Regional Partnership Grants Cross-Site Evaluation and Evaluation-Related Technical Assistance

May 2014

Regional Partnership Grant Program Cross-Site Evaluation Design Report

MATHEMATICA Policy Research

Children's Bureau

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Regional Partnership Grant Program Cross-Site Evaluation Design Report

Contract Number:
HSP233201250024A

Mathematica Reference Number:
40170.032

Submitted to:
Office on Child Abuse and Neglect
Children's Bureau, ACYF, ACF, HHS
8th Fl. No. 8111, 1250 Maryland Ave., SW
Washington, DC 20024
Project Officer: Melissa Lim Brodowski

Submitted by:
Mathematica Policy Research
P.O. Box 2393
Princeton, NJ 08543-2393
Telephone: (609) 799-3535
Facsimile: (609) 799-0005
Project Director: Debra A. Strong

May 2014

Debra A. Strong
Diane Paulsell
Russell Cole
Sarah A. Avellar
Angela V. D'Angelo
Juliette Henke
Rosalind E. Keith

Suggested citation:
Strong, Debra A., Diane Paulsell, Russell Cole, Sarah A. Avellar, Angela V. D'Angelo, Juliette Henke, Rosalind E. Keith, "Regional Partnership Grant Program Cross-Site Evaluation Design Report." Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. May 2014. Contract No.: HSP233201250024A. Available from Mathematica Policy Research, Princeton, NJ.

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Regional Partnership Grants and Cross-Site Evaluation

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EXECUTIVE SUMMARY

To address the far-reaching consequences of adult substance use disorders on families and children, Congress authorized competitive grants to support partnerships among child welfare, substance abuse treatment, and related organizations. The Child and Family Services Improvement Act of 2006 (Pub. L 109-288) provided funding over a five-year period for regional partnerships to improve the well-being, permanency, and safety outcomes of children who were in or at risk of out-of-home placement as a result of a parent's or caregiver's substance use disorder. The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) funded a new round of grants through 2016. With the funding, the Children's Bureau (CB) within the Administration for Children and Families, Administration on Children, Youth, and Families at the U.S. Department of Health and Human Services (HHS) established the Regional Partnership Grant (RPG) program.

In 2012, CB funded 17 grants (Table ES.1). Reflecting increasing interest in evidence-based decision making, HHS required grantees to implement well-defined service es and activities that were *evidence-based or evidence-informed*. Evidence-based programs or practices (EBPs) are those that evaluation research has shown to be effective (SAMHSA n.d. (a)). Grantees are also required to conduct well-designed outcome evaluations.

To further build knowledge of effective services for children and youth, HHS established a cross-site evaluation of RPG projects. It required grantees to contribute to the cross-site evaluation by providing data on participants and services provided. CB funded Mathematica Policy Research, along with its subcontractor Walter R. MacDonald & Associates (WRMA), to conduct a five-year cross-site evaluation of the grantees' RPG projects. The primary purposes of this evaluation are to describe grantee performance and conduct a cross-site evaluation of the RPG program, including a rigorous test of program effectiveness.

A. Research Questions

The cross-site evaluation is designed to address the following research questions:

1. Who was involved in each RPG project and how did the partners work together? To what extent were the grantees and their partners prepared to sustain their projects by the end of the grant period?
2. Who were the target populations of the RPG projects? Did RPG projects reach their intended target populations?
3. Which EBPs did the RPG projects select? How well did they align with RPG projects' target populations and goals?
4. What procedures, infrastructure, and supports were in place to facilitate implementation of the EBPs?
5. How were the EBPs implemented? What services were provided? What were the characteristics of enrolled participants?
6. To what extent were the RPG projects prepared to sustain their EBPs at the end of the grant period?

7. What were the well-being, permanency, and safety outcomes of children, and the recovery outcomes of adults, who received services from the RPG projects?

