiative involving 53 diverse partnerships, it is not surprising there were substantial challenges along the way.

Even with the many challenges, grantees continued to refine and modify their local data systems and processes to enhance client-level data collection and improve overall data quality and program monitoring. Not only did individual grantees make progress, their collective experiences in monitoring and assessing progress across agencies provide important lessons that are instructive for future initiatives, including the second round of regional partnership grants.

Similar to program sustainability, evaluation sustainability requires that all partners view performance monitoring and program evaluation as directly relevant and important to their own agency’s mission. For some partnerships, this did in fact happen. The RPG Program served as a catalyst to improving the extent and quality of their cross-systems data collection and sharing. It helped build a foundation to institutionalize information sharing processes to measure family outcomes across substance abuse and child welfare systems.

In one site, the leadership of the key partner agencies has made coordination and integration of data management for future projects a priority. All three of the grantee’s RPG sites are in the process of moving to an electronic medical records data system. The advisory board is working together with managed care and the courts to develop a system to identify, track, and proactively manage the behavioral health care and other needs of the population served.

CHAPTER XII: HHS TECHNICAL ASSISTANCE, TRAINING, AND SUPPORT ACTIVITIES FOR GRANTEES

INTRODUCTION AND OVERVIEW

HHS established an extensive technical support infrastructure to support the 53 grantees' long-term efforts to address the needs of children and families affected by methamphetamine and other substance abuse. This infrastructure included securing a support contractor to develop and maintain the RPG Data Collection and Reporting System, provide programmatic and evaluation-related technical assistance to grantees, and produce various reports on grantees' activities and performance.¹⁹⁶

HHS also assigned each grantee a support team that included a federal project officer, a grants management specialist, and a performance management liaison. The team worked together to ensure grantees' programmatic and evaluation technical assistance needs were effectively met. In addition, the NCSACW, which ACF and SAMHSA jointly fund, provided ongoing technical assistance on collaborative practice and program development and implementation.

Throughout the five years, the regional partnerships emphasized just how valuable the technical training and support HHS provided was to their success. As one grantee stated, "This grant has been unlike any other in terms of partnership with federal agencies and technical assistance providers." Another grantee concluded, "The provision of a technical assistance team to guide the process should serve as a model for future funding."

"With ongoing support and guidance from the Children's Bureau and [the support contractor], we were able to develop an integrated, family focused, comprehensive approach to providing substance abuse treatment for families. A successful three-county partnership was formed and working with community partners has become a true collaboration."

Regional Partnership Grantee

This chapter provides a brief overview of the key support activities provided during the five-year grant period. To assist grantees, HHS:

- Convened nine grantee meetings to disseminate and promote the use of evidence-based clinical or best practices to facilitate RPG program improvements, strengthen cross-systems collaboration to enhance services to families and improve outcomes, and provide opportunities for grantees to network with one another

¹⁹⁶ In September 2007, HHS awarded a Regional Partnership Grantee Support Contract (RPG SC) to the Center for Children and Family Futures (CCFF). CCFF teamed with two subcontractors, Planning and Learning Technologies and ICF International (formerly Macro International), to carry out the designated Support Contract tasks. Refer to the First Report to Congress for additional information.

- Conducted 95 site visits with grantees to gain a thorough understanding of each regional partnership and help sites address ongoing or new project challenges, particularly in the areas of partnership collaboration, cross-systems data sharing and evaluation, and sustainability
- Responded to 675 grantee technical assistance and training requests and provided approximately one dozen webinars on various programmatic and evaluation topics¹⁹⁷
- Developed several practical guides and planning tools to assist grantees with sustainability tasks and cost analyses

GRANTEE ANNUAL AND SPECIAL TOPICS MEETINGS

HHS held nine grantee meetings over the five-year grant period. On average, more than 200 RPG management, program, and evaluation staff attended each meeting. HHS convened two types of meetings: annual and special topics.

The annual grantee meetings focused on pertinent RPG-specific program and evaluation issues (e.g., cross-systems collaboration, sustainability, RPG performance measures), and allowed the partnerships to share their successes, challenges, and key lessons learned. For example, at the final grantee closeout meeting in year five, approximately three-fourths of grantees participated in a poster session to highlight their program models and positive outcomes achieved. In addition, 23 different grantees presented in plenary or workshops sessions on program and evaluation topics.

Special topics meetings addressed pressing and emerging clinical treatment and practice issues in the field affecting child welfare families affected by parental substance abuse. HHS often held the special topics meetings in conjunction with other major national conferences to leverage other important training opportunities. The NCSACW was responsible for bringing in national subject-matter experts to present on various topics throughout the grant period. Further, several grantees also presented at some of these national events, disseminating information about their RPG programs and effective strategies for serving families.

The overall purpose of both the annual and special topics meetings was to disseminate and promote the use of evidence-based clinical or best practices to facilitate RPG program improvement and to strengthen cross-systems collaboration to enhance services and improve family outcomes. Both types of meetings also provided an opportunity for grantees to network with each other.

RPG project staff and evaluators emphasized the value of opportunities to learn new information from the variety of workshops and special discussion and problem-solving sessions—to be part of such “a rich learning environment,” as one grantee described. Another grantee working to

¹⁹⁷ HHS also leveraged an additional program development opportunity for the RPGs: a Family Drug Court (FDC) Learning Academy webinar series developed by the RPG support contractor for the Office of Juvenile Justice and Delinquency Prevention (OJJDP) grantees. The FDC Learning Academy provides training to enhance, expand, and sustain FDC programs. HHS offered this training to the RPG sites as 20 grantees had implemented FDCs or served a majority of FDC participants.

expand their RPG model by developing a family drug court noted, “It has been invaluable to hear from others who have already settled issues . . . as we develop our program.”

Grantees applied what they learned from these meetings to enhance and strengthen their partnerships and programs. They continued to use and build on the information and discussions from all of the meetings held over the five years. In general, most all grantees described how they shared knowledge and resources gained with their partnerships and providers. Grantees often used their advisory board, steering committee, or other institutionalized RPG collaborative meetings as effective dissemination venues.

Grantees also used meeting information and resources to develop their own related trainings for partners, providers, and the larger community. As one grantee stated, “The grantee meetings highlight emerging issues in the field and provide a blueprint for possible training topics. The workshops from these meetings have guided the development of a curriculum outline for local staff. . . . While we can identify local needs, the broader framework offered at the grantee meetings will help us develop training to extend beyond the boundaries of the service area.”

Further, many grantees noted certain presentations (e.g., health care reform, sustainability) prompted them to initiate follow-up discussions with potential new partners and key stakeholders at the local and state level. Such discussions focused on how reforms may help sustain, expand, or improve services to families affected by parental substance use. For example, one grantee commented the meeting presentations “painted the larger vision of where child welfare was going and what the impact of health care reform may be.” The grantee added, “We believe it is important for our front line staff to be a part of this larger discussion and we have used the grantee meetings to help grow our staff and engage community partners.”

Grantees provided specific examples of how they incorporated knowledge gained to improve program services and service delivery. Highlighted below are the areas in which grantees most often reported translating meeting information into improved practice:¹⁹⁸

- To provide **trauma services** to both children and adults. Grantees implemented training and other policy and procedural changes to ensure their agencies and staff established a trauma-informed service delivery approach. They also implemented more direct evidence-based trauma services to facilitate a parent’s trauma recovery and healing and address the effects of trauma on children.
- To develop or enhance **motivational incentive programs** to increase parents’ engagement and retention in substance abuse and other treatment services.
- To strengthen outreach and engagement of custodial and non-custodial **fathers** and implement specific services to meet their unique needs.

¹⁹⁸ The Second and Third Reports to Congress provided more detailed individual grantee examples, particularly in the area of trauma services (a major focus of many grantee meetings). These reports are available at: <http://www.cffutures.com/projects/rpg>.

- To implement **process improvement** change processes, typically the NIATx change model. (Chapter III, Lesson 4 provides more information and examples of how grantees used the NIATx change process to improve their programs.)
- To enhance and strengthen their local **process and outcome evaluation** by incorporating new qualitative methods or data analysis approaches.
- To improve continuing care and **recovery support services** to promote parents' sustained recovery and help maintain safe and stable families.

These additional grantee comments reinforce the importance and value of the grantee meetings.

"These conversations allow us to gain insight into ways in which we can evaluate our project at the local level, keep in tune to initiatives that are important to policy and practice at the federal level, and share the successes we have gained through this partnership."

"The grantee meetings are consistently successful at providing an excellent forum for sharing new ideas, best practices, and increasing opportunities for collaboration and coordination of services."

"The grantee meetings have been wonderful. Where do we start? Lots of information, lots of experts, lots of great speakers, lots of networking opportunities, lots of time to learn from our colleagues, lots of time to talk with our federal officers . . . we always come back more energized and knowledgeable than when we arrived."

GRANTEE SITE VISITS

Over the course of the grant period, the RPG support contractor's performance management liaisons conducted 95 site visits with grantees. During the first year, all 53 grantees participated in an onsite visit. These initial site visits served multiple purposes. HHS was able to:

- Gain a thorough understanding of each grantee's regional partnership and project, and the local community context in which the project was being implemented
- Assess the local site's data collection and reporting capabilities
- Identify programmatic and implementation strengths and challenges
- Discuss any immediate or anticipated grantee technical assistance requests

HHS developed a structured site visit protocol utilizing the NCSACW's 10-element collaborative framework to assess both daily practice and systems-level protocols and operations (see Chapter III). After the site visits, the performance management liaisons prepared after action reports that detailed the project's strengths, opportunities for improvement, and implementation changes needed to adhere to the RPG Program requirements.

During program years two through four, the performance management liaisons conducted 30 follow-up site visits with selected grantees specifically to help their partnerships address key issues that included:

- Strengthening collaborative relationships with core partners, particularly as leadership and project staff changed due to budget cuts and other fiscal impacts
- Improving client outreach, engagement, and retention in services by addressing emerging and unmet needs of children, parents, and families
- Resolving ongoing data collection issues, particularly difficulties or delays in accessing child welfare and comparison group data
- Dealing with programmatic and evaluation staffing challenges, in particular continued turnover or loss of staff due to larger state or county budget cuts and agency reorganizations
- Advancing sustainability planning, in particular identifying major tasks to be completed and developing strategies to overcome major sustainability barriers

In the final year, the performance management liaisons conducted targeted site visits with 12 grantees that had demonstrated significant progress and accomplishments with their regional partnerships. This final round of site visits focused on their experiences in establishing strong collaborative relationships, institutionalizing innovative practices to serve families more effectively, and implementing strategies to sustain critical RPG program components. These site visits also assessed their program's larger impact on local child welfare, substance abuse treatment, and other service systems.

The insights gained from these (and the prior) site visits are reflected in the key program and evaluation implementation lessons in Chapter III and XI, respectively.

TECHNICAL ASSISTANCE PROGRAM

As noted above, HHS created a support structure to ensure grantees received comprehensive ongoing technical assistance to address program development and other issues that arose during implementation. Technical support emphasized cross-systems collaboration, client engagement and retention, effective treatment approaches, and sustainability strategies. Technical assistance also addressed program evaluation tasks and data collection, reporting, and analysis challenges.

During the five-year grant period, the partnerships made 675 programmatic and evaluation technical assistance requests (some sites made multiple requests). Requests covered a broad range of topics regarding effective collaborative practices, direct child and adult service interventions, process and outcomes data and evaluation, and other issues affecting families involved in child welfare, substance abuse treatment, and the court systems.

Overall, the majority (86.8 percent) of all requests were for basic information and resources or brief expert consultations from the NCSACW. The other 13.2 percent required more intensive NCSACW assistance, such as extensive expert consultation, workgroup facilitation, conference presentations, or training sessions. It is worth noting the percentage of requests for more intensive assistance was substantially higher during the latter half of the grant period (20.4 percent) than the first half of the grant (9.9 percent). This reflects the growth of the regional

partnerships over time and how, as their collaborative practice advanced and understanding of families' needs deepened, they often grappled with more complex and difficult issues.

Highlighted below are the top five topic areas. Among all technical assistance requests:

- More than one-fourth (28.7 percent) involved assistance with funding and program sustainability. However, from the middle of program year two to the end of program year four, funding and sustainability issues accounted for an average of 40.4 percent of all technical assistance requests.
- Nearly one-fifth (18.8 percent) addressed data and information systems and outcomes evaluation. However, during the latter half of the grant period, these topics were more predominant: they accounted for 31.3 percent of all requests received.
- 17.9 percent pertained to screening and assessment of children and adults (for various issues). Requests in this area made up a somewhat higher proportion (23.8 percent) of all requests during the final year of the grant. This trend may be due to some grantees' efforts later in the grant to implement or strengthen screening and assessment for more specialized issues, such as trauma and co-occurring mental health disorders.
- A slightly smaller proportion (16.9 percent) addressed collaborative values among partners and working with related agencies to serve families effectively.
- More than 1 in 10 requests (11.6 percent) related to client engagement and retention issues.
- Finally, while issues affecting children of parents with substance use disorders comprised only 8.4 percent of all technical assistance requests, this became an area of greater interest at the end of the grant period. Among all program year five requests, more than one-third (35.0 percent) sought assistance in this area.

In addition, a smaller percentage of all requests (less than 10 percent) addressed staff training and development, systems reform models (e.g., family drug courts), building community and family supports, and issues affecting other specific target populations (e.g., parents involved in criminal justice system).

To enhance grantees' access to available technical assistance and resources, HHS also established the Collaborative Project Management (CPM) system in the first program year. CPM provided a central web location for RPG communication among HHS, support contract staff, and the 53 grantees. CPM served to promote sharing of information and resources among the 53 grantees through its various functions, which included a library, discussion forums, and other communication tools.

Sustainability Technical Assistance

Throughout the initial RPG Program period, HHS provided grantees with assistance to help sustain their programs and partnerships. This was a primary focus area from the outset, given the RPG Program's funding structure (see Chapter I). HHS's support included practical guides and

tools on sustainability planning and conducting cost analysis that grantees could apply to their local sites. Specific sustainability technical assistance activities are highlighted below.

- A web-based two-part introductory series on sustainability conducted in program year two. Part one provided an overview of key principles and steps in developing a sustainability plan. Part two presented basic principles of cost analyses and featured three grantees who had initiated work on this topic.
- A webinar targeted specifically to helping the three-year grantees develop and strengthen their project sustainability plans as they entered their final program year.
- A three-part webinar series focused on the most current and critical sustainability issues facing grantees (e.g., health care reform, budget cuts). Participants were grouped according to lead agency type (e.g., community based-agency, state child welfare or substance abuse treatment agency) to ensure a rich and focused dialogue. Grantees were able to share and discuss effective sustainability strategies.
- Development and continued dissemination of sustainability resource materials developed for the RPG Program. These included *A Discussion Guide for the Sustainability of Programs for Children and Families* and accompanying *Sustainability Matrix, a Sustainability Planning Worksheet for Children’s Bureau Discretionary Grantees*, in addition to a companion *Cost Rationale and Framework for Initial Cost Analysis Discussion Guide* and *Cost Analysis Template*.¹⁹⁹
- Creation and expansion of sustainability resources on the RPG Collaborative Project Management website to facilitate the sharing of information and suggested strategies among grantees. The website included approximately 50 products, such as local resources inventories and video stories about specific programs.
- Specialized and targeted sustainability planning and development breakout sessions at nearly all grantee meetings. These sessions focused on conducting and using cost analyses as an essential component of sustainability planning.
- Individual conference calls with the technical assistance team that focused on addressing site-specific challenges as they arose.

Health Care Reform—An Emerging Opportunity

The Patient Protection and Affordable Care Act became law about midway through this initial RPG Program grant period (March 2010). The Affordable Care Act provides the regional partnerships with several new potential opportunities to integrate substance abuse treatment services within the broader health care system, while providing greater access to family-centered treatment services for families in or at risk of entering the child welfare system.

¹⁹⁹ These materials are available from the Center for Children and Family Futures at <http://www.cffutures.org/publications> (within the budgets and program sustainability category).

To help grantees prepare for health care reform implementation and capitalize on its associated opportunities for program expansion and sustainability, HHS provided targeted technical assistance that included:

- Grantee meeting plenary and workshop presentations on implementation of the Affordable Care Act.
- A webinar for all grantees regarding the potential effects of health care reform on families with substance use and mental disorders in the child welfare system, and the systems that are serving them.
- Two regional-level webinars to provide focused technical assistance and facilitated discussions to a) the Texas grantees and b) the nine California grantee sites. These webinars were designed to help the partnerships and their key stakeholders engage their state in discussions regarding essential health benefits, Medicaid, client and provider enrollment, and health insurance exchanges.

As discussed in Chapter III (see Lesson 10), for several RPG sites, sustainability planning became a natural part of the health care reform discussions and evolved into an integral component of their long-term sustainability strategy for services. Grantees initiated discussions with FQHCs, managed care providers, and local primary care providers to establish a permanent medical and behavioral health care home for their RPG families.

Cultivating these collaborative relationships will become even more of a priority as health care reform further advances and more states undertake various delivery system changes, including managed care reforms and physical and behavioral health care coordination. The second round of regional partnerships (awarded in 2012) have a timely opportunity to incorporate Affordable Care Act reforms into their sustainability planning, as their RPG programs progress and the legislation is fully implemented.

SUMMARY

Over the initial five-year grant period, HHS provided extensive and varied technical assistance to address the inherent challenges associated with 53 different grantees working to integrate the efforts of multiple agencies to improve the lives of thousands of children, parents, and families. Through the NCSACW, HHS was able to draw on the expertise of ACF-SAMHSA partnership to develop a menu of onsite and online resources, delivered in one-on-one and group exchanges.

The programmatic and evaluation technical assistance HHS provided helped grantees work through new and ongoing challenges in the difficult areas of funding and sustainability, advanced partnership collaboration, staff recruitment and retention, and measuring cross-system outcomes and cost savings. It also responded to significant contextual events facing grantees, such as the fiscal environment and health care reform implementation. During the course of the grant, grantees repeatedly expressed how valuable the HHS technical assistance infrastructure was to their overall success.

GLOSSARY

Below is a list of acronyms that appear in the Fourth Report to Congress.

AAPI-2: Adult-Adolescent Parenting Inventory-2

ACF: Administration for Children and Families

ACYF: Administration on Children, Youth and Families

AFCARS: Adoption and Foster Care Analysis and Reporting System

ASI: Addiction Severity Index

ASQ: Ages and Stages Questionnaire

ASQ-SE: Ages and Stages Questionnaire: Social-Emotional

ATRIUM: Addictions and Trauma Recovery Integrated Model

CANS: Child and Adolescent Needs and Strength instrument

CARF: Commission on Accreditation of Rehabilitation Facilities

CBCL: Child Behavior Checklist

CBT: Cognitive Behavioral Therapy

CCI: Collaborative Capacity Instrument

CFSR: Child and Family Services Review

CPM: RPG Collaborative Project Management System

CPP: Child-Parent Psychotherapy

FDC: Family Drug Court

FQHC: Federally Qualified Health Center

FY: Federal fiscal year

HC-MC: Honoring Children, Mending the Circle

HHS: U.S. Department of Health and Human Services

IM: Information Memorandum

IRB: Institutional Review Board

MAT: Medication-Assisted Treatment

MFT: Marriage and Family Therapist

MCO: Managed care organization

MOU: Memorandum of Understanding

NCANDS: National Child Abuse and Neglect Data System

NCFAS: North Carolina Family Assessment Scales

NCSACW: National Center on Substance Abuse and Child Welfare
NCTSN: National Child Traumatic Stress Network
NIATx: Network for the Improvement of Addiction Treatment
NOMs: National Outcomes Measures (related to substance abuse treatment and prevention)
NPP: Nurturing Parenting Programs
PCIT: Parent-Child Interaction Therapy
PCAT: Parent-Child Attunement Therapy
PIP: Performance Improvement Plan
PSSF: Promoting Safe and Stable Families program
PSI: Parenting Stress Index
PTSD: Post Traumatic Stress Disorder
RPG: Regional Partnership Grant/Grantee
SAMHSA: Substance Abuse and Mental Health Services Administration
SDM: Structured Decision Making
SFP: Strengthening Families Program
TEDS: Treatment Episode Data Set
TF-CBT: Trauma Focused Cognitive Behavioral Therapy
TREM: Trauma Recovery and Empowerment Model
TSI: Trauma Symptom Inventory
WBRR: Walking in Beauty on the Red Road curriculum

APPENDIX A: RPG REPORT TO CONGRESS DATA SOURCES

This Report to Congress drew on substantial qualitative and quantitative data sources to provide a comprehensive descriptive and analytical picture of the 53 grantees’ activities and services, collaborative progress to meet families’ needs, and performance measure results. These information sources are briefly summarized below.

REPORT TO CONGRESS DATA SOURCES			
<u>Data Source</u>	<u>Data Type</u>	<u>Frequency</u> (each fiscal year)	<u>Brief Description</u>
Grantee Semi-Annual Progress Reports	Qualitative and Quantitative	April; October	<ul style="list-style-type: none"> • Contain narrative information on a grantee’s major activities and accomplishments, program and evaluation challenges, contextual events or community changes, technical assistance activities, and use of knowledge from grantee meetings. • Contain overview of major local evaluation findings; may include qualitative and quantitative program outcome and process evaluation data. • Include selected client and partnership data (e.g., trainings conducted, new partner agencies, families served) that provide a snapshot of RPG operations; these data are not part of the performance measure data files submitted to the RPG Data Collection and Reporting System (see below). • Systematic review of qualitative information conducted using a collaborative framework that outlines 10 elements of collaborative practice and systems linkages as organizing principle.

REPORT TO CONGRESS DATA SOURCES

<u>Data Source</u>	<u>Data Type</u>	<u>Frequency</u> (each fiscal year)	<u>Brief Description</u>
Grantee Final	Qualitative	Within 90 days of	<ul style="list-style-type: none"> • Contains overview of grantee’s community and target population, regional partnership, program model, and evaluation plan. • Describes each major program strategy implemented, including dosage and duration, number served, contextual events or community changes that influenced the strategy, challenges and barriers encountered, and lessons learned. • Presents and discusses findings on each of the grantee’s selected performance measures and any additional local evaluation indicators used to track progress. • Provides other process or qualitative evaluation results (e.g., focus groups, key stakeholder interviews) regarding the grantee’s efforts to serve families and strengthen collaborative capacity. • Includes sustainability information such as what parts of program grantee will sustain, effective sustainability strategies, cost study findings (if applicable), and description of any products developed. • Describes the grantee’s overall impact on families served, agencies and organization involved, and the larger community where operated. • Provides recommendations to project administrators, funding agencies, and the general field regarding cross-systems collaboration and meeting the needs of children, parents, and families.
Grantee Performance Measure Data Files	Quantitative	June; December	<ul style="list-style-type: none"> • Case-level grantee data on children, adults, and families served (RPG participants and control and/or comparison groups, if applicable). • Contains core demographics and data elements needed to calculate each of the performance measures. • Files are cumulative and contain data on all clients served to date (most recent reporting period end date); final data upload was December 2012. • Whenever possible, existing state (or county) child welfare and substance abuse treatment information systems were used to provide these data.

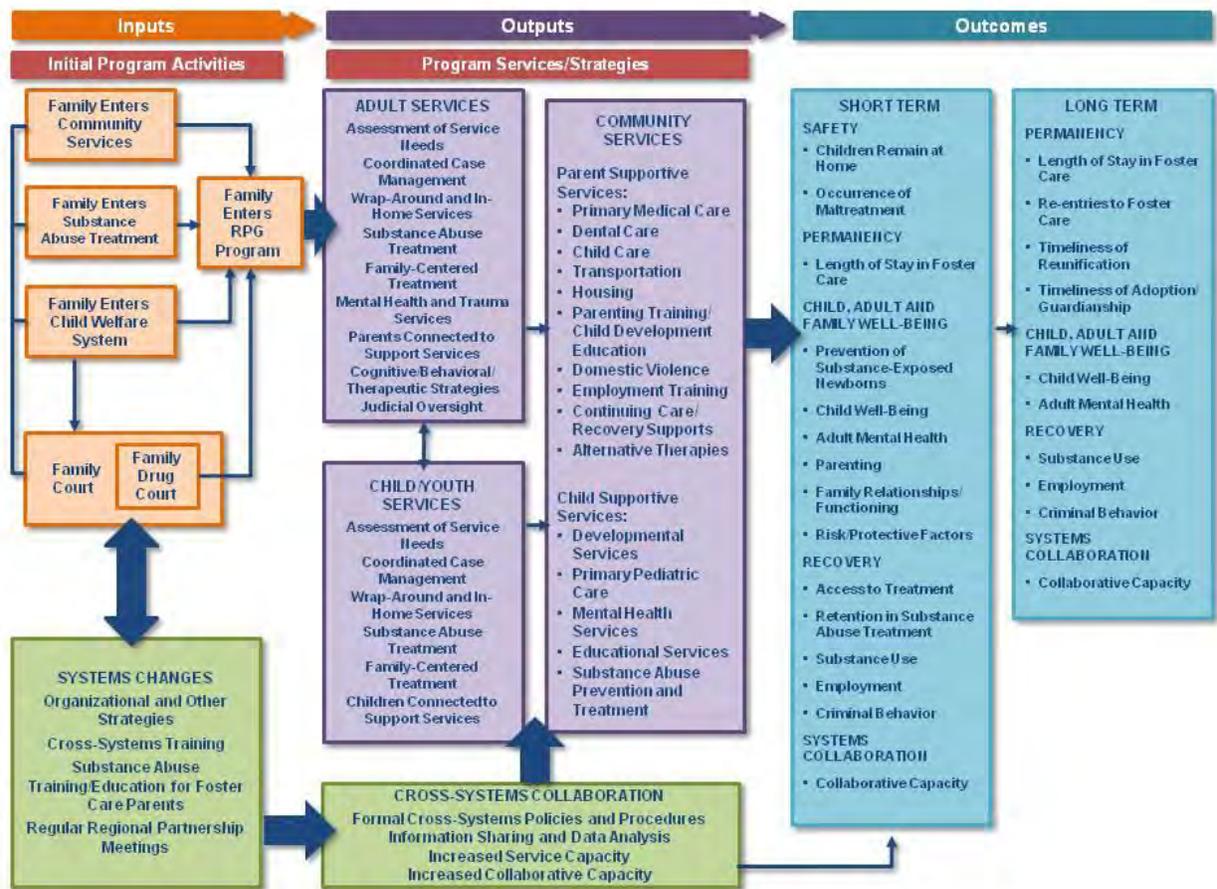
REPORT TO CONGRESS DATA SOURCES

<u>Data Source</u>	<u>Data Type</u>	<u>Frequency</u> (each fiscal year)	<u>Brief Description</u>
Grantee Site Visit Reports	Qualitative	Number site visits varied each year based on need	<ul style="list-style-type: none"> Contain summary of grantee’s overall strengths and challenges; most significant issues impacting the program; status and progress on serving clients; primary areas of concern discussed during site visit; next steps and work plan for addressing those issues; data collection and reporting issues; sustainability plans and progress; and any identified technical assistance needs.
Grantee Annual and Special Topics Meetings	Qualitative	Fall/Winter (Special Topics); Summer (Annual)	<ul style="list-style-type: none"> Meeting evaluations, which include open-ended grantee feedback and summary discussion notes from individual sessions, were compiled and reviewed. How grantees use the knowledge and information gained from the meetings is captured in the Grantee Semi-Annual Progress Reports (see above).

APPENDIX B: RPG PROGRAM DATA ANALYSIS LOGIC MODEL

HHS developed a comprehensive RPG Program logic model to illustrate how successful cross-systems practice and services can positively affect safety, permanency, recovery, well-being, and systems collaboration. This logic model represents the 53 RPG-funded programs and shows how programmatic components and systemic factors connect to impact critical outcomes. It also served as a framework for planning the data analyses and testing relationships between specific program services and outcomes.

The logic model depicts the relationships and connections between the inputs, outputs (e.g., program services and activities for children, adults, families, and the larger community), and short- and long-term outcomes. Each component is explained further below.



INPUTS

Inputs refer to the initial program activities regarding families' entry to the grantees' programs and certain systems changes that may affect both participants' program entry and broader cross-systems collaboration.

A family typically becomes involved in an RPG program through four pathways:

- Family enters community services
- Family enters substance abuse treatment
- Family enters the child welfare system
- Family becomes involved through the family court or family drug court.

System changes that may affect a family's RPG program entry and broader cross-systems collaboration include:

- Organizational and other strategies to facilitate client identification and engagement (e.g., co-located staff)
- Training on clinical treatment issues and RPG program and policy issues
- Substance abuse training and education for foster care parents and other substitute caregivers
- Regular regional partnership meetings on programmatic issues and collaborative management and administration

System changes can then affect larger cross-systems collaboration, which in turn may influence the program services grantees provide to families (see outputs below) and ultimately the short- and long-term outcomes. Cross-systems collaboration includes:

- Formal cross-systems policies and procedures to improve communication, identification, referrals, and service delivery
- Information sharing and data analysis
- Increased service capacity
- Increased collaborative capacity

OUTPUTS

Outputs are the program services and activities grantees implemented. These outputs are organized into three major areas: adult services, child and youth services, and community services.

Adult services include:

- Assessment of service needs
- Coordinated case management
- Wrap-around and in-home services
- Substance abuse treatment
- Mental health and trauma services
- Family-centered treatment

- Parents connected to supportive services
- Cognitive/behavioral/therapeutic strategies to facilitate treatment engagement and retention
- Judicial oversight

Child and youth services include:

- Assessment of service needs
- Coordinated case management
- Wrap-around and in-home services
- Substance abuse treatment
- Family-centered treatment
- Children connected to support services

Community services center on core supportive services to parents and children. Core supportive services to parents include:

- Primary medical care
- Dental care
- Mental health services
- Child care
- Transportation
- Housing
- Parenting training and child development education
- Domestic violence services
- Employment or vocational training and education
- Continuing care/recovery support services
- Alternative therapies

Core supportive services to children and youth include:

- Developmental services
- Primary pediatric care
- Mental health services
- Educational services
- Substance abuse prevention/education and treatment
- Educational services

OUTCOMES

The various outputs and collaborative activities then connect to short- and long-term safety, permanency, recovery, well-being, and improved systems collaboration outcomes. Certain outcomes may be both short- and long-term; they are not necessarily mutually exclusive.

Short-Term Outcomes

Short-term safety and permanency outcomes include:

- Children remain at home
- Occurrence of child maltreatment
- Length of stay in foster care

Short-term child, adult, and family well-being outcomes include:

- Prevention of substance-exposed newborns
- Child well-being
- Adult mental health
- Parenting capacity
- Family relationships and functioning
- Risk and protective factors

Short-term recovery outcomes include:

- Timely access to substance abuse treatment
- Retention in substance abuse treatment
- Substance use
- Employment
- Reduced criminal behavior

Short-term systems collaboration outcomes include:

- Increased collaborative capacity to serve families with a parental substance use disorder and current or potential child welfare involvement

Long-Term Outcomes

Long-term safety and permanency outcomes include:

- Length of stay in foster care
- Re-entries to foster care

- Timeliness of reunification
- Timeliness of adoption or guardianship

Long-term child, adult, and family well-being outcomes include:

- Child well-being
- Adult mental health

Long-term recovery outcomes include:

- Reduced substance use
- Employment
- Reduced criminal behavior

Long-term systems collaboration outcomes include:

- Increased collaborative capacity to serve families with a parental substance use disorder and current or potential child welfare involvement

APPENDIX C: REGIONAL PARTNERSHIP PROGRAM – OPERATIONAL DEFINITION OF MAJOR PROGRAM STRATEGIES

As described in Chapter II, grantees provided information on their major program strategies using a set of operational definitions. These definitions provided a common frame of reference across all 53 grantees.

Intensive/Coordinated Case Management

Two program strategy classifications:

Traditional case management, which most all programs tend to do, typically involves identifying and referring a family to other community resources and supports, coordinating resources, advocating for a family, or providing other services that help children/families gain access to needed medical, social, educational, and other services. “Traditional” case management services – in contrast to intensive/coordinated case management as defined below – are usually provided on an ad-hoc, as-needed basis as an adjunct to traditional treatment services.

Intensive/coordinated case management is a participant-centered, goal-oriented approach to facilitate a client’s recovery, self-sufficiency, and overall well-being that, at a minimum, involves:

1. Assessing needs, resources, and priorities
2. Planning for how the needs can be met
3. Establishing linkages to enhance access to comprehensive treatment and support services to meet those identified needs for the child, adult, and/or family
4. Coordinating and monitoring service provision through active cross-system communication and coordinated service plans
5. Removing barriers to treatment and advocating for services.¹

Intensive/coordinated case management should be considered distinct from more “traditional” case management (as defined above) based on the following: The grantee has dedicated program funds and/or staff to ensure that each family is assigned a case manager to carry out the above minimum activities; activities are coordinated across partner services.

¹ These five essential functions come from Joint Commission on Accreditation of Healthcare Organizations (1995). *Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/ Developmental Disabilities Services. Vol. 1, Standards*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations.

Family Group Decision Making/Family Case Conferencing (or other formal multidisciplinary team decision-making processes)

Related Terms: FGDM, Family Group Conferencing, Family Team Conferencing, Family Team Decision Making, Family Unity Meetings

Family Group Decision Making and related multidisciplinary strategies are formal team-based case planning processes to assist families in creating a plan to address safety concerns within their family network and offer long-term help to carry out their safety plan; families are actively engaged in planning and decision-making. All interested parties (immediate and extended family, trained professionals, and anyone who has a significant relationship with either the child or parent) meet together to develop resolutions to the issues facing the family. This forum provides for team decision-making and designs a plan in which consensus is reached.

Wraparound/Intensive In-Home Comprehensive Services

The wraparound/intensive in-home approach is more an overall service delivery process in which a child's or family's individual needs are addressed by the full range of needed services, *with the overall goal typically being to keep families together and keep children stabilized in the least restrictive environment and prevent them from being placed in a higher out-of-home level of care or more intensive residential placement.* Wraparound goes beyond the simple provision of comprehensive support services for the child, adult, and family, as reflected by an integrated, individualized services plan that addresses the key clinical services and supports necessary for the child to remain at home or in his/her community. Services are designed, and in some cases created, around the needs of the child and family and provided through a multi-agency collaborative approach. Intensive/coordinated case management and/or a multidisciplinary team decision-making process could be one component of a grantee's broader wraparound approach.

Definitions of wraparound have been developed by various public agencies and research organizations, including the National Mental Health Association, U.S. Surgeon General's Office, the National Wraparound Initiative, and SAMHSA. Common elements derived from these definitions include:

- Collaborative, community-based interagency team that is responsible for designing, implementing, and overseeing the wraparound initiative
- Formal interagency agreement that records design of initiative and spells out exactly how wraparound effort will work
- Care coordinators who are responsible for helping creating a customized treatment program and guiding families through the system of care
- Child and family teams consisting of family members, service providers, and community members who know the family and are familiar with the family's changing needs

- A unified plan of care developed and updated collectively by all members of the child and family team; plan of care identifies strengths/weaknesses, goals, steps to achieve goals, and roles and responsibilities of team members
- Systematic, outcomes-based services

“**Regular**” or “**Traditional**” **In-Home Services** refer to individual services, such as behavioral therapy, that can be provided in an in-home or other setting. They do not involve a multi-agency collaborative approach and are part of the service continuum in standard services (i.e., they are not augmented by the RPG program).

Parenting and Family Strengthening Program or Activities

Parenting/family strengthening activities have been broken out to the following classifications:

- **Standard parenting skills training and education or parenting classes** – which are designed to teach basics of parenting and child development (e.g., appropriate discipline techniques, developmentally appropriate behavioral expectations of children).
- **Enhanced parenting services** – in which standard parenting skills training are enhanced or augmented with parent-child interaction time and activities, observation, communication, and related activities in a formal setting.
- **Implementation of a manualized parenting curriculum or evidence-based parenting or family strengthening program** – that is specifically designed or has been adapted or modified to address the unique needs of families with high-risk behaviors, including substance use (e.g., Strengthening Families Program, Celebrating Families, Nurturing Families). Grantees specified which curriculum or program they were using. (“Evidence-based” generally refers to any program, policy, strategy, or practice that appears on a federal list or registry of approved interventions that uses terms such as “Model,” “Best Practice,” “Promising Practice,” Evidence-based,” “Principle of Effectiveness,” or related term.)

Visitation Services

This refers to visitation services provided separate from or outside of parent/child interaction components that may be part of a broader parenting program (e.g., Celebrating Families, Strengthening Families Program) grantees have implemented. For RPG Program purposes, visitation services are divided into three categories:

- **Supervised Visitation:** In general, this describes parent/child contact overseen by a third party. It also is a term for contact between a noncustodial parent and child(ren) in the presence of a third person, in which the only focus is the protection and safety of the child and adult participants. This also may be referred to as “monitored visitation.”
- **Supportive Supervised Visitation:** Described as contact between a noncustodial parent and child(ren) in the presence of a third person, in which the supervisor is actively involved in promoting behavioral change in parent/child relationships; has a supportive, educational, or

modeling component to it. This also may be referred to as “directed,” “educational,” or “facilitated” visitation.

- **Therapeutic Visitation/Therapeutic Supervised Visitation:** A combination of therapeutic intervention provided by a licensed or certified mental health or other professional and the protective and/or supportive functions of supervised visitation. The general purpose is to actively assist children and families in maintaining or reestablishing relationships that are safe and healthy for the child; intended to achieve specific therapeutic goals (which distinguishes it from supportive supervised visitation above).

Family Therapy/Family Counseling

Family therapy is a collection of therapeutic approaches that share a belief in the effectiveness of family-level assessment and intervention. Family therapy in substance abuse treatment has two main purposes: (1) to use family’s strengths and resources to help find or develop ways to live without substances of abuse, and (2) to ameliorate the impact of chemical dependency on both the identified patient and family. In family therapy, the unit of treatment is the family and/or the individual within the context of the family system. The familial relationships are the points of therapeutic interest and intervention.

Models of family therapy include, but are not limited to: marriage and family therapy (MFT), strategic family therapy, structural family therapy, cognitive-behavioral family therapy, couples therapy, solution-focused family therapy, multidimensional family therapy, multisystemic family therapy, brief strategic family therapy, functional family therapy, and network therapy.

Family therapies can be roughly divided into two major groups:

- **Traditional/Short-Term:** Those that focus primarily on problem solving, where therapy is generally brief, more concerned with the present situation and more pragmatic.
- **Intensive/Long-Term:** Those that are oriented toward intergenerational, dynamic issues; these are longer-term, more exploratory, and concerned with family growth over time (may involve several hours of therapy week).

Engagement/Involvement of Fathers

The following classifications are not necessarily mutually exclusive; a grantee may be doing both:

- **Targeted Outreach:** Conduct targeted outreach to engage and involve fathers of children involved in the child welfare system to actively participate in the larger family’s treatment/service plan or to address their own treatment and service needs.
- **Specialized Program or Services for Fathers:** Provide specific program, curriculum, or services for fathers of children involved in the child welfare system (e.g., 24/7 Dad, Dads for Life, Parenting Together, Inside Out Dads, Project Fatherhood).

Mental Health and Trauma Services (for adults)

Mental Health Services: This includes, but is not limited to services—other than psychiatric care including medication management and trauma services described separately below—such as cognitive behavioral therapy, individual and group counseling/therapy, and services for depression, anxiety, affective, and somatization disorders.

Psychiatric Care Including Medication Management: These are services provided by a psychiatrist. The intent here is to determine if RPG program clients have access to a psychiatrist and psychotherapeutic medications, in contrast to receiving just counseling or therapy.

Trauma services are classified according to the two following groupings:²

Trauma-informed services take into account knowledge about trauma and incorporate it into all aspects of service delivery; every part of the program’s organization, management, and service delivery system includes a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

Trauma-specific services are focused on and designed specifically to address the impact and consequences of trauma in the individual and facilitate their trauma recovery and healing. They have a manualized curriculum with some kind of evidence or research base. Models of trauma-specific treatment include, but are not limited to:

- The Addictions and Trauma Recovery Integration Model (ATRIUM)
- Helping Women Recover (HWR) [Stephanie Covington’s model]
- Seeking Safety
- The Trauma Recovery and Empowerment Model (TREM)
- Triad
- Risking Connections

² Sources: National Center for Trauma-Informed Care, SAMHSA Center for Mental Health Services, www.samhsa.gov/nctic/trauma.asp; Finkelstein, N., VandeMark, N., Fallot, R., Brown, V., Cadiz, S. & Heckman, J. (2004). *Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment*. Sarasota, FL: National Trauma Consortium.

Substance Abuse Treatment

Substance abuse treatment services are broken out into the following classifications; more than one may apply.

Residential/Inpatient or Therapeutic Community

Facility-based level of care providing rehabilitation of substance abuse and dependency 24 hours a day, 7 days a week. It includes residential care settings such as therapeutic communities, as well as ASAM's medically monitored (planned regimen of around-the-clock, professionally directed evaluation, care, and treatment in an inpatient setting) and medically managed intensive inpatient treatment (planned regimen of 24-hour medically directed evaluation, care, and treatment in an acute care inpatient setting). Residential care may be:

- Short-term (less than or equal to 30 days)
- Long-term (more than 30 days)
- Specialized residential services for women (or parents) with children. These programs provide a safe and structured therapeutic environment where women/parents may obtain residential substance abuse treatment services while still maintaining custody and care of their children.

Partial Hospitalization

A licensed freestanding or non-hospital-based, non-residential facility that provides a broad range of highly clinically intensive interventions. Services are provided in a structured environment for a minimum of 20 hours per week, on four or more separate occasions each week. Interventions include substance abuse counseling, educational, and community support services. Programs have ready access to psychiatric, medical, and laboratory services.

Intensive Outpatient

A licensed, non-residential facility that provides structured, clinically intensive intervention. Interventions include individual, group, and family counseling services, relapse prevention training, education, and supportive services. Services are provided in a structured environment for a minimum of nine hours per week, on three or more separate occasions each week. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in special residences. Intensive outpatient represents a continuum of services that range from less to more intensive treatment. (Grantees were asked to specify whether they are using the Matrix Model.)

Non-Intensive Outpatient or Other Step-Down

Organized nonresidential treatment service or an office practice with addiction professionals and clinicians providing professionally directed alcohol and other drug treatment. Treatment occurs in regularly scheduled sessions, usually totaling fewer than nine hours per week. Examples

include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups.

Aftercare/Continuing Care/Recovery Community Support Services

(not mutually exclusive from Substance Abuse Treatment)

Aftercare, or continuing care, is the stage following treatment discharge, when the client no longer requires services at the intensity required during primary substance abuse treatment. Aftercare can occur in a variety of settings and supports an individual's recovery by providing both formal and informal community-based recovery supports that may include relapse prevention services, peer recovery groups, 12-Step programs, spiritual support, recovery coaching, home visits after the client has completed treatment or entered a lower level of care, and other services to help the client maintain sobriety and begin work on remediating various areas of their lives.

Specialized Outreach, Engagement and Retention Services

This refers to a broad range of specific services and activities designed to reduce barriers and increase timely access to treatment as well as facilitate treatment engagement and retention. Such services or strategies tend to stress the importance of developing long-term, supportive client-staff relationships to support the client's immediate engagement and maintained interest in and commitment to treatment. For purposes of the RPG Program, these strategies are broken out into two groupings (more than one may apply):

- **Cognitive/Behavioral/Therapeutic Services.** Such services and interventions may include, but are not limited to motivational interviewing, contingency management, motivational enhancement therapy, or other cognitive and behavioral-based interventions.
- **Organizational or Other Strategies.** Such services and interventions may include, but are not limited to parent partners, peer mentors, specialized intake units, out-stationed workers, co-located staff, or similar types of strategies and activities.

Family-Centered Substance Abuse Treatment or Family-Based Substance Abuse Services

(not mutually exclusive to Substance Abuse Treatment, but another cut at classifying services for those who indicate they are providing family-based services or family treatment)

Since there is no current universally accepted definition of family-centered treatment, grantees were asked to use the levels below to classify the type of services they are providing:

Level 1: Women's Treatment with Family Involvement. Services for women with substance use disorders. Treatment plan includes family issues, family involvement. Goal is improved outcomes for women.

Level 2: Women's Treatment with Children Present. Children accompany women to treatment. Children participate in child care but do not receive therapeutic services. Only women have treatment plans. Goal is improved outcomes for women.

Level 3: Women's and Children's Services. Children accompany women to treatment. Women and attending children have treatment plans and receive appropriate services. Goals are improved outcomes for women and children, and better parenting.

Level 4: Family Services. Children accompany women to treatment; women and children have treatment plans. Some services are provided to other family members. Goals are improved outcomes for women and children, and better parenting.

Level 5: Family-Centered Treatment. Each family member has a treatment plan and receives individual and family services. Goals are improved outcomes for women, children, and other family members; and better parenting and family functioning.

Substance Abuse Prevention Services

The Substance Abuse Prevention and Treatment (SAPT) Block Grant regulations require that each state receiving a block grant adopt a comprehensive prevention program that includes a broad array of prevention strategies for individuals not identified to be in treatment. The operational definition of this program strategy refers to one or more of the six prevention activities listed below, recognized by the Center for Substance Abuse Prevention (CSAP). This is intended to capture broader prevention and education services that are beyond/outside the scope of what may be provided as a standard component of a client's substance abuse treatment program.

Information Dissemination: Focuses on building awareness and knowledge of the nature and extent of substance use, abuse and addiction, and their effects on individuals, families, and communities, as well as dissemination of information about prevention programs and resources. The strategy is characterized by one-way communication from source to audience, with limited contact between the two. Examples include clearinghouses, resource directories, media campaigns, speaking engagements, and health fairs.

Prevention Education: Involves two-way communication between an educator or facilitator and participants. The strategy focuses on improving critical life and social skills such as decision making, refusal, critical analysis of media messages, and improved judgment. Examples include classroom sessions for all ages, parenting and family management classes, and peer leader programs.

Alternatives Activities: Provide opportunities for substance-free leisure activities as an effective means of halting or reducing substance abuse. Alternative programs include a wide range of activities: athletics, art, music, movies, and community service projects.

Problem Identification and Referral: Aims to identify those who indulged in illegal or age-inappropriate use of tobacco or alcohol, and identify first use of illicit drugs in order to reverse their behavior in the early stages. Examples of activities include employee and student assistance programs and driving under the influence/driving while intoxicated programs.

Community-based Process: Aims to enhance community resource involvement in substance abuse prevention. For example, this strategy involves building interagency coalitions and training community members and agencies in substance use education and prevention.

Environmental Approaches: Establishes or changes community standards, codes, and attitudes to reduce risk factors and enhance protective factors for substance abuse. Approaches can center on legal and regulatory issues or can relate to service and action-oriented initiatives. Examples of these policies may be community laws prohibiting alcohol and tobacco advertisements in close proximity to schools, community policies increasing the barriers youth encounter for obtaining alcohol and tobacco products, and community laws increasing punishments for driving while under the influence.

Screening and Assessments for Child Welfare Issues

Screening for Child Welfare Issues. Child welfare screening for child abuse and/or neglect involves observations and questions to determine if a child may have been the victim of abuse and/or neglect. These observations or questions center on issues of physical or sexual abuse, deprivation, and neglect of child's basic needs or well-being. Screening also includes initial safety assessment at the front end to determine the degree of immediate danger of child maltreatment. Results of the initial screening determine the need for a more in-depth assessment.

Assessment for Child Welfare Issues. Assessing needs for child welfare services *other than initial safety assessments* generally begin once the screening process for child maltreatment has been completed, a child welfare department response has been determined, and the family is assigned to a child welfare services worker. These assessments fall generally into two categories: risk assessments and family assessments. Child welfare assessment broadly refers to the in-depth process to determine potential risk of future harm to a child and the family's level of functioning and well-being based on its strengths and needs in several areas. (Grantees identified a specific evidence-based protocol used, such as Structured Decision Making, if applicable.)

Screening and Assessment for Child Trauma

Screening for Trauma in Children. Trauma screening involves administration of a brief tool to estimate the prevalence of trauma symptoms and/or traumatic experiences, and identify children who may require further assessment and intervention.

Assessment for Trauma in Children. Assessing for trauma involves a more in-depth exploration of the nature and severity of the traumatic events, the impact of those events, current trauma-related symptoms, and functional impairment to identify the appropriate services and supports a child may need.

Other Specialized Child Screening and Assessments

Other Specialized Child Screening. This refers to other specialized initial or brief screenings for children (e.g., mental health, psychological, developmental, occupational/physical therapy, speech/language, behavioral, educational). In general, screening refers to a brief process to determine if there is a potential problem in the specified area and a need for a more extensive assessment.

Other Specialized Child Assessment. This refers to other specialized assessments for children (e.g., mental health, psychological, developmental, occupational/physical therapy,

speech/language, behavioral, educational). In general, assessments refer to the more in-depth information gathering process to determine the extent of a given problem and identify the appropriate services and supports needed. Assessments are done by trained and qualified professionals.

Screening and Assessments for Substance Use Disorders

Screening for Substance Use Disorders. Screening for substance use disorders involves a brief set of routinely administered observations and questions to determine the risk or probability that a person has a substance use disorder. Screening is conducted by child welfare service staff as well as community-based providers, hospital staff, other health or social services agency staff (including those with little clinical expertise), or may be a specialized service conducted by an alcohol or drug counselor.

Assessing for Substance Use Disorders. A substance abuse assessment, which is conducted by a staff member trained in substance abuse issues, involves the use of a standardized set of questions regarding an individual's functioning, needs, and strengths to diagnose the nature or extent of substance use disorders or to make decisions regarding level of care required and alcohol and drug treatment services needed.

Other Specialized Adult Screening. This refers to other specialized initial or brief screenings for adults (e.g., mental health, psychological, educational, employment). In general, screening refers to a brief process to determine if there is a potential problem in the specified area and need for a more extensive assessment.

Other Specialized Adult Assessment. This refers to other specialized assessments for adults (e.g., mental health, psychological, educational, employment). In general, assessments refer to the more in-depth information gathering process to determine the extent of a given problem and identify the appropriate services and supports needed. Assessments are done by trained and qualified professionals.

Children's Services

Early Intervention. Early intervention refers to those services provided to children aged 0 to 3 years or 0 to 5 years (depending on the funding) who have been assessed as experiencing delays or disabilities, or are at risk of delays/disabilities, in any area of functioning (e.g., cognitive, physical, social-emotional, motor, language, vision, and hearing). Early intervention is typically provided by qualified service providers that might include: special educators, speech-language pathologists and audiologists, occupational therapists, physical therapists, psychologists, social workers, nurses, nutritionists, family therapists, orientation and mobility specialists, and pediatricians/physicians.

Developmental Services. Developmental services are provided to support children of any age in developing skills for functional living and achieving greater self-sufficiency.

Remedial/Academic Supports. This refers to specific strategies and supports that are designed to assist children 5 years and older to improve their cognitive/academic functioning.

Mental Health Counseling Services. This refers to traditional individual, group, and/or family counseling sessions provided in either residential/inpatient or outpatient settings that engage individuals, families, or groups to achieve mental health/well-being, wellness, and personal goals. *Note: Trauma services and other therapeutic services are listed separately below.*

Trauma Services for Children/Youth. Trauma-focused interventions are designed specifically for children suffering from child traumatic stress who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the traumatic events have ended. Trauma services may be designed to address children and families' traumatic stress reactions and experiences; enhance emotional regulation and anxiety management skills; facilitate adaptive coping and maintain adaptive routines; promote adaptive developmental progression; address grief and loss; promote safety skills; and other similar things. Examples of trauma-focused interventions include, but are not limited to:

- Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)
- Adapted Dialectical Behavior Therapy for Special Populations (DBT-SP)
- Attachment, Self-Regulation, and Competence (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth
- Child Adult Relationship Enhancement (CARE)
- Child Parent Psychotherapy (CPP)
- Cognitive Behavioral Intervention for Trauma in Schools
- Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse (CPC-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Trauma Systems Therapy (TST)

Therapeutic Services. For purposes of the RPG Program classification, therapeutic services refer to the other types of psychiatric and psychological services – other than mental health counseling and trauma services listed above – designed to address a child's socio-emotional areas of development such as attachment difficulties, personality disorders, offending behavior, addictions, and others. Therapeutic services can be provided to any age child and do not include such things as motor skills and cognitive development (e.g., reading, writing).

Substance Abuse Treatment for Children/Youth with Substance Use Disorders. For purposes of the RPG Program process, this refers to substance abuse treatment provided to children/youth who have their own identified substance use disorder requiring treatment. (See above description of substance abuse treatment for adults.) This is *not* intended to refer to

substance abuse-related services a child may be receiving due to their parent or caregiver's substance use disorder (but the child/youth does not have a substance use problem).

Housing Services and Support

The following program strategy classifications under housing services are not necessarily mutually exclusive; a grantee may provide more than one type of housing service:

Housing Support Services, which includes basic assistance in obtaining safe, affordable, permanent housing and developing needed life skills to maintain housing.

Housing Assistance Services, which includes help with things like accessing housing funds and subsidies, completing housing applications, working with property owners or assistance programs, negotiating leases on behalf of families, understanding and complying with the housing program's regulations, and other related assistance.

Emergency Shelter, which is designed to meet the immediate, short-term needs of an individual or family and is typically provided for purposes of crisis intervention and immediate stabilization. The length of stay can range from one night up to as long as 90 days, but typically averages 30 days or less.

Transitional, Interim, or Temporary Short-Term Housing, which is designed to provide housing and appropriate support services (e.g., case management, budgeting, parenting, employment assistance, substance abuse treatment) to facilitate a client's movement to independent living typically within 12 to 24 months. These types of programs assist people who are ready to move beyond emergency shelter, but need additional support services to develop the skills needed to move towards and sustain permanent housing.

Permanent Supportive Housing is long-term community-based housing provided with direct social support services for a given time period. The intent of this type of supportive housing is to enable individuals with special needs (e.g., substance use disorders) live as independently as possible in a permanent setting. The supportive services may be provided on-site or at agency offices by the organization managing the housing or by other public or private service agencies. There is no definite length of stay. While many people remain in permanent supportive housing for many years, some successfully transition into private, permanent housing. (The Housing First model is an example of permanent supportive housing.)

Permanent Housing, which is housing that is safe, stable and meets the client's long-term housing needs. In contrast to permanent supportive housing, permanent housing does not provide additional supportive services. Tenants of permanent housing sign legal lease documents.

Cross-Systems/Interagency Collaborative Activities

Collaborative activities can be broken down into two broad categories. The first category includes activities that are more *clinical* and operational in nature, and designed to improve services and service delivery to children/families. The focus of these activities is on the family and case planning. The second grouping includes more cross-agency *policy- or program-*

centered activities, which look at barriers to integrated service delivery and are designed to improve the overall RPG program and its functioning as a cross-agency partnership.

Clinical-Related Activities

- Cross-systems clinical training on substance abuse, child welfare, and related clinical issues (focus on how these issues impact the family and implications for serving families)
- Development of formalized cross-systems policies and procedures that are designed to improve communication, identification, referrals, and service delivery
- Regular joint case staffing meetings (e.g., to discuss families' case plans or other clinical and treatment issues)
- Co-location of staff to assist with screening, assessment, identification, referral, and/or provision of services

Program and Policy-Related Activities

- Staff training on admission criteria, referral protocols, and other policies and procedures related to how the overall RPG program functions and operates
- Cross-systems information sharing and data analysis
- Regular regional partnership meetings to discuss program and policy issues (e.g., committee or workgroup meetings)
- Regular program management/administrative meetings to review RPG progress and direct policy change

APPENDIX D: OVERVIEW OF SELECTED EVIDENCE-BASED PRACTICES GRANTEES IMPLEMENTED

As described in Chapter II, the grantees implemented various evidence-based practices, most frequently in the areas of trauma services and parenting or family strengthening. This appendix provides a brief description of some of the evidence-based practices that grantees implemented. Descriptions come primarily from SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) and the California Evidence-Based Clearinghouse for Child Welfare.³ This is not an exhaustive list of all evidence-based practices available for families involved in child welfare who are impacted by parental substance use disorders.

Addictions and Trauma Recovery Integrated Model (ATRIUM)

ATRIUM is a 12-session recovery model designed for groups as well as for individuals and their therapists and counselors. The acronym, ATRIUM, is meant to suggest the recovery groups are a starting point for healing and recovery. This model has been used in local prisons, jail diversion projects, AIDS programs, and drop-in centers. The ATRIUM model brings together peer support, psycho-education, interpersonal skills training, meditation, creative expression, spirituality, and community action to support individuals in addressing and healing from trauma.⁴

Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT)

AF-CBT (originally named Abuse-Focused Cognitive-Behavioral Therapy) is based on principles derived from learning and behavioral theory, family systems, cognitive therapy, developmental victimology, and the psychology of aggression. The treatment integrates specific techniques to target school-aged children who have experienced maltreatment, their caregivers, and the larger family system. Through training in specific intrapersonal and interpersonal skills, AF-CBT seeks to promote the expression of appropriate/pro-social behavior and discourage the use of aggressive or hostile behavior.

AF-CBT addresses the key risks for and clinical consequences of exposure to family aggression, conflict, and coercion. Key risks include coercive parenting practices, anger hyperarousal, negative child attributions, and family conflict. The clinical consequences include child aggression, poor interpersonal skills/functioning, and emotional reactivity. In general, AF-CBT attempts to address both clinical (well-being) and safety concerns by integrating training in

³ NREPP (<http://nrepp.samhsa.gov/>) is a searchable online database of mental health and substance abuse interventions. All interventions in the database have met NREPP's minimum requirements for review and been independently assessed and rated for Quality of Research and Readiness for Dissemination. The California Evidence-Based Clearinghouse for Child Welfare (<http://www.cebc4cw.org/>) provides child welfare professionals with information about the research evidence for selected child welfare related programs.

⁴ Healing from Trauma: Trauma-Specific Interventions (n.d.). *SAMHSA Substance Abuse and Mental Health Services Administration*. Retrieved July 24, 2013 from <http://www.samhsa.gov/nctic/healing.asp#atrium>.

general psychological skills and, if relevant, treatment focusing upon a specific aggressive, abusive, or traumatic experience.⁵

Celebrating Families!

Celebrating Families! (CF!) is a 16-week parenting skills training program designed for families in which one or both parents are in early stages of recovery from substance addiction and there is a high risk for domestic violence and/or child abuse. CF! is currently used by drug courts, dependency courts, faith-based organizations, residential and outpatient treatment services, and social service agencies serving parents and children 3 to 17 years of age. The CF! program uses a cognitive behavioral theory (CBT) model to achieve three primary goals:⁶

- Break the cycle of substance abuse and dependency within families.
- Decrease substance use and reduce substance use relapse.
- Facilitate successful family reunification.

Child-Parent Psychotherapy (CPP)

CPP is a treatment for trauma-exposed children aged 0 to 5 years. Typically, the child is seen with his or her primary caregiver, and the dyad is the unit of treatment. CPP examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.⁷

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a frequently used psychotherapeutic orientation that integrates the rationale and techniques from both cognitive therapy and behavioral therapy. For example, as cognitive therapy seeks to change behavior by challenging maladaptive thoughts, behavioral therapy employs more direct, yet complimentary methods, such as pairing reinforcing

⁵ Alternatives for Families: A Cognitive-Behavioral Therapy (n.d.). *The California Evidence-Based Clearinghouse for Child Welfare (CEBC)*. Retrieved July 24, 2013 from <http://www.cebc4cw.org/program/alternatives-for-families-a-cognitive-behavioral-therapy/>. More information is available at www.afcbt.org.

⁶ Celebrating Families! (n.d.). *SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)*. Retrieved July 24, 2013 from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100>. More information is available at www.celebratingfamilies.net.

⁷ Child-Parent Psychotherapy (n.d.). *The California Evidence-Based Clearinghouse for Child Welfare (CEBC)*. Retrieved July 24, 2013 from <http://www.cebc4cw.org/program/child-parent-psychotherapy/>

stimuli with a desired behavior or aversive stimuli with an undesired behavior. While the efficacy of CBT has been firmly established in the treatment of a variety of disorders and problems, its history and utility are deeply rooted in the treatment of anxiety and depression symptoms. In contrast to other forms of psychotherapy, CBT aims to quickly resolve maladaptive thoughts or behaviors without necessarily delving too deeply into why they may occur. Thus, effective courses of therapy might be as short as a single session, or as long as a lifetime, depending on the specific needs of the individual. CBT helps individuals deal with their difficulties by changing their thinking patterns, behaviors, and emotional responses.⁸

Helping Women Recover: A Program for Treating Substance Abuse and Beyond Trauma: A Healing Journey for Women

Helping Women Recover: A Program for Treating Substance Abuse and Beyond Trauma: A Healing Journey for Women are manual-driven treatment programs that, when combined, serve women in criminal justice or correctional settings who have substance use disorders and are likely to have co-occurring trauma histories (i.e., sexual or physical abuse). A community version of the intervention also is available; it has been delivered in residential and outpatient substance abuse treatment settings, mental health clinics, and domestic violence shelters.

The goals of the intervention for women in a criminal justice or correctional setting are to reduce substance use, encourage enrollment in voluntary aftercare treatment upon parole, and reduce the probability of re-incarceration following parole. The trauma-informed treatment sessions are delivered by female counseling staff (who may be assisted by peer mentors, typically women serving life sentences) to groups of 8 to 12 female inmates, in a non-confrontational and non-hierarchical manner. The counselors use a strengths-based approach with a focus on personal safety to help clients develop effective coping skills, build healthy relationships that foster growth, and develop a strong, positive interpersonal support network.

Helping Women Recover and Beyond Trauma sessions both use cognitive behavioral skills training, mindfulness meditation, experiential therapies (e.g., guided imagery, visualization, art therapy, movement), psycho-education, and relational techniques to help women understand the different forms of trauma, typical reactions to abuse, and how a history of victimization interacts with substance use to negatively impact lives. The two programs can be delivered together as one intervention or separately as independent, stand-alone treatments.

The Helping Women Recover program consists of 17 sessions organized around 4 domains: (1) Self, (2) Relationship/Support Systems, (3) Sexuality, and (4) Spirituality. The Beyond Trauma program consists of 11 sessions organized around 3 domains: (1) Violence, Abuse, and Trauma, (2) Impact of Trauma, and (3) Healing From Trauma.⁹

⁸ Cognitive Behavioral Therapy for Depression and Anxiety Disorders (n.d.). *SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)*. Retrieved July 24, 2013 from <http://www.nrepp.samhsa.gov/CBT.aspx>.

⁹ Helping Women Recover and Beyond Trauma (n.d.). *SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)*. Retrieved July 24, 2013 from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=181>. More information is available from www.stephaniecovington.com.

Honoring Children, Mending the Circle (HC-MC)

Honoring Children, Mending the Circle (HC-MC) is a tribal, cultural adaptation of Trauma-Focused Cognitive Behavior Therapy (TF-CBT). This model combines trauma-sensitive interventions with elements of cognitive behavioral therapy into a treatment designed to address the unique needs of children with Post-Traumatic Stress Disorder and other problems related to traumatic life experiences. It is appropriate for most types of trauma and for children up to the age of 18.¹⁰ Project Making Medicine (PMM) is a national clinical training program built around the Honoring Children, Mending the Circle curriculum. PMM is for mental health professionals from tribal, urban, Indian Health Service, and residential treatment agencies who provide child abuse prevention services and treatment to children and youth.

Matrix Model

The Matrix Model is an intensive outpatient treatment approach for stimulant abuse and dependence that was developed through 20 years of experience in real-world treatment settings. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use through urine testing. The program includes education for family members affected by the addiction.

The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct, but not confrontational or parental. Trained therapists conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth.¹¹

Moral Reconciliation Therapy

Moral Reconciliation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth.

MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments. The MRT workbook is structured around 16 objectively defined steps (units) focusing on 7 basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning. Participants meet

¹⁰ Evidence Based Interventions for Culturally Appropriate Treatment for American Indian/Alaska Native Children (n.d.). *Indian Country Child Trauma Center*. Retrieved July 24, 2013 from <http://www.icctc.org/treatment.htm>.

¹¹ Matrix Model (n.d.) *SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)*. Retrieved July 24, 2013 from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=87>. More information is available at www.matrixinstitute.org.

in groups once or twice weekly and can complete all program steps in a minimum of 3 to 6 months.¹²

Motivational Interviewing

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. MI's operational assumption is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change; examination and resolution of ambivalence become the key goal. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. Although many variations in technique exist, the MI counseling style generally includes the following elements:¹³

- Establishing rapport with the client and listening reflectively
- Asking open-ended questions to explore the client's own motivations for change
- Affirming the client's change-related statements and efforts
- Eliciting recognition of the gap between current behavior and desired life goals
- Asking permission before providing information or advice
- Responding to resistance without direct confrontation
- Encouraging the client's self-efficacy for change
- Developing an action plan to which the client is willing to commit

Nurturing Parenting Program

The Nurturing Parenting Program (NPP) is a universal, curriculum-based parenting program. The approach is to teach age-specific parenting skills along with addressing the need to nurture oneself. Curricula are available for parents and their children aged 0 to 18 years. The curricula may be delivered in a group-based setting or through individual home visits. The program focuses on developing nurturing skills as alternatives to punitive parenting practices. The sessions include parenting instruction on discipline, nurturing, communication, and child

¹² Moral Reconciliation Therapy (n.d). *SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)*. Retrieved July 24, 2013 from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=34>. More information is available at www.moral-reconciliation-therapy.com.

¹³ Motivational Interviewing (n.d). *SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)*. Retrieved July 24, 2013 from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=130>. More information also is available at www.motivationalinterviewing.org.

development. Self-nurturing instruction is always included. Role playing, discussions, skills practice, and role modeling are methods employed as teaching strategies.¹⁴

Nurturing Program for Families in Substance Abuse Treatment and Recovery

The Nurturing Program for Families in Substance Abuse Treatment and Recovery is an adaptation of NPP that focuses on the effects of substance abuse on families, parenting, and the parent-child relationship. The approach combines experiential and didactic exercises to enhance parents' self-awareness and thereby increase their capacity to understand their children. The program assists parents in re-establishing strong connections with their children.¹⁵

Parent Child Interaction Therapy (PCIT)

Parent-child interaction therapy (PCIT) is a prevention program focused on improving the quality of the parent-child relationship through skill-building and promoting positive parent-child interaction. It was developed specifically for conduct-disordered young children (preschool and early elementary school age) and includes use of a one-way mirror and "bug in the ear." The treatment focuses on two basic interactions:

- Child Directed Interaction (CDI), which is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship.
- Parent Directed Interaction (PDI), which resembles clinical behavior therapy in that parents learn to use specific behavior management techniques as they play with their child.¹⁶

Parent-Child Attunement Therapy (PCAT)

Parent-child attunement therapy (PCAT), an adaptation of PCIT, is a promising intervention for toddlers (aged 12 to 30 months) who have experienced child maltreatment. PCAT has two overall purposes: 1) to strengthen caregivers' relationship with their children and 2) to facilitate caregivers' learning of appropriate child management techniques. As toddlerhood represents a critical period for enhancing the relationship between caregivers and children and is a stage when

¹⁴ FRIENDS National Resource Center for Community-Based Child Abuse Prevention (September 2009). *Evidence-Based and Evidence-Informed Programs: Prevention program descriptions classified by CBCAP evidence-based and evidence-informed categories*. Retrieved July 24, 2013 from <http://friendsnrc.org/cbcap-priority-areas/evidence-base-practice-in-cbcap/evidence-based-program-directory>. More information is available at www.nurturingparenting.com.

¹⁵ Nurturing Program for Families in Substance Abuse Treatment and Recovery (n.d.). *The California Evidence-Based Clearinghouse for Child Welfare (CEBC)*. Retrieved July 24, 2013 from <http://www.cebc4cw.org/program/nurturing-program-for-families-in-substance-abuse-treatment-and-recovery/detailed>. More information is available at www.healthrecovery.org.

¹⁶ FRIENDS National Resource Center for CBCAP (September 2009). *Evidence-Based and Evidence-Informed Programs: Prevention program descriptions classified by CBCAP evidence-based and evidence-informed categories*. Retrieved July 24, 2013 from <http://friendsnrc.org/cbcap-priority-areas/evidence-base-practice-in-cbcap/evidence-based-program-directory>. More information is available at www.pcit.org.

youngsters are at increased risk for maltreatment, the objectives of PCAT become even more salient during the toddler years.¹⁷

Positive Indian Parenting¹⁸

Positive Indian Parenting (PIP) is a parent education curriculum developed by the National Indian Child Welfare Association to promote positive parenting. The curriculum relies heavily on values clarification and development, using traditional cultural teaching as a base for effective parenting. The curriculum was developed through extensive consultation with tribal elders, Native social welfare professionals, and parents. While the specific content of PIP may be flexible from tribe to tribe, core principles are maintained across sites:

- Traditional culture offers positive parenting that was effective for centuries
- Positive parenting is rooted in spiritual teachings that direct how children should be treated
- The oral traditions of tribes necessitate effective communication skills
- Parents are the first teachers and are responsible for transmission of values
- Nurturing a child is an essential cultural value
- Children cannot learn a skill until they are developmentally ready
- Teaching self discipline is the ultimate form of behavior management
- Teaching children their place in the world and helping them develop skills to successfully interact with their environment is an essential part of parenting
- Reinforcement based in ceremony, ritual, relationship, and non-verbal communication is a powerful tool for shaping positive behavior, identity, and self and group esteem

Seeking Safety

Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psycho-education and has five key principles:

¹⁷ Dobrowski, S.C., Timmer, S.G., Blacker, D.M., & Urquiza, A.J. (2005). A positive behavioural intervention for toddlers: Parent-child attunement therapy. *Child Abuse Review*. 14(2), 132-151. More information is available at www.pcit.org.

¹⁸ Sources include: Positive Indian Parenting: Honoring our Children by Honoring our Traditions (n.d.). National Indian Child Welfare Association. Retrieved July 24, 2013 from http://www.nicwa.org/resources/curriculum/?p=Curriculum_12; and Cross, T., Friesen, B. & Maher, N. (2007). Successful strategies for improving the lives of American Indian and Alaska Native youth and families. Vol. 21:2. Portland, OR: Regional Research Institute for Human Services, Portland State University. Retrieved September 18, 2013 from <http://www.pathwaysrtc.pdx.edu/pdf/fpS0704.pdf>. More information on PIP is available from www.nicwa.org.

- Safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions)
- Integrated treatment (working on both posttraumatic stress disorder and substance abuse at the same time)
- A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse
- Addressing four content areas: cognitive, behavioral, interpersonal, and case management
- Attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).¹⁹

Strengthening Families Program

The Strengthening Families Program (SFP) is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3 to 16 years old. Dr. Carol Kumpfer developed and tested the original evidence-based SFP with a NIDA research grant with children of substance abusing parents. SFP comprises three life-skills courses delivered in 14 weekly, 2-hour sessions.

- Parenting Skills sessions help parents learn to increase desired behaviors in children by using attention and rewards, clear communication, effective discipline, substance use education, problem solving, and limit setting.
- Children's Life Skills sessions help children learn effective communication, understand their feelings, improve social and problem-solving skills, resist peer pressure, understand the consequences of substance use, and comply with parental rules.
- Family Life Skills sessions engage families in structured family activities and enable them to practice therapeutic child play, conduct family meetings, learn communication skills, practice effective discipline, reinforce positive behaviors in each other, and plan family activities together.

Trauma Recovery and Empowerment Model (TREM)

The Trauma Recovery and Empowerment Model (TREM) is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24- to 29-session group emphasizes the development of coping skills and social support. TREM addresses both short-term and long-term consequences of violent victimization, including mental health symptoms, especially post-traumatic stress disorder (PTSD) and depression, and substance abuse. TREM has been successfully

¹⁹ Seeking Safety (n.d). *SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)*. Retrieved July 24, 2013 from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=139>. More information is available at www.seekingsafety.org.

implemented in a wide range of service settings (mental health, substance abuse, criminal justice) and among diverse racial and ethnic populations.²⁰

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. While initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement.

The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. TF-CBT generally involves 12 to 16 sessions of individual and parent-child therapy. However, TF-CBT also may be provided in the context of a longer-term treatment process or in a group therapy format. The acronym PRACTICE reflects the components of the treatment model:²¹

- Psychoeducation and parenting skills
- Relaxation skills
- Affect expression and regulation skills
- Cognitive coping skills and processing
- Trauma narrative
- In vivo exposure (when needed)
- Conjoint parent-child sessions
- Enhancing safety and future development

Triple P – Positive Parenting Program

The Triple P-Positive Parenting Program is a multi-level system of parenting and family support. The program focuses on enhancing children's healthy social and emotional development by building the knowledge, skills, and confidence of parents. It can be provided individually, in a group, or in a self-directed format. Triple P incorporates five levels of intervention (below) on a

²⁰ Trauma Recovery and Empowerment Model (TREM). (n.d). *SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)*. Retrieved July 24, 2013, from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=158>. More information is available from www.cdc1.org.

²¹ Trauma-Focused Cognitive Behavioral Therapy (n.d). *SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP)*. Retrieved July 24, 2013 from <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=135>. More information is available at <http://tfcbt.musc.edu>.

tiered continuum of increasing intensity for parents of children 0-16. Practitioners determine the scope of the intervention given their own service priorities and funding.²²

- Level 1 is a public awareness strategy, providing information about parenting through a coordinated media campaign.
- Level 2 is a brief health care intervention providing anticipatory developmental guidance to parents of children with mild behavior difficulties through print material and multimedia.
- Level 3 is mild direct intervention for parents of children with mild to moderate behavior difficulties and includes skills training.
- Level 4 is an intensive, group parenting program for parents of children with more severe behavior difficulties.
- Level 5 is an intensive individual family intervention program for families where parenting difficulties are complicated and other risk factors are present.

Walking in Beauty on the Red Road (WBRR)

The primary goal of WBRR is to reduce the substance abuse epidemic affecting American Indian and Alaska Native (AI/AN) youth and help positively transform negative aspects of subsequent behavioral health and social issues. The model identifies and addresses the spiritual and cultural needs of youth and their families. It weaves together indigenous cultural beliefs and teachings with Westernized approaches (e.g. cognitive behavioral therapy, motivational interviewing, and crisis debriefing techniques) while providing therapeutic treatment services. The WBRR curriculum is designed as a foundation for substance abuse treatment programs to develop and replicate substance abuse treatment for AI/AN adolescents and families. WBRR was formulated for rural programs that may wish to adapt this model to fit local need.²³

²² FRIENDS National Resource Center for CBCAP (September 2009). *Evidence-Based and Evidence-Informed Programs: Prevention program descriptions classified by CBCAP evidence-based and evidence-informed categories*. Retrieved July 24, 2013 from <http://friendsnrc.org/cbcap-priority-areas/evidence-base-practice-in-cbcap/evidence-based-program-directory>. More information available at www.triplep.net/glo-en/home.

²³ Sabin, C., Benally, H., Bennett, S. & Jones, E (n.d.). *Walking In Beauty on the Red Road: A Holistic Cultural Treatment Model for American Indian and Alaska Native Adolescents and Families*. Chestnut Health Systems. Retrieved July 24, 2013 from http://www.chestnut.org/Portals/14/PDF_Documents/Lighthouse/Manuals/Shiprock-Walking_In_Beauty_on_the_Red_Road.pdf.

APPENDIX E: EXISTING FEDERAL CHILD WELFARE AND SUBSTANCE ABUSE TREATMENT DATA AND MONITORING SYSTEMS

As described in Chapter IV, the RPG performance measure results are presented, where appropriate, in relation to national child welfare data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS) and national substance abuse data from the National Outcomes Measures (NOMs) and Treatment Episode Data Set (TEDS) for the 29 states in which the RPGs are operating.

While these national data provide additional context for understanding RPG Program performance, they are not intended to serve as a comparison group for the RPG Program and do not allow for statistical comparisons to RPG participants. These systems are briefly described below.

CHILD WELFARE

Adoption and Foster Care Analysis and Reporting System (AFCARS). AFCARS is a national federally mandated reporting system that collects data on children in foster care and children who have been adopted under the auspices of the state child welfare agency. States submit their AFCARS data semi-annually.

National Child Abuse and Neglect Data System (NCANDS). NCANDS is a voluntary national data collection system that gathers state-level data once a year regarding reporting, assessment, and service provision for all investigated reports of maltreatment to state child protective service agencies. Currently, 50 states (including the District of Columbia) submit case-level data to NCANDS; one state submits aggregate data.

SUBSTANCE ABUSE

Treatment Episode Data Set (TEDS). TEDS is the federal compilation of data collected by state substance abuse agencies to monitor treatment admissions. TEDS includes client demographic data and characteristics of admissions to and discharges from publicly funded substance abuse treatment.

National Outcome Measures (NOMs). The NOMs are performance targets for state and federally funded initiatives and programs for substance abuse and mental health prevention, early intervention, and treatment services. NOMs tracks and measures real-life outcomes for people in recovery from mental health and substance use disorders.

APPENDIX F: DETAILED PERFORMANCE MEASURE METHODOLOGY

INTRODUCTION

As discussed in Chapter IV, due to the flexibility and discretion HHS allowed grantees in developing both their program models and local evaluation designs, assessment of the overall RPG Program's progress was not designed as or intended to be a cross-site evaluation. Rather, HHS implemented a mixed-methods performance measurement approach that used multiple quantitative and qualitative data sources to provide a comprehensive descriptive and analytical picture of the 53 grantees' performance.

This Appendix provides additional detail²⁴ on:

- Definitions of grantees' research designs.
- Data collection, reporting, analyses, and limitations of the standardized safety, permanency, and recovery performance measures.
- Data collection, reporting, analyses, and limitations of the child, adult, and family well-being measures.

GRANTEE RESEARCH DESIGNS: BRIEF DEFINITIONS

Grantee designs were categorized based on inclusion or exclusion of randomized control groups or non-randomized comparison groups, resulting into three types of research designs:

1. Experimental treatment with a randomized control group. Experimental treatment designs are those in which eligible participants are randomly assigned either to a treatment group to receive specified intervention services or to a control group with no intervention. Randomized control groups are those in which control group members are randomly drawn from a larger sample. With experimental design, random selection occurred after appropriate cases have been identified for treatment. Four grantees used this type of design.
2. Quasi-experimental treatment with a non-randomized comparison group. Quasi-experimental designs are those in which the treatment group is compared to a non-equivalent comparison group. There are several types of quasi-experimental designs. A same-time comparison group is where the treatment group is compared with a similar but different group at the same point in time; for instance, to those in a neighboring jurisdiction or those wait-listed for treatment (21 grantees used this type of design). A historical comparison group is one in which the treatment group is compared with a similar but different group at a

²⁴ The additional information included here supplements, but does not necessarily repeat what is contained in the discussion of each performance measure in Chapters VI through IX. Please refer to the full report for pertinent background or contextual information related to each measure's definition or calculation (where needed), and noteworthy data analysis, interpretation, and clarification issues.

different point in time; for instance, prior to program implementation (17 grantees used this type of design). These comparison groups may be matched, unmatched, or aggregate.

Matched comparison groups are drawn based on specified demographic characteristics, in some cases using propensity score matching techniques. This method also is used with stratified samples selected to represent (and over-represent) groups with certain characteristics, and can be at the population or case level. Population-level matched comparisons may be a county with similar demographic characteristics or another provider's caseload that is similar to the treatment group. Case-level matched comparisons are those in which matching occurs at a case-specific basis. For instance, each case receiving RPG services is matched and compared with a similar case not selected for services.

An unmatched comparison group would be a non-equivalent comparison group in which cases are selected without regard to key demographic variables or other criteria shared by the treatment group. Aggregate comparison groups are those in which the grantee plans to use statewide, countywide, or some other jurisdiction statistics as a comparison.

3. Pre-experimental treatment with no comparison group. These are designs in which the grantee did not plan to use a comparison group. Eleven grantees used this approach.

DATA COLLECTION, REPORTING, ANALYSES, AND LIMITATIONS OF STANDARDIZED CHILD AND ADULT PERFORMANCE MEASURES

Data Collection and Reporting

During the first year of the RPG Program, HHS, with Office of Management and Budget approval, developed a robust web-based RPG Data Collection and Reporting System to compile the performance measure data across all 53 grantees. Grantees began submitting case-level child and adult data to the RPG Data System in December 2008 and then uploaded their latest cumulative data files in December and June of each program year. Grantees' final data upload was in December 2012. The RPG Data System links data for children and adults together as a family unit and follows clients served over the course of the grant project, making it the most extensive quantitative dataset currently available on outcomes for children, adults, and families affected by substance abuse and child maltreatment.

Grantees collected and reported on the performance measures that aligned with their program models, services and activities, goals, and intended outcomes.²⁵ While grantee programs may have varied in terms of the interventions implemented, grantees reporting on the same performance measures submitted their data with specified data elements drawn from existing substance abuse and child welfare treatment reporting systems. Thus, grantees submitted data using standardized definitions and coding to ensure consistency across RPG grantees collecting the same performance measures. Each grantee was provided with individualized customized

²⁵ The variance and diversity in program-specific strategies across the 53 grantees necessitated flexibility regarding which of the 23 RPG performance measures each grantee reported. For example, some grantees' program strategies targeted adults, while others focused specifically on child-centered interventions. Grantees also may have collected additional measures beyond the 23 RPG measures and reported those results as part of their Semi-Annual or Final Progress Reports or in a separate local evaluation report.

data plans for each of their RPG participant and control/comparison groups (some grantees had multiple treatment and control/comparison groups). Each customized data plan included child and adult demographic information and the distinct data elements required to calculate the selected standardized child and adult performance measures. The creation of individual data plans allowed for case-level data to be submitted in a standardized uniform file format,²⁶ which further ensured consistent data collection and reporting across RPG grantees. This standardization and consistency in reporting allowed for statistical analyses with the RPG participant groups and additional contextual comparison in relation to selected national child welfare and substance abuse performance measures (see *Data Analyses* section below).

To further strengthen data quality and consistency, two immediate levels of automated quality assurance checks occurred when grantees submitted their data to the RPG Data System. The first level of checks validated the accuracy of individual data elements based on valid coding and date ranges (e.g., a date of 2015 is identified as invalid, as the year has not occurred). The second level of review involved approximately 150 data validation checks that addressed illogical coding (e.g., a male client is coded as pregnant), as well as potential relational inconsistencies or possible errors between data elements (e.g., a substance abuse assessment that occurs after substance abuse treatment entry instead of prior to entry). To complete their data uploads, grantees had to correct definite coding errors and confirm or correct warnings regarding potential data inconsistencies.

Data Analyses

All performance measure calculations and analyses were conducted using IBM SPSS software. Specific data analysis steps taken included:

- Restructuring the child and adult data were so that child maltreatment and substance abuse treatment data for the same person could be seen on the same line rather than as multiple records for the same case. This allowed for individual level analysis of sequential child maltreatment or substance abuse treatment episodes over time.
- Coding data for children, adults, and families as RPG participant, RPG control, or RPG comparison group, based on a grantee's research design classification.
- Testing for equivalence between RPG participant (i.e., treatment) and RPG control/comparison groups, given the variation in grantees' research designs. One-way ANOVA and chi-square analyses were used to determine if baseline differences existed between the populations. Statistically significant differences were detected between the groups on several key demographic characteristics for both children and adults. Due to these differences in demographics, statistical tests of significance between RPG participant and control/comparison groups on the performance measures were not conducted for this report. However, if a subgroup of grantees submitted sufficient control/comparison group data (a sample size of 35 or more for both their participant and comparison/control groups) on a given measure, a brief summary of grantees' performance in relation to their own control or comparison groups was provided.

²⁶ All grantees submitted their case-level data in standardized Extensible Markup Language (XML) format.

- Conducting descriptive statistics to yield means, medians, ranges, frequency distributions, and percentages for the RPG participant groups. For the descriptive findings presented, data on all RPG program participants across all grantees were combined
- Conducting performance measure analyses by selected child and adult demographics (e.g., age, gender, race/ethnicity, program year) for the RPG participant groups.
- Where appropriate, presenting the RPG performance measure results in relation to the median performance (50th percentile) based on the national child welfare data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS) and substance abuse treatment data from the National Outcomes Measures (NOMs) and Treatment Episode Data Set (TEDS) for the 29 states in which the grantees are operating. The national data provide additional comparative context for interpreting the RPG performance measures. However, the national data are not intended to serve as a comparison group for the RPG Program and do not allow for inferential analyses of comparisons to RPG participants, as these data do not reflect random assignment or matched characteristics of RPG program participants.

General Child Welfare Data Limitations and Caveats

The majority of the RPG child performance measures align with existing standardized performance measures in federal child welfare outcome reporting systems (e.g., AFCARS, NCANDS). Thus, the required data elements exist in a state or county's automated child welfare data systems. These measures primarily assess child welfare outcomes (e.g., child maltreatment, placement in foster care, timeliness of reunification and permanency).

Despite standardized reporting, variations in state data persist. Each state has its own definitions of child abuse and neglect based on minimum standards set by federal law. Federal legislation provides a foundation for states by identifying a minimum set of acts or behaviors that define child abuse and neglect. The *Federal Child Abuse Prevention and Treatment Act (CAPTA)*, (42 U.S.C.A. §5106g), as amended by the *Keeping Children and Families Safe Act of 2003*, defines child abuse and neglect as: Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm. Within the minimum standards set by CAPTA, each state is responsible for providing its own definitions of child abuse and neglect.

Differences in state statutes, policies, and practices regarding definitions of child maltreatment and evidentiary requirements for substantiation of a child maltreatment allegation may affect data. The data also may be affected by decisions regarding investigations of maltreatment allegations (i.e., whether an allegation is "screened out," and therefore not investigated, or whether an allegation is referred for an alternative response rather than an investigation).²⁷ For

²⁷ U.S. Department of Health and Human Services, Administration for Children and Families: *Child Welfare Outcomes 2002-2005: Report to Congress*. Washington, DC: Author, 2007. Available online at: www.acf.hhs.gov/programs/cb/pubs/cwo05/index.htm.

the purposes of the RPG analysis, a child is considered a maltreatment victim if he or she is the subject of a substantiated or indicated allegation of child abuse or neglect.

*General Substance Abuse Treatment Data Limitations and Caveats*²⁸

The majority of the RPG adult performance measures align with existing standardized performance measures in the federal substance abuse treatment outcome reporting system (TEDS) and the required data elements exist in a state or county's automated substance abuse treatment data system. These measures primarily measure adult substance abuse treatment outcomes (e.g., improved access and retention, increased employment, and reduced substance use and criminal behavior).

TEDS is the federal compilation of data collected by state substance abuse agencies to monitor treatment admissions. It includes client demographic data and characteristics of admissions to and discharges from publicly funded substance abuse treatment. TEDS comprises a significant proportion of, but not all substance abuse treatment admissions. In general, facilities reporting TEDS data receive state substance abuse agency funds (including federal block grant funds) for the provision of treatment services. However, the scope of treatment facilities included in TEDS is affected by differences in state licensure, certification, accreditation, and disbursement of public funds. TEDS also typically does not include data on facilities operated by federal agencies including the Bureau of Prisons, the Department of Defense, and the Veterans Administration, though some facilities operated by the Indian Health Service are included.

The number and client mix of TEDS admissions does not represent the total national demand for substance abuse treatment or the prevalence of substance abuse in the general population. TEDS is an admission-based system and does not represent the number of unique individuals. For example, an individual admitted to treatment twice within a calendar year would be counted as two admissions, as would transfers to a different level of service.

The primary, secondary, and tertiary substances of abuse at admission that are reported to TEDS are the substances that led to the treatment episode, and do not necessarily provide a complete account of all substances the client may have been using at the time of admission. In addition, four states (Arkansas, Connecticut, Oregon, and Texas) do not distinguish between methamphetamine and amphetamine use at admission; however, nationally, methamphetamine comprises the vast majority of methamphetamine/amphetamine admissions.

States continually review their data quality and may revise or replace historical TEDS data files with corrected or updated data, if needed. While this process serves to improve the overall data system, it may mean that the historical data reported in current TEDS reports may differ slightly from those published in earlier reports. Though the number of admissions for a reporting period

²⁸ Sources include the following reports from Substance Abuse and Mental Health Services Administration, Office of Applied Studies: *Treatment Episode Data Set (TEDS): 2005. Discharges from Substance Abuse Treatment Services*, DASIS Series: S-41, DHHS Publication No. (SMA) 08-4314, Rockville, MD, 2008; *The DASIS Report: Primary Methamphetamine/Amphetamine Treatment Admissions: 1992-2002*. (2004, September 14). Rockville, MD; and *Treatment Episode Data Set (TEDS):1994-1999. National Admissions to Substance Abuse Treatment Services*, DASIS Series: S-14, DHHS Publication No. (SMA) 01-3550, Rockville, MD, 2001.

may increase as submissions continue, additional submissions are unlikely to have a significant effect on the larger percentage distributions reported by TEDS.

DATA COLLECTION, REPORTING, ANALYSES, AND LIMITATIONS OF THE WELL-BEING MEASURES

Data Collection and Reporting

As discussed in Chapters IV and IX, grantees assessed five of the well-being measures (child well-being, adult mental health, parenting capacity, family relationships and functioning, and risk and protective factors) using valid and reliable clinical instruments they identified as appropriate for their specific program model and target population. HHS did not require grantees to use specific clinical instruments or the same instruments to measure these indicators. Therefore, there was variability among grantees in which instruments they selected, how they used them, and the specific data variables they collected.

Among the more than 50 different instruments grantees used to measure these well-being concepts, HHS identified nine of the most commonly selected valid and reliable instruments expected to yield sufficient sample sizes over the course of the RPG Program for analysis:

- Addiction Severity Index (ASI)
- Adult-Adolescent Parenting Inventory (AAPI)
- Ages and Stages Questionnaire (ASQ)
- ASQ Social-Emotional (ASQ-SE)
- Beck Depression Inventory
- Child Behavior Checklist (CBCL)
- North Carolina Family Assessment Scales (NCFAS, NCFAS-G or NCFAS-R)
- Parenting Stress Index (PSI)
- Protective Factors Survey

The subsets of grantees using these instruments submitted their cumulative, case-level, instrument-specific data files to the RPG Data System every six months. Their final data upload was December 2012.²⁹ Each of the case-level instrument-specific data files were standardized using the same format and coding structure across grantees and combined into a uniform database for each of the nine specified instruments.

²⁹ Grantees that used other instruments and methods to assess the well-being measures reported their findings in their Semi-Annual Progress Reports, Final Progress Report, and/or local evaluation reports.

Follow-up was conducted with grantees (as needed) after their data submission to obtain additional information, clarify the grantee's file structure, and resolve issues regarding missing, incomplete, or duplicate data that affected the ability to analyze the data. HHS provided continued technical assistance to grantees to address and reduce errors and missing data.

Table 1 below provides a brief description of each instrument, how it is scored, the number of grantees using that instrument, and final sample sizes.

Table 1: Selected Common Instruments Used by Subgroups of Grantees to Measure Child, Adult, and Family Well-Being: Description of Instruments and Current Sample Sizes for RPG Participants (as of September 30, 2011)

Instrument	Brief Description	Structure/Domains	Scoring	Administration	Current RPG Sample Size (N) ³⁰	Number of RPGs Data Represent
Addiction Severity Index (ASI) and ASI-Lite	Designed to measure the severity of an individual's potential problems prior to or after treatment.	The instrument gathers information about specific areas of a patient's life and calculates composite scores for seven areas commonly affected by substance dependence: <ul style="list-style-type: none"> • Medical Status • Employment Status • Alcohol Use • Drug Use • Legal Status • Family/Social Status • Psychiatric Status 	5-point patient rating scale (ranging from 0=Not at all to 4=Extremely) is used as a subjective measure for patients to rate the severity of their own problems in each domain. Composite scores are calculated for each domain and used to measure change in clients over time. The full ASI also includes interviewer severity ratings for each domain and lifetime severity. The ASI-Lite includes all questions necessary to compute the composite scores and meets the minimum requirements needed to conduct outcomes research.	Semi-structured interview. Follow-up interviews may be conducted no earlier than one month from the previous interview.	171 Baseline and Discharge	4 ³¹
Adult-Adolescent Parenting Inventory (AAPI)	Designed to assess parenting and child-rearing attitudes and provide an index of risk for practicing behaviors known to be associated with child abuse and neglect. Scores parent perceptions about parenting and raising children or can be used to diagnose abuse/neglect in adolescent populations. Adolescents as young as 13 can respond to the AAPI.	Assesses five constructs: Construct A – Inappropriate Expectations of Children Construct B – Parental Lack of Empathy towards Children's Needs Construct C – Strong Belief in the Use of Corporal Punishment as a Means of Discipline Construct D – Reversing Parent-Child Role Responsibilities Construct E – Oppressing Children's Power and Independence	Each item is rated on 5-point scale ranging from Strongly Agree to Strongly Disagree. Scores are totaled and converted into standard (sten) scores ranging from 1 to 10 to provide an index of high (1-3), moderate (4-7), and low (8-10) risk.	There are 2 forms: Form A and Form B. Alternate forms may be used to conduct a pre- and post- test.	280 Baseline and Discharge	5

³⁰ Sample sizes represent the number of children, adults/caregivers, or families, depending on the instrument. Within a given instrument, sample sizes may vary somewhat by subscale or domain.

³¹ An additional three grantees collected ASI data at baseline only; these data were excluded from the change analyses presented in the report.

Table 1: Selected Common Instruments Used by Subgroups of Grantees to Measure Child, Adult, and Family Well-Being: Description of Instruments and Current Sample Sizes for RPG Participants (as of September 30, 2011)

Instrument	Brief Description	Structure/Domains	Scoring	Administration	Current RPG Sample Size (N) ³⁰	Number of RPGs Data Represent
Ages and Stages Questionnaire (ASQ)	Designed to assess the developmental progress of children 1 month to 5.5 years of age. Children are screened using the correct age interval questionnaire.	Assesses five developmental domains: <ul style="list-style-type: none"> • Communication • Gross Motor • Fine Motor • Problem Solving • Personal-Social 	Each question is rated on whether the child performs the activity regularly (10), sometimes (5), or not yet (0). Cutoff scores are provided that indicate whether there is a need for further and more in-depth assessment or additional monitoring to track the child's development at that point in time. Cutoff scores vary by age interval of the questionnaire.	Observation rating form is designed to be completed by parents/caregivers who spend time with the child on a regular basis. Program staff may choose an appropriate interval of follow-up screening depending on the child's scores.	742 Baseline only	9
ASQ - Social Emotional (ASQ-SE)	Designed to identify children 3 months to 5.5 years of age who are at risk of social or emotional difficulties. Questionnaires are included for eight age intervals.	Assesses seven behavioral areas: <ul style="list-style-type: none"> • Self-regulation • Compliance • Communication • Adaptive Functioning • Autonomy • Affect • Interaction with People 	Each question is rated on whether the child performs a behavior most of the time (0), sometimes (5), or rarely/never (10). High scores indicate higher risk for difficulties. Scores above the cutoff indicate the need for a more in-depth assessment and evaluation.	Observation rating form is designed to be completed by parents/caregivers who spend time with the child on a regular basis. Program staff may choose an appropriate interval of follow-up screening depending on the child's scores.	1,073 Baseline only	7
Beck Depression Inventory (BDI)	Measures the severity and depth of depression symptoms (minimal, mild, moderate, and severe) consistent with the criteria of the Diagnostic and Statistical Manual of Mental Disorders. May be administered to individuals 13 to 80 years old.	Measures two subscales: <ul style="list-style-type: none"> • Affective subscale (pessimism, past failures, guilty feelings, punishment feelings, self-dislike, self-criticalness, suicidal thoughts or wishes, and worthlessness) • Somatic subscale (sadness, loss of pleasure, crying, agitation, loss of interest, indecisiveness, loss of energy, change in sleep patterns, irritability, change in appetite, concentration difficulties, tiredness and/or fatigue, and loss of interest in sex) 	Each of the 21 items is rated on a 4-point scale (0 to 3) and totaled; higher ratings indicate more severe symptoms. Cutoff scores indicate minimal, mild, moderate, and severe depressive symptoms.	Self-administered, or administered verbally by a trained administrator.	570 Baseline only	5

Table 1: Selected Common Instruments Used by Subgroups of Grantees to Measure Child, Adult, and Family Well-Being: Description of Instruments and Current Sample Sizes for RPG Participants (as of September 30, 2011)

Instrument	Brief Description	Structure/Domains	Scoring	Administration	Current RPG Sample Size (N) ³⁰	Number of RPGs Data Represent
Child Behavior Checklist (CBCL)	Designed to screen for internalizing and externalizing behavioral problems in children. There are two versions: one for children aged 1.5 to 5 years and one for children aged 6 to 18 years. Other versions of this assessment are available for use by child care workers and/or teachers.	<p>The 1.5 to 5 year version screens for the following syndromes:</p> <ul style="list-style-type: none"> • Emotionally Reactive • Anxious/Depressed • Somatic Complaints • Withdrawn • Attention Problems • Aggressive Behavior • Sleep Problems <p>The 6 to 18 year version screens for the following syndromes:</p> <ul style="list-style-type: none"> • Aggressive Behavior • Anxious/Depressed • Attention Problems • Rule-Breaking Behavior • Social Problems • Somatic Complaints • Thought Problems • Withdrawn/Depressed 	Each item rated on a 3-step response scale: 0-not true, 1-somewhat/sometimes true, and 2-very true or often true. Cutoffs are provided for behavior in the normal, borderline, and clinical range. For both forms, Internalizing, Externalizing, and Total Problems scales are scored based on the syndromes. For the 6 to 18 year form, scores also are calculated for three competence scales (Activities, Social, and School) and Total Competence.	Designed to be completed by a parent/caregiver or other close relatives. A Teacher Report Form (TRF) and Youth Self Report Form (YSF) also are available to collect information from multiple raters for children aged 6 to 18 years.	<p>1.5-5 years: 406 Baseline only</p> <p>6-18 years: 153 Baseline only</p>	<p>6</p> <p>4</p>

Table 1: Selected Common Instruments Used by Subgroups of Grantees to Measure Child, Adult, and Family Well-Being: Description of Instruments and Current Sample Sizes for RPG Participants (as of September 30, 2011)

Instrument	Brief Description	Structure/Domains	Scoring	Administration	Current RPG Sample Size (N) ³⁰	Number of RPGs Data Represent
North Carolina Family Assessment Scales (NCFAS)	Designed to assess family functioning; may help determine risk of out-of-home placement for a family in the context of family strengths and problems. There are several versions of the instrument. The NCFAS is for families receiving intensive family preservation services. The NCFAS-G (General Services) is for families that may be at low to moderate risk of child maltreatment, but could benefit from services intended to reduce future risk of child maltreatment or increase the family's level of functioning. The NCFAS-R (Reunification) is targeted to reunification cases in which children have been removed from the home due to substantiated child maltreatment. The NCFAS G+R combined scale is for use by agencies that provide a wide variety of services for both intact and reunifying families. Designed to assess family functioning; may help determine the risk of out-of-home placement for a family in the context of family strengths and problems.	<p>The following domains are common to all versions (though individual items within a domain may vary slightly by instrument version):</p> <ul style="list-style-type: none"> • Environment • Parental Capabilities • Family Interactions • Family Safety • Child Well-Being <p>The NCFAS-G includes three additional domains:</p> <ul style="list-style-type: none"> • Social/Community Life • Self-Sufficiency • Family Health <p>The NCFAS-R includes two additional domains:</p> <ul style="list-style-type: none"> • Caregiver/Child Ambivalence • Readiness for Reunification 	<p>Each item is scored (by a trained worker) on a 6-point scale: +2 (clear strength), +1 (mild strength), 0 (baseline/adequate), -1 (mild problem), -2 (moderate problem), and -3 (serious problem).</p> <p>Practitioners assess if a family is in either the strength or problem range and to what degree. There is no midpoint rating, rather the "baseline/adequate" level of functioning is "that level above which there is no legal, moral or ethical reason for exercising an intervention mandate."³²</p>	Recommended to be completed within 1-2 weeks of intake (or within 2-3 weeks of beginning case activities for the NCFAS-R) and again within 1-2 weeks of service or case closure.	783 Baseline and Discharge	10

³² Kirk, R. & Griffith, D. (2007). An Examination of Intensive Family Preservation Services. Durham, NC: Independent Living Resources, Inc.

Table 1: Selected Common Instruments Used by Subgroups of Grantees to Measure Child, Adult, and Family Well-Being: Description of Instruments and Current Sample Sizes for RPG Participants (as of September 30, 2011)

Instrument	Brief Description	Structure/Domains	Scoring	Administration	Current RPG Sample Size (N) ³⁰	Number of RPGs Data Represent
Parenting Stress Index (PSI) –Short Form	Designed to identify stressful areas in parent-child interactions and risk for development of dysfunctional parenting behaviors or behavior problems in the child involved. Looks at domains of stressors a parent may experience that are directly related to his/her role of being a parent. For parents of children ranging from 1 month to 12 years.	The PSI Short Form includes: <i>Total Stress Scale</i> a. Parental Distress subscale b. Parent-Child Dysfunctional Interaction subscale c. Difficult Child subscale <i>Defensive Responding subscale.</i> Used to determine if the respondent is attempting to present the most favorable impression of self and minimize indications of problems or stress in the parent-child relationship.	Each statement is rated by the parent on the following continuum: Strongly agree, Agree, Not sure, Disagree, or Strongly disagree. Raw scores are computed and translated to percentiles. In general, scores at or above the 85 th percentile are considered high (i.e., at risk) and suggest a need for intervention. A Total Stress score at or above the 90 th percentile indicates the parent is experiencing clinically significant levels of stress.	Forms should be filled out by the parent/caregiver.	356 Baseline and Discharge	5 ³³
Protective Factors Survey (PFS)	Designed to evaluate caregivers receiving child maltreatment prevention services. Results are designed to provide agencies with a snapshot of the families they serve; changes in protective factors; and areas where workers can focus on increasing individual family protective factors.	Measures protective factors in five areas: <ul style="list-style-type: none"> • Family functioning and resiliency • Social support • Concrete support • Nurturing and attachment • Knowledge of parenting and child development 	Each item is scored on a 7-point scale ranging from 1=Strongly Disagree/Never to 7=Strongly Agree/Always. Composite scores are calculated for the first 4 subscales. (Calculation of a subscale score for knowledge of parenting and child development is not recommended; means, standard deviations, and percentages are used to assess progress in this area.) No cutoff scores are identified. Change is measured by the percent of clients with improvements in scores from pretest to posttest.	May be administered before, after, or during services. Surveys can be administered in a group setting or in one-on-one interview.	527 Baseline only	5

³³ In addition, seven grantees administered the PSI Full version. These data were excluded from analysis for the following reasons. Only two grantees accounted for 90 percent of the total matched baseline-discharge sample. Further, one of those grantees primarily targeted children in out-of-home placement and administered the PSI Full to foster parents, which is a very different adult target population than the other grantees administering the PSI.

Data Analyses for the Well-Being Measures – General Overview

Analyses for these five measures (measured with one or more of the instruments identified above) were limited to RPG participant group data.³⁴ Where instrument-specific sample sizes were sufficient, matched baseline and discharge data are presented in the report; for other instruments where current sample sizes were limited due to lack of discharge data, only baseline data are provided.

All analyses were conducted using IBM SPSS software. In general, data analysis steps included:

- Standardizing the structure and coding of the case-level, instrument-specific data files across grantees and combining them into a uniform database for each of the nine specified instruments.
- Calculating composite scores for a given instrument's subscales/domains (where needed and applicable) in accordance with the instrument manual specifications to facilitate data analysis.
- Running descriptive statistics to obtain overall instrument and/or subscale score means.
- Running descriptive baseline statistics (i.e., percentages of children or adults categorized at a particular level of functioning) to provide a snapshot of RPG participant children and adults at baseline.
- Conducting categorical chi-square analyses to test the percentages of children, adults, or families who improve from baseline to discharge. This type of analysis is appropriate and aligns with the overall performance measurement approach HHS used to review grantees' progress.
- Conducting paired sample t-tests for selected instruments to examine changes in mean scores from baseline to discharge.
- Where appropriate, conducting repeated measures multivariate analyses of variance (MANOVAs) to test whether the results varied by individual grantee. That is, these analyses tell us whether the results were consistent across grantees or varied by grantee.³⁵

³⁴ Analyses for this fourth report were limited to the RPG participant group data due to insufficient comparison group sample sizes. Grantees' ability to collect and report comparison group data for the well-being measures was more limited because it requires significant primary data collection efforts. In contrast, grantees largely obtained comparison data on the standardized child and adult performance measures through existing administrative data sets. Where available, norm data or empirical research on use of an instrument in the general population is included in Appendix G for comparative context.

³⁵ As previously noted, assessment of the overall RPG Program's progress was not designed as or intended to be a cross-site evaluation; as such, attempts to define and control for site variability at the grantee level were not required and were beyond the scope of the analyses. However, these more detailed statistical results provide supplemental confirmatory tests of baseline-discharge change. Repeated measures analyses capitalize on within- and between-subjects variance so that small sample sizes can still be used to test for baseline-discharge effects. Still, generalizations to the larger RPG Program population should not be made based on small sample sizes.

The next section provides more detailed information about the chi-square, paired t-tests, and MANOVA analyses of the available baseline and discharge data.

Table 2 below summarizes additional instrument-specific steps taken to analyze the data.

Table 2: Additional Data Analysis Steps by Instrument	
Instrument	Data Analysis Preparation Summary
Addiction Severity Index (Full Version and ASI Lite)	<ul style="list-style-type: none"> Grantees submitted interval level and/or composite data. Domain scores calculated using mathematical formula provided by instrument developer (if composite score not provided).
Adolescent and Adult	<ul style="list-style-type: none"> Grantees submitted interval and/or subscale scores. For interval level data, raw scores for each subscale were totaled and converted into standard scores using tables provided by the instrument developers. Grantee responses were coded into high and medium risk levels based upon the instrument classifications.
Ages and Stages Questionnaire (ASQ)	<ul style="list-style-type: none"> Grantees submitted interval level scores for each item and/or total domain scores for the five instrument domains. Total domain scores were compared to normed age-specific cutoff score provided by the instrument developer to determine if score were below or above the cutoffs for “at risk” (i.e., requiring further and more in-depth assessment or additional monitoring) of developmental delay.
ASQ Social-Emotional (ASQ-SE)	<ul style="list-style-type: none"> Grantees submitted data in interval and/or total domain score formats. Same process as ASQ was used to calculate and then classify total domain score as “at risk.”
Beck Depression Inventory (BDI)	<ul style="list-style-type: none"> Grantees submitted interval level data and/or a total score. A sum score was calculated on all items and assessed against a clinical diagnostic range of minimal to severe depression.
Child Behavior Checklist (CBCL)	<ul style="list-style-type: none"> Grantees submitted interval level data and/or total calculated scores on a given domain. Interval level data was used to calculate total raw scores for multiple individual syndrome scales and an “other” problems score. Specific syndrome scales were grouped to comprise a total internalizing and externalizing behavior score. Externalizing and internalizing scores were added to total of any remaining syndrome scale and the “other” problems score to calculate the Total Problems score. Each total raw score was converted into a standard T score used in the manual clinical scoring chart. Scores above a certain percentile cutoff were coded as “At Risk” for being in the clinical range of requiring intervention. Scores slightly below the clinical “At Risk” percentile but above a given threshold were coded as “Borderline At Risk.”
North Carolina Family Assessment Scales (NCFAS)	<ul style="list-style-type: none"> Grantees submitted interval level data and/or provided an overall item score for each domain. Mean overall domain scores were calculated across subsets of grantees.
Parenting Stress Index (PSI)	<ul style="list-style-type: none"> Grantees submitted interval level data and/or raw composite scores for each domain. All scores were converted into percentiles and composite scores above a certain percentile (per manual instructions) were coded as “At Risk” (i.e., meets clinical level in need of referral for intervention).
Protective Factors Survey (PFS)	<ul style="list-style-type: none"> Grantees submitted interval level data and/or domain composite scores. Where needed, interval level data were averaged to create a domain composite score.

Baseline-Discharge Data Analyses – Additional Detail

Subsets of grantees provided sufficient sample sizes of matched baseline and discharge data for analysis for the AAPI, ASI, NCFAS, and PSI-SF. As previously noted, three major statistical analyses were conducted to analyze RPG participants' change over time for these four instruments: categorical chi-square tests, paired sample t-tests, and repeated measures multivariate analysis of variance (MANOVAs). These are discussed below and results from each instrument are shown.

Categorical Chi-Square Tests. Chi-square tests are one of the most basic inferential statistics tests used to examine the association between two categorical variables. Chi-square compares counts of categorical (or nominal) data; it does not compare means. Several of the identified well-being instruments grantees used have been traditionally analyzed using chi-square tests to show categorical change from one ratings category to another. For example, for each NCFAS item, practitioners categorize families using the following designations: clear strength, mild strength, baseline/adequate, mild problem, moderate problem, or serious problem. Researchers often analyze whether individuals move from one category designation to another over time and present data on the percentage of individuals who scored in a given category at program admission (i.e., baseline) compared to program discharge. In general, for the NCFAS and PSI, mean scores are rarely used to convey progress over time; the categorical designations are a more common presentation format as they are readily understood and easier to interpret.

Chi-square tests are used to determine if change from baseline to discharge is statistically significant. To conduct categorical chi-square analysis, grantees' data was aggregated and analyzed together. One limitation of chi-square analysis is that it only identifies whether or not there is a signification relationship between the two variables being investigated (in this case, whether the number of individuals of within a given ratings category changed from baseline to discharge) in the population from which the sample has been drawn. It does not provide any information about the strength of the relationship, nor does it allow one to conclude that each and every individual observed frequency is different from its expected frequency.

In other words, chi-square analysis does not address any potential differences in results among individual grantees. It does not treat "grantee" as an independent variable to determine if there are significant differences between the grantees on categorical change from baseline to discharge. However, the chi-square test is an important first step in analyzing grantees' data. Where the initial chi-square tests suggest a difference beyond what would be expected to by chance, subsequent repeated measures multivariate analyses of variance (MANOVAs) were conducted as a second step to test whether the results varied by individual grantee (see below).

For this report, chi-square tests were conducted on the matched baseline-discharge NCFAS and PSI-SF data submitted by the subset of grantees using these instruments. Table 3 presents the detailed results of each chi-square test for the overall NCFAS subscale domains, while Table 4 includes the chi-square analyses for each of the individual items within the NCFAS subscales. Table 5 presents the results for the PSI-SF subscales. In the tables, the rows show the test of change between baseline and discharge for each category (e.g., clear strength to severe problem for the NCFAS domains) or subscale (e.g., parental distress for the PSI-SF). For example, for

the NCFAS child well-being domain, there was a significant difference across all grantees in the number of RPG children for whom this area was rated a clear strength at baseline compared to discharge, as indicated by the significant X^2 of 55.9 with a p-value of <.0001. P-values of less than .05 indicate there is a significant association or difference from baseline to discharge ratings for a given category.³⁶

Table 3: NCFAS Categorical Chi-Square Analyses – Results for Percent Change from Baseline to Discharge, by NCFAS Subscale		
NCFAS Subscale Items	X² (df)	p-value
Overall Child Well-Being (N=778)		
Clear Strength	55.9(1)	.000
Mild Strength	47.6(1)	.000
Baseline	13.6(1)	.000
Mild Problem	81.3(1)	.000
Moderate Problem	10.2(1)	.001
Severe Problem	.481(1)	.488
Overall Parental Capabilities (N=780)		
Clear Strength	60.8(1)	.000
Mild Strength	97.9(1)	.000
Baseline	.184(1)	.668
Mild Problem	98.0(1)	.000
Moderate Problem	45.6(1)	.000
Severe Problem	.606(1)	.436
Overall Family Interactions (N=783)		
Clear Strength	60.0(1)	.000
Mild Strength	40.1(1)	.000
Baseline	.722(1)	.395
Mild Problem	60.8(1)	.000
Moderate Problem	27.5(1)	.000
Severe Problem	.610(1)	.435
Overall Environment (N=749)		
Clear Strength	42.6(1)	.000
Mild Strength	40.2(1)	.000
Baseline	2.24(1)	.134
Mild Problem	56.4(1)	.000
Moderate Problem	37.6(1)	.000
Severe Problem	5.06(1)	.025
Overall Family Safety (N=718)		
Clear Strength	41.4(1)	.000

³⁶ These tables are intended to provide supplemental statistical detail for the baseline and discharge findings presented in Chapter IX; refer to the full chapter for discussion of the summary findings.

Table 3: NCFAS Categorical Chi-Square Analyses – Results for Percent Change from Baseline to Discharge, by NCFAS Subscale		
NCFAS Subscale Items	χ^2 (df)	p-value
Mild Strength	40.7(1)	.000
Baseline	1.06(1)	.303
Mild Problem	72.9(1)	.000
Moderate Problem	29.9(1)	.000
Severe Problem	.950(1)	.330
Overall Social/Community Life (N=231)		
Clear Strength	8.32(1)	.004
Mild Strength	4.45(1)	.035
Baseline	1.25(1)	.264
Mild Problem	3.51(1)	.061
Moderate Problem	1.55(1)	.214
Severe Problem	3.12(1)	.077

Table 4 below provides the chi-square analyses for each of the individual items within the NCFAS subscales.

Table 4: NCFAS Categorical Chi-Square Analyses – Results for Percent Change to Mild/Clear Strength Rating from Baseline to Discharge, by Individual Subscale Items			
	Total RPG Families	χ^2 (df)	p-value
Child Well-Being Subscale Items			
Behavior	714	74.2(1)	.000
Mental Health	558	68.0(1)	.000
School Performance	523	41.6(1)	.000
Cooperation	703	59.8(1)	.000
Relationship with Parents	724	86.6(1)	.000
Relationships with Siblings	532	36.1(1)	.000
Relationships with Peers	486	29.6(1)	.000
Parental Capabilities Subscale Items			
Supervision	716	137.0(1)	.000
Disciplinary Practices	701	99.6(1)	.000
Development/Enrichment Opportunities	697	72.1(1)	.000
Promotes Education	143	5.05(1)	.025
Controls Access to Media	121	4.15(1)	.042
Parent's Literacy	184	2.85(1)	.092
Parents use of Drugs/Alcohol	747	210.0(1)	.000
Family Interactions Subscale Items			
Bonding with Children	535	74.0(1)	.000
Expectations of Children	519	94.6(1)	.000

Table 4: NCFAS Categorical Chi-Square Analyses – Results for Percent Change to Mild/Clear Strength Rating from Baseline to Discharge, by Individual Subscale Items			
	Total RPG Families	X² (df)	p-value
Mutual Support Within Family	550	64.7(1)	.000
Relationships Between Parents	467	38.6(1)	.000
Family Recreation	145	11.3(1)	.001
Family Routines	157	7.17(1)	.007
Communication with Children	167	3.65(1)	.056
Environment Subscale Items			
Housing Stability	507	78.2(1)	.000
Safety in the Community	498	43.0(1)	.000
Habitability of Housing	489	39.4(1)	.000
Personal Hygiene	503	28.8(1)	.000
Learning Environment	459	53.4(1)	.000
Environmental Risks	170	5.19(1)	.023
Safety Subscale Items			
Domestic Violence	585	53.3(1)	.000
Family Conflict	160	6.04(1)	.014
Child Neglect	672	88.9(1)	.000
Emotional Child Abuse	640	43.6(1)	.000
Sexual Child Abuse	610	13.4(1)	.001
Physical Child Abuse	553	33.9(1)	.000
Social/Community Subscale Items			
Parent(s)/Caregiver(s)'s Initiative and Acceptance of Available Help/Support	192	2.44(1)	.118
Connection to Spiritual/Religious Community	146	3.9(1)	.048
Connection to Neighborhood, Cultural/Ethnic Community	153	2.69(1)	.101
Relationships with Child Care, Schools, and Extracurricular Services	126	9.26(1)	.002
Social Relationships	190	5.70(1)	.017

Table 5 below provides the chi-square analyses for the PSI-SF subscales.

Table 5: PSI-SF Categorical Chi-Square Analyses – Results for Percent Change in Clinical Levels of Stress from Baseline to Discharge, by PSI-SF Domain			
PSI-SF Domain	Total RPG Adults	X² (df)	p-value
Total Stress	356	14.2(1)	.000
Parental Distress	356	38.5(1)	.000
Parent-Child Dysfunctional Interaction	356	10.1(1)	.001
Difficult Child	356	12.2(1)	.000

Paired Sample T-Tests

Paired sample t-tests were conducted to examine changes in mean ASI and AAPI scores at RPG program admission and RPG program discharge. This type of analysis compares the means of two variables or paired observations (i.e., the baseline and discharge scores) for a single case (i.e., the parent). The procedure computes the differences between the two variables' values for each case and tests whether the average between them differs from zero. Essentially, this tests the null hypothesis that the difference between the two values is zero or that the scores at admission and discharge do not differ. In short, if the treatment or intervention had no effect, the average difference between the two scores is equal to zero and the null hypothesis is accepted. Conversely, if the treatment did have an effect, the average difference is not zero and the null hypothesis is rejected. In this case, paired t-tests were conducted on ASI mean domain scores and AAPI Sten scores of the same RPG participants at RPG program admission and discharge.

Table 6 below presents the ASI sample sizes, t-scores, degrees of freedom, and significance tests for the scores found in the main body of the report. Sample sizes differ for the ASI because not all grantees collected data on all domains and not all individuals completed the ASI at both admission and discharge.

ASI Domain	Total RPG Adults	t-score (df)	p-value
Legal	171	4.53(170)	.000
Employment	161	2.06(160)	.041
Alcohol Use	162	5.75(161)	.000
Drug Use	118	5.16(117)	.000
Psychiatric	170	7.97(169)	.000
Family/Social	168	7.48(167)	.000
Medical	169	3.23(168)	.002

Table 7 below presents the AAPI sample sizes, t-scores, degrees of freedom, and significance tests for the results found in the full report.

AAPI Domain	Total RPG Adults	t-score (df)	p-value
Inappropriate Expectations	280	-2.30(279)	.022
Empathy	280	.965(279)	.335
Corporal Punishment	280	-2.31(279)	.021
Role Reversal	280	-1.35(279)	.179
Power/Independence	280	.000(279)	1.00

Repeated Measures Multivariate Analysis of Variance (MANOVA) Tests

To confirm or qualify the significant associations found in the chi-square analyses and paired sample t-tests and determine if there were any potential differences or variance in scores controlling for grantee, repeated measures multivariate analyses of variance (MANOVA) were conducted on mean scores for the ASI, AAPI, PSI-SF, and NCFAS.³⁷ This analysis provides the strongest and most robust statistical test to determine if there are significant differences in scores over time and if there are significant differences in scores across grantees. MANOVA tests whether there are group differences in well-being as a function of grantee, time, or an interaction between these two factors.

In this analysis, GRANTEE was included as a between-subjects factor and TIME was included as a within-subjects factor. The analyses yield three results:

- *TIME Main Effects*: Tests whether individual item scores are significantly different at RPG admission compared to RPG discharge. A significant TIME main effect means significant differences between admission and discharge scores are consistent and do not vary by grantee.
- *GRANTEE Main Effects*: Tests whether individual item scores are significantly different across RPG grantees.
- *TIME x GRANTEE Interaction Effects*: Tests whether the relative difference in baseline-discharge scores on individual items is significantly different across RPG grantees. In other words, a significant TIME x GRANTEE interaction effect means significant differences between admission and discharge scores vary by individual grantee.

In essence, one expects to find significant time effects without an interaction effect. This means the change between baseline and discharge does not vary or differs based on an individual grantee's intervention. This helps confirm the consistency and robustness of results. If a significant interaction effect is found, this means the relative difference between admission and discharge scores varies as a function of the grantee. In such cases, it may not be surprising that grantees' interventions can have a different level of effect on the measures.

Because MANOVA includes an analysis of shared variance between grantee group and within time, all cells of the design must have valid data on the full instrument contained in the analysis. This means all grantees in the subset must have collected data on every instrument item for each child, adult, or family at both admission and discharge to be included in the analyses. As a result, sample sizes for the repeated measures MANOVA are smaller than for the chi-square or paired sample t-tests, which are done on individual items within a given subscale or domain.

However, because repeated measures MANOVA is a robust statistical test that capitalizes on the shared variance of the within-subjects factor (TIME) and the between-subjects factor

³⁷ While the categorical chi-square analyses test changes in the number of individuals within a given category (e.g., clear strength, serious problem), MANOVA tests analyze the mean scores on the instrument items from which categorical designations are defined.

(GRANTEE), it is capable of testing for statistical differences in smaller sample sizes. This is a more conservative test of effects in that the intervention must be sufficiently strong to show significant effects with a smaller sample size. The effect size for each factor provides additional information on the strength of the intervention on improving scores and helps confirm findings from the categorical chi-square analyses.

Multivariate tests were conducted on the full instrument and univariate tests were conducted on individual items within an instrument. The overall multivariate tests are in the shaded rows; the univariate tests for the individual instrument subscale or domain items follow below the multivariate tests. These show tests of differences from baseline to discharge (TIME main effect), differences between grantees in each analysis (GRANTEE main effect), and differences from baseline to discharge as a function of grantee (TIME x GRANTEE interaction).

Multivariate tests must be significant before placing interpretive value on the univariate tests. Further, for univariate tests, the interaction effect must be interpreted first before main effects. Significant TIME x GRANTEE interaction effects suggest pre-post changes in scores differ depending upon the grantee. Non-significant interaction effects allow the main effects to be examined. The tables also include the F statistic and degrees of freedom (df) and the p value for each test.

Table 8 below presents the multivariate and univariate tests of each repeated measures MANOVA for the NCFAS.

Table 8: Repeated Measures Multivariate Analysis of Variance on NCFAS Baseline-Discharge Mean Scores ³⁸								
NCFAS Subscale	Sample Size and Grantee Subset ³⁹		Time Main Effect		Grantee Main Effect		Time x Grantee Interaction	
	Number RPG Families	Number Grantees Data Represent	F(df)	p-value	F(df)	p-value	F(df)	p-value
Child Well Being	326	4	F(8,315)=3.95	.0001	F(24,951)=5.88	.0001	F(24,951)=2.36	.0001
Overall Well-Being			F(1,322)=59.17	.0001	F(7,282)=8.21	.0001	F(3,322)=3.78	.01
Mental Health			F(1,322)=41.37	.0001	F(7,282)=4.27	.0001	F(3,322)=2.89	.036
Behavior			F(1,322)=43.95	.0001	F(7,282)=5.78	.0001	F(3,322)=3.32	.02
School Performance			F(1,322)=31.57	.0001	F(7,282)=3.19	.003	F(3,322)=4.51	.004
Relations with Parents			F(1,322)=39.40	.0001	F(7,282)=3.46	.001	F(3,322)=5.68	.001
Relations with Siblings			F(1,322)=16.85	.0001	F(7,282)=3.36	.002	F(3,322)=2.19	.090
Relations with Peers			F(1,322)=12.48	.0001	F(7,282)=6.19	.0001	F(3,322)=3.62	.013
Cooperation			F(1,322)=14.23	.0001	F(7,282)=5.59	.0001	F(3,322)=6.92	.0001
Family Interactions	94	4	F(8,83)=5.09	.0001	F(24,255)=2.74	.0001	F(24,255)=2.61	.0001
Overall Family Interaction			F(1,90)=16.07	.0001	F(3,90)=3.76	.014	F(3,90)=4.01	.010
Family Recreation			F(1,90)=11.65	.001	F(3,90)=4.49	.006	F(3,90)=2.15	.100
Family Routines			F(1,90)=3.75	.056	F(3,90)=1.77	.158	F(3,90)=2.37	.076
Relationship Between Parents			F(1,90)=7.81	.006	F(3,90)=2.92	.038	F(3,90)=.313	.816
Mutual Support Within Family			F(1,90)=.945	.334	F(3,90)=2.67	.053	F(3,90)=2.12	.103
Expectations of Children			F(1,90)=2.29	.133	F(3,90)=2.74	.048	F(3,90)=.301	.824
Communication with Children			F(1,90)=.030	.863	F(3,90)=1.86	.143	F(3,90)=.226	.878

³⁸ The first shaded row of each instrument displays the overall multivariate tests for the given subscale, while the univariate tests for each item is on the subsequent rows.

³⁹ The sample sizes and number of grantees the data represent differs for the repeated measures MANOVA compared to the categorical chi-square analysis. The MANOVA requires data from every individual and grantee at every point in time and every item included in the analysis. The chi-square analysis aggregates data across grantees on individual items resulting in higher sample sizes. The categorical chi-square analyses are conducted on individual items within a subscale, resulting in higher sample sizes. (For instance, a grantee that may only have data on three of six subscale items would be included in the chi-square analysis, but excluded from the MANOVA.)

Table 8: Repeated Measures Multivariate Analysis of Variance on NCFAS Baseline-Discharge Mean Scores³⁸

NCFAS Subscale	Sample Size and Grantee Subset ³⁹		Time Main Effect		Grantee Main Effect		Time x Grantee Interaction	
	Number RPG Families	Number Grantees Data Represent	F(df)	p-value	F(df)	p-value	F(df)	p-value
Bonding with Children			F(1,90)=.807	.371	F(3,90)=2.79	.045	F(3,90)=1.85	.143
Parental Capabilities	92	4	F(8,81)=10.36	.0001	F(24,249)=4.97	.0001	F(24,249)=3.32	.0001
Overall Parent Capacity			F(1,88)=10.11	.002	F(3,88)=1.41	.246	F(3,88)=3.94	.011
Parent's Literacy			F(1,88)=3.55	.063	F(3,88)=2.39	.074	F(3,88)=4.31	.007
Controls Access to Media			F(1,88)=27.1	.0001	F(3,88)=2.29	.084	F(3,88)=5.92	.001
Promotes Education			F(1,88)=2.38	.127	F(3,88)=.720	.543	F(3,88)=1.09	.356
Use of Drugs/Alcohol			F(1,88)=55.68	.0001	F(3,88)=7.29	.0001	F(3,88)=7.20	.0001
Development/Enrichment Opportunities			F(1,88)=9.51	.003	F(3,88)=.237	.870	F(3,88)=.747	.527
Disciplinary Practices			F(1,88)=.740	.392	F(3,88)=2.57	.059	F(3,88)=.814	.490
Supervision of Children			F(1,88)=2.67	.105	F(3,88)=1.09	.356	F(3,88)=1.82	.150
Family Environment	129	4	F(7,119)=5.81	.0001	F(21,363)=2.98	.0001	F(21,363)=2.39	.001
Overall Family Environment			F(1,125)=22.10	.0001	F(3,125)=.511	.657	F(3,125)=4.21	.007
Learning Environment			F(1,125)=16.26	.0001	F(3,125)=.093	.964	F(3,125)=2.19	.093
Personal Hygiene			F(1,125)=2.41	.123	F(3,125)=2.99	.034	F(3,125)=2.73	.047
Habitability of Housing			F(1,125)=15.29	.0001	F(3,125)=1.93	.128	F(3,125)=1.18	.321
Environmental Risks			F(1,125)=8.14	.005	F(3,125)=3.44	.019	F(3,125)=1.94	.127
Safety in the Community			F(1,125)=4.73	.031	F(3,125)=1.32	.271	F(3,125)=3.60	.016
Housing Stability			F(1,125)=23.14	.0001	F(3,125)=1.92	.13	F(3,125)=4.46	.005
Family Safety	56	4	F(8,45)=14.88	.0001	F(24,141)=3.36	.0001	F(24,141)=4.43	.0001
Overall Family Safety			F(1,52)=25.69	.0001	F(3,52)=.086	.968	F(3,52)=9.16	.0001
Child Neglect			F(1,52)=2.20	.144	F(3,52)=2.02	.123	F(3,52)=4.16	.010

Table 8: Repeated Measures Multivariate Analysis of Variance on NCFAS Baseline-Discharge Mean Scores ³⁸								
NCFAS Subscale	Sample Size and Grantee Subset ³⁹		Time Main Effect		Grantee Main Effect		Time x Grantee Interaction	
	Number RPG Families	Number Grantees Data Represent	F(df)	p-value	F(df)	p-value	F(df)	p-value
Sexual Child Abuse			F(1,52)=1.61	.210	F(3,52)=15.16	.0001	F(3,52)=1.34	.272
Emotional Child Abuse			F(1,52)=7.31	.009	F(3,52)=1.96	.131	F(3,52)=7.74	.0001
Physical Child Abuse			F(1,52)=57.32	.0001	F(3,52)=7.11	.0001	F(3,52)=25.07	.0001
Family Conflict			F(1,52)=5.58	.022	F(3,52)=.039	.989	F(3,52)=5.48	.002
Domestic Violence			F(1,52)=25.01	.0001	F(3,52)=.319	.811	F(3,52)=6.72	.001

Table 9 below presents the multivariate and univariate tests of each repeated measures MANOVA for the ASI, PSI-SF, and AAPI mean scores.

Table 9: Repeated Measures Multivariate Analysis of Variance on ASI, PSI-SF, and AAPI Baseline-Discharge Mean Scores								
Instrument	Sample Size and Grantee Subset ⁴⁰		Time Main Effect		Grantee Main Effect		Time x Grantee Interaction	
	Number RPG Families	Number Grantees Data Represent	F(df)	p-value	F(df)	p-value	F(df)	p-value
ASI	87	4	F(7,77)=1.92	.078	F(21,237)=3.93	.0001	F(21,237)=2.22	.002
Medical Issues			F(1,83)=.004	.953	F(3,83)=3.79	.013	F(3,83)=.739	.532
Employment Issues			F(1,83)=4.30	.041	F(3,83)=5.17	.003	F(3,83)=1.73	.166
Alcohol Issues			F(1,83)=.953	.332	F(3,83)=2.89	.041	F(3,83)=1.93	.131
Drug Issues			F(1,83)=1.43	.235	F(3,83)=8.79	.0001	F(3,83)=10.61	.0001

⁴⁰ The sample sizes and number of grantees the data represent differs for the repeated measures MANOVA compared to the categorical chi-square analysis. The MANOVA requires data from every individual and grantee at every point in time and every item included in the analysis. The chi-square analysis aggregates data across grantees on individual items resulting in higher sample sizes. The categorical chi-square analyses are conducted on individual items within a subscale, resulting in higher sample sizes. (For instance, a grantee that may only have data on three of six subscale items would be included in the chi-square analysis, but excluded from the MANOVA.)

Table 9: Repeated Measures Multivariate Analysis of Variance on ASI, PSI-SF, and AAPI Baseline-Discharge Mean Scores

Instrument	Sample Size and Grantee Subset ⁴⁰		Time Main Effect		Grantee Main Effect		Time x Grantee Interaction	
	Number RPG Families	Number Grantees Data Represent	F(df)	p-value	F(df)	p-value	F(df)	p-value
Legal Issues			F(1,83)=7.32	.008	F(3,83)=.487	.692	F(3,83)=1.17	.325
Family Issues			F(1,83)=.692	.408	F(3,83)=27.93	.0001	F(3,83)=.391	.760
Psychiatric Issues			F(1,83)=.423	.517	F(3,83)=11.44	.0001	F(3,83)=2.33	.08
PSI-SF	356	4	F(4,348)=10.52	.0001	F(16,1404) = 14.92	.0001	F(16,1404)=5.66	.0001
Total Stress			F(1,351)=21.72	.0001	F(3,351)=73.70	.0001	F(3,351)=15.47	.0001
Parent Distress			F(1,351) =33.34	.0001	F(3,351)=37.40	.0001	F(3,351)=10.57	.0001
Parent-Child Dysfunctional Interaction			F(1,351) =11.80	.001	F(3,351)=79.95	.0001	F(3,351)=5.42	.0001
Difficult Child			F(1, 182) =1.35	.246	F(3,351)=47.61	.0001	F(3,351)=7.06	.0001
AAPI	275	6	F(5,270)=1.41	.222	F(25,1370)=13.84	.0001	F(25,1370)=6.60	.0001
Inappropriate Expectations			F(1,274)=.517	.473	F(5,274)=12.06	.002	F(5,274)=7.09	.0001
Empathy			F(1,274)=1.79	.182	F(5,274)=25.76	.0001	F(5,274)=7.89	.0001
Corporal Punishment			F(1,274)=1.18	.279	F(5,274)=29.09	.0001	F(5,274)=12.66	.0001
Role Reversal			F(1,274)=1.81	.180	F(5,274)=13.60	.0001	F(5,274)=11.60	.001
Power/Independence			F(1,274)=.476	.491	F(5,274)=65.30	.0001	F(5,274)=13.35	.0001

APPENDIX G: NORMATIVE DATA FOR SELECTED WELL-BEING INSTRUMENTS

As discussed in Chapters IV and IX (and Appendix D), analyses for the well-being measures were limited to grantees' participant groups due to insufficient comparison group sample sizes. For additional comparative context, where available, this appendix provides normative data on the general population for the following selected instruments that subsets of grantees used to measure child, adult, and family well-being:

- Ages and Stages Questionnaire (ASQ)
- ASQ-Social Emotional (ASQ-SE)
- Addiction Severity Index (ASI)
- Adult-Adolescent Parenting Inventory (AAPI)
- Child Behavior Checklist (CBCL)
- Parenting Stress Index (PSI)

It is important to reiterate that these well-being data represent a small subset of grantees using these specific instruments and a small percentage of all children, adults, and families served by the larger RPG Program. Thus, the data should be interpreted with caution and cannot be generalized to the whole RPG population.

AGES AND STAGES QUESTIONNAIRE (ASQ)

Table 1 below provides ASQ mean scores, by domain, for the subset of nine grantees submitting ASQ baseline data, in relation to a normative population.

Table 1: ASQ-3 Domain Mean Scores – RPG Children and Normative Population*

Age (Months)	Sample Size (N)		Communication		Gross Motor		Fine Motor		Problem Solving		Personal-Social	
	RPG Children (N=736)	Normative (N=18,572)	RPG Children	Normative	RPG Children	Normative	RPG Children	Normative	RPG Children	Normative	RPG Children	Normative
2	27	352	38.15	47.62	47.78	55.32	44.81	49.80	37.04	48.48	44.07	50.57
4	87	1,824	47.83	52.28	51.82	54.63	45.75	51.58	49.31	53.79	48.94	51.92
6	49	633	48.98	48.90	45.41	45.64	49.06	48.93	48.96	50.41	47.81	48.31
8	40	1,362	52.00	52.40	52.88	52.09	56.38	55.75	53.63	53.92	52.58	53.35
10	28	899	46.43	48.17	48.39	53.02	49.46	54.72	50.04	52.19	44.46	49.49
12	42	2,088	42.38	43.22	47.26	49.92	48.73	52.22	44.93	48.99	42.20	45.73
14	24	811	46.88	45.85	51.25	53.09	48.54	46.87	47.92	47.08	47.71	48.34
16	14	1,191	41.07	44.08	52.14	56.31	48.21	51.96	46.07	51.39	44.64	48.01
18	25	616	39.60	42.30	56.80	55.46	49.60	52.44	46.72	45.99	49.28	47.90
20	23	1,278	45.43	48.14	53.54	55.82	49.08	52.73	46.17	48.24	51.25	52.04
22	15	404	49.00	44.94	54.33	50.48	48.67	48.58	48.00	49.02	54.67	50.54
24	42	1,443	51.31	51.23	56.10	54.73	50.31	51.70	45.33	49.40	51.79	51.14
27	34	559	48.68	50.43	51.76	50.27	42.50	43.74	48.29	49.95	51.26	46.92
30	28	953	46.79	53.81	50.04	53.54	37.32	46.78	40.36	50.18	47.54	51.87
33	28	546	50.89	49.38	56.79	53.28	43.93	43.52	45.18	50.65	49.82	50.74
36	50	1,006	48.92	51.88	54.51	54.68	44.31	47.07	50.29	51.97	52.30	52.82
42	42	956	48.55	50.02	54.64	54.03	43.45	47.55	49.88	51.54	53.07	51.39
48	58	672	51.90	52.92	56.38	52.71	43.71	45.35	50.78	52.78	49.66	50.34
54	33	590	53.18	53.79	56.97	53.98	41.52	46.12	44.39	51.25	50.12	52.77
60	47	389	52.60	52.42	55.63	52.17	47.77	51.57	48.51	52.59	55.00	54.84

* Total possible score is 60; the higher the scores the better. RPG data represent subset of nine grantees. Source for norm data: Squires, J., Twombly, E., Bricker, D. & Potter, L. (2009). *ASQ-3 User's Guide*. Baltimore, MD: Paul H. Brookes Publishing Co.

ASQ SOCIAL-EMOTIONAL (ASQ-SE)

Table 2 below shows ASQ-SE baseline mean scores for a subset of seven grantees' RPG participant children in relation to a general population of a) children with one or no identified environmental or medical risk factors and b) a population of children with two or more risk factors (the latter of which likely shares similar characteristics to the RPG population).⁴¹

ASQ-SE Age Interval	RPG Children		Normative Sample – No Risk**		Normative Sample – At Risk***	
	N	Mean	N	Mean	N	Mean
6 month	225	14.0	84	19.2	166	20.6
12 month	146	19.9	103	22.1	145	26.2
18 month	126	65.4	115	22.2	100	32.2
24 month	129	42.9	172	25.8	141	37.5
30 month	81	41.3	114	33.5	78	46.2
36 month	115	60.7	191	33.3	81	47.5
48 month	152	75.3	176	31.6	123	52.2
60 month	97	40.8	134	30.1	85	47.7
Overall	1,071	45.0	1,089	27.2	919	38.8

Note: Higher scores indicate higher risk for difficulties.

* RPG data represent subset of seven grantees.

** One or no identified risk factors

*** Two or more identified risk factors

CHILD BEHAVIOR CHECKLIST (CBCL): 1.5 – 5 YEARS⁴²

Table 3 below provides baseline CBCL problem scale scores for a subset of grantees' RPG participant children aged 1.5 to 5 years in relation to a normative sample of young children. The table provides both raw scores and total scores, or T scores. T scores can be computed for Internalizing Problems and Externalizing Problems, as well as for each of the eight syndrome scales. Raw scores can be converted to age-standardized scores that can be compared with scores obtained from normative samples of children within the same broad age range. For the syndrome scales, T scores less than 67 are considered in the normal range, T scores ranging from 67 to 70 are considered to be borderline clinical, and T scores above 70 are in the clinical range.⁴³ Internalizing, Externalizing, and Total Problems scales are scored based on the syndromes.

⁴¹ Variables used to determine level of risk included: 1) family income of less than \$12,000, 2) mother younger than 18 years old when child was born, 3) mother has less than high school graduation education level, 4) family is involved with child protective services, 5) child is in foster care, and 6) child's birth weight was less than pounds, 5 ounces. Source: ASQ-SE Technical Report (no date); accessed January 17, 2011 from http://agesandstages.com/pdfs/asqse_technical_report.pdf.

⁴² Norm data for the CBCL 6 to 18 years is not provided due to small RPG participant sample sizes.

⁴³ Achenbach, T. M. (1991). *Integrative Guide for the 1991 CBCL/4-18, YSR, and TRF Profiles*. Burlington, VT: University of Vermont, Department of Psychiatry.

Table 3: CBCL 1.5 – 5 Years Problem Scale Scores – RPG Participant Children and Normative Population*

Problem Scale**	RPG Participant Children	Normative Sample (N=700)
Emotionally Reactive		
Raw Score – Mean	2.5	2.4
T Score – Mean	54.5	54.0
Anxious/Depressed		
Raw Score – Mean	3.1	2.9
T Score – Mean	54.7	54.2
Somatic Complaints		
Raw Score – Mean	1.4	1.8
T Score – Mean	53.0	54.0
Withdrawn		
Raw Score – Mean	1.8	1.5
T Score – Mean	55.4	54.1
Sleep Problems		
Raw Score – Mean	2.9	2.8
T Score – Mean	54.8	54.2
Attention Problems		
Raw Score – Mean	2.9	2.5
T Score – Mean	55.2	54.1
Aggressive Behavior		
Raw Score – Mean	9.7	10.4
T Score – Mean	54.5	54.2
Internalizing		
Raw Score – Mean	9.4	8.6
T Score – Mean	49.7	50.0
Externalizing		
Raw Score – Mean	13.1	12.9
T Score – Mean	49.0	50.0
Total Problems		
Raw Score – Mean	36.9	33.3
T Score – Mean	51.7	50.1

*RPG data represent subset of five to six grantees, depending on the problem scale: RPG sample size for Total Problems is 406; sample sizes for all other scales is 266. Source for normative sample: Achenbach, T.M. & Rescorla, L.A. (2000). *Manual for the ASEBA Preschool forms and Profiles*. Burlington, VT: University of Vermont Department of Psychiatry.

** Raw scores can be converted to age-standardized scores that can be compared with scores obtained from normative sample of children. For the syndrome scales, T scores less than 67 are considered in the normal range, T scores ranging from 67 to 70 are considered borderline clinical, and T scores above 70 are in the clinical range.

ADULT-ADOLESCENT PARENTING INVENTORY (AAPI)

Table 4 below provides mean baseline AAPI scores and the percentage of parents by risk level for a subset of seven grantees' RPG female participants in relation to a normative sample of female parents. Normative data for males is not included due to small RPG sample sizes.

Table 4: AAPI Profile – RPG Females Compared to Normative Female Sample Percentage of Parents by Risk Level and Mean Sten Score*								
AAPI Construct	RPG Female Parents (N=444)				Normative Female Parents (N=988)			
	High Risk	Moderate Risk	Low Risk	Mean Sten Score	High Risk	Moderate Risk	Low Risk	Mean Sten Score
Inappropriate Expectations	13%	74%	12%	5.3	1%	60%	39%	7.0
Low Level of Empathy	41%	52%	7%	4.4	4%	55%	51%	7.3
Strong Belief in Corporal Punishment	16%	75%	9%	5.1	5%	59%	37%	6.9
Role Reversal	17%	72%	11%	5.4	5%	65%	31%	6.8
Restricts Power and Independence	52%	34%	13%	4.0	4%	35%	62%	7.9

* Sten scores range from 1 to 10 with scores ranging from 1-3 being high risk, 4-7 moderate risk, and 8-10 low risk. RPG data represent a subset of seven grantees submitting AAPI baseline data. Normative data from Bavolek, S. (2001). Assessing the Parenting Attitudes of Professional Parent Educators. Family Development Resources, Inc. Percentages may not add to 100 due to rounding.

ADDICTION SEVERITY INDEX (ASI)

Table 5 below provides mean baseline composite scores for the subset of six grantees' RPG participants in relation to a normative sample, for all adults as well as by gender.⁴⁴

Table 5: ASI Baseline Scores – RPG Adults Compared to Normative Sample Mean Composite Score for Selected ASI Domains*									
Domain	Total Adults			Female			Male		
	Norm (N=8,429)	RPG	RPG N	Norm (N=2,890)	RPG	RPG N	Norm (N=5,539)	RPG	RPG N
Medical	.17	.21	859	.21	.26	492	.15	.13	117
Employment	.65	.73	863	.70	.72	499	.62	.62	118
Alcohol Use	.21	.08	715	.20	.09	391	.22	.10	77
Drug Use	.12	.08	774	.15	.09	423	.10	.07	102
Psychiatric	.19	.22	868	.27	.26	502	.15	.17	119
Legal	.18	.14	849	.19	.16	484	.18	.12	116

*Higher scores indicate greater problem severity. RPG data represents six grantees submitting baseline ASI data; excludes RPG cases with missing data on gender.

⁴⁴ McLellan, A., Cacciola, J., Alterman, A., Rikoon, S. & Carise, D. (2006). The Addiction Severity Index at 25: Origins, contributions and transitions. *American Journal of Addiction*, 15 (2): 113-24. The normative sample consists of more than 8,400 admission ASI-5 interviews collected during the past 3 years from 42 programs.

APPENDIX H: CHILDREN AND ADULTS ASSESSED FOR AND CONNECTED TO SUPPORTIVE SERVICES – ADDITIONAL DETAIL

The findings presented in the full report regarding children (see Chapter IX) and adults (see Chapter VIII) connected to supportive services are limited to those individuals known to be in need of a given supportive service. In certain cases, a grantee may find that a given support service is not needed or pertinent to a particular individual’s situation (e.g., a child is already receiving developmental services, an adult is already employed).

However, to provide a fuller understanding of the needs of families served by the RPG programs, it is instructive to know what are the most predominant supportive services needed. Additional information is presented in the tables below on the number of children and adults assessed, and of those assessed, the number for whom a service was identified as a need.

Table 1: RPG Children Assessed for and Connected to Needed Supportive Services*

	ASSESSED				IDENTIFIED AS A NEED				RECEIVED SERVICES			
		Number	Percent		Number	Percent		Number	Percent		Number	Percent
Developmental Services	Yes	6,885	68.1%	● →	Yes	5,126	76.2%	● →	Yes	3,843	75.0%	
	No	3,230	31.9%	→ ●	No	1,600	23.8%	→ ●	No	1,283	25.0%	
Mental Health or Counseling Services	Yes	6,521	69.3%	● →	Yes	4,736	75.5%	● →	Yes	3,787	80.0%	
	No	2,888	30.7%	→ ●	No	1,534	24.5%	→ ●	No	949	20.0%	
Primary Pediatric Care	Yes	7,065	84.0%	● →	Yes	6,097	86.9%	● →	Yes	5,198	85.3%	
	No	1,341	16.0%	→ ●	No	923	13.1%	→ ●	No	899	14.7%	
Educational Services	Yes	4,356	77.1%	● →	Yes	2,948	70.3%	● →	Yes	2,425	82.3%	
	No	1,291	22.9%	→ ●	No	1,244	29.7%	→ ●	No	523	17.7%	
Substance Abuse Prevention	Yes	1,674	78.2%	● →	Yes	983	62.8%	● →	Yes	896	91.1%	
	No	467	21.8%	→ ●	No	583	37.2%	→ ●	No	87	8.9%	
Substance Abuse Treatment	Yes	645	55.6%	● →	Yes	364	57.1%	● →	Yes	252	69.2%	
	No	516	45.2%	→ ●	No	274	42.9%	→ ●	No	112	30.8%	

* The number and percentage “Identified as a Need” excludes cases with missing or unknown data; calculations for “Received Services” is limited to those identified as needing a given service.

Table 2: RPG Adults Assessed for and Connected to Needed Supportive Services*

	ASSESSED			IDENTIFIED AS A NEED			RECEIVED SERVICES				
		Number	Percent		Number	Percent		Number	Percent		
Primary Medical Care	Yes	5,038	83.9%	→	Yes	3,830	83.5%	→	Yes	3,013	78.7%
	No	967	16.1%	→	No	759	16.5%	→	No	817	21.3%
Dental Services	Yes	4,149	77.4%	→	Yes	2,605	70.6%	→	Yes	1,826	70.1%
	No	1,213	22.6%	→	No	1,085	29.4%	→	No	779	29.9%
Mental Health Services	Yes	7,641	94.0%	→	Yes	6,211	88.6%	→	Yes	5,241	84.4%
	No	484	6.0%	→	No	601	11.4%	→	No	970	15.6%
Child Care Services	Yes	6,376	86.1%	→	Yes	4,709	79.3%	→	Yes	2,910	61.8%
	No	1,030	13.9%	→	No	1,230	20.7%	→	No	1,799	38.2%
Transportation Services	Yes	6,814	86.7%	→	Yes	5,398	84.5%	→	Yes	4,683	86.8%
	No	1,047	13.3%	→	No	993	15.5%	→	No	715	13.2%
Housing Assistance	Yes	6,974	87.5%	→	Yes	5,426	83.2%	→	Yes	3,754	69.2%
	No	1,000	12.5%	→	No	1,092	16.8%	→	No	1,672	30.8%
Parenting Training	Yes	7,551	90.6%	→	Yes	6,802	96.0%	→	Yes	5,845	85.9%
	No	782	9.4%	→	No	282	4.0%	→	No	957	14.1%
Domestic Violence Services	Yes	6,748	87.5%	→	Yes	4,750	76.2%	→	Yes	3,264	68.7%
	No	962	12.5%	→	No	1,480	23.8%	→	No	1,486	31.3%
Employment-Vocational Services	Yes	6,330	85.8%	→	Yes	5,010	85.2%	→	Yes	3,479	69.4%
	No	1,049	14.2%	→	No	872	14.8%	→	No	1,531	30.6%
Continuing Care/Recovery Support	Yes	6,944	90.5%	→	Yes	6,239	91.2%	→	Yes	5,436	87.1%
	No	726	9.5%	→	No	599	8.8%	→	No	803	12.9%
Alternative Therapies	Yes	1,611	72.5%	→	Yes	1,067	67.1%	→	Yes	726	68.0%
	No	611	27.5%	→	No	524	32.9%	→	No	341	32.0%

* The number and percentage "Identified as a Need" excludes cases with missing or unknown data; calculations for "Received Services" is limited to those identified as needing a given service.