Table ES.1. Information on RPG Program Grantees

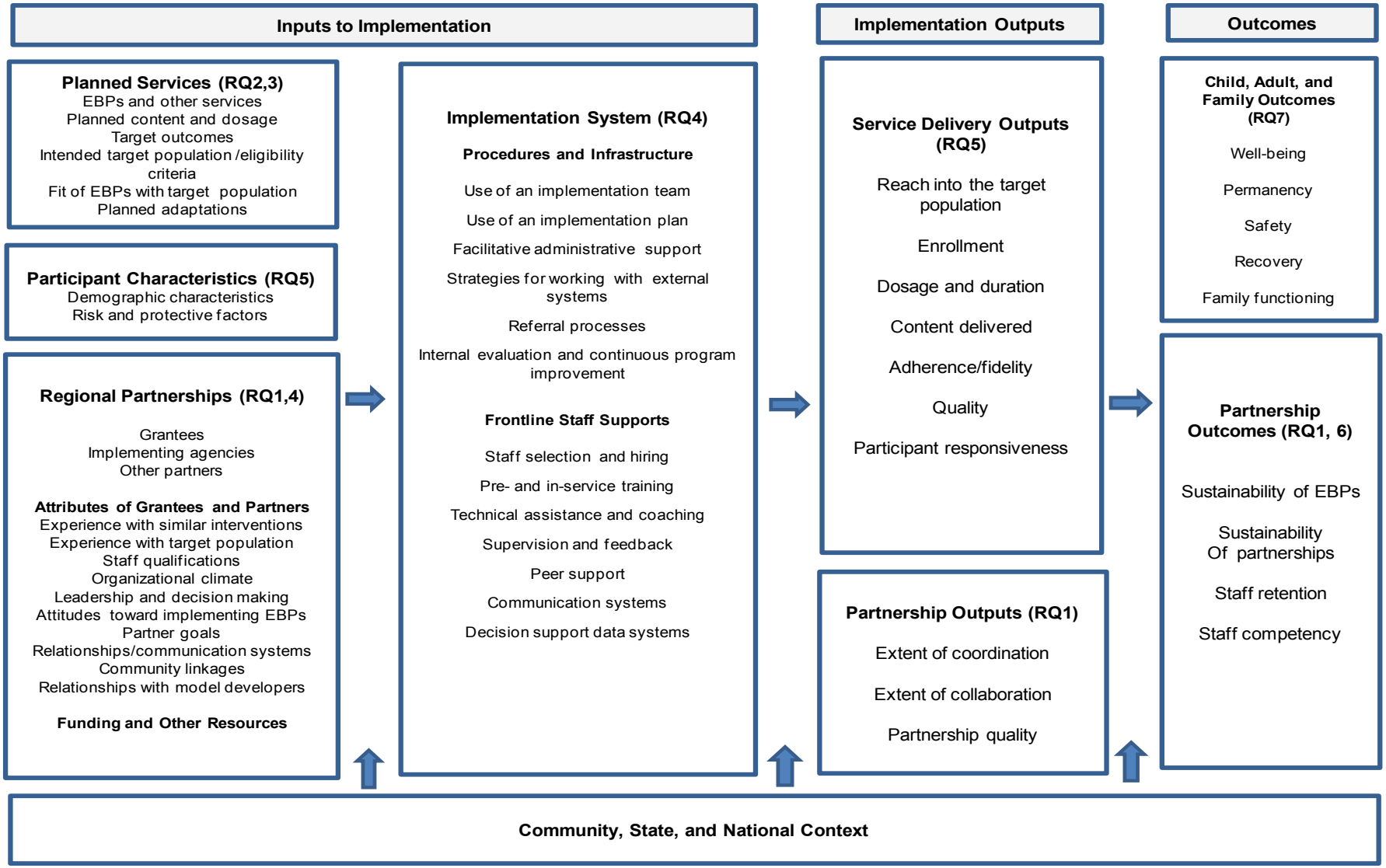
Grantee Organization	State	Organization Type
Center Point, Inc.	California	Substance abuse treatment agency/ provider
Georgia State University Research Foundation, Inc.	Georgia	Research corporation—nonprofit
Judicial Branch, State of Iowa	Iowa	State judicial agency
Northwest Iowa Mental Health Center/Seasons Center	Iowa	Community mental health service provider
Children's Research Triangle	Illinois	Child and family services provider
Kentucky Department for Community-Based Services	Kentucky	State child welfare agency
Commonwealth of Massachusetts	Massachusetts	Joint state child welfare/ substance abuse agency
Families and Children Together	Maine	Child welfare services provider—nonprofit
Alternative Opportunities, Inc.	Missouri	Substance abuse treatment agency/ provider
The Center for Children and Families	Montana	Child and family services provider
State of Nevada Division of Child and Family Services	Nevada	State child welfare agency
Summit County Children Services	Ohio	County child welfare agency
Oklahoma Department of Mental Health and Substance Abuse Services	Oklahoma	State substance abuse agency
Health Federation of Philadelphia, Inc.	Pennsylvania	Community health services provider
Helen Ross McNabb Center	Tennessee	Substance abuse treatment agency/ provider
Tennessee Department of Mental Health and Substance Abuse Services	Tennessee	State substance abuse agency
Rockingham Memorial Hospital	Virginia	Community health services provider

B. The Conceptual Framework for the RPG Cross-Site Evaluation

To guide the evaluation design process, Mathematica/WRMA developed a conceptual framework that illustrates how the 17 RPG projects will implement and support EBPs (Figure ES.1). Similar to a logic model, this framework describes and draws connections between inputs to implementation, implementation outputs, and outcomes for children, adults, and families as well as for the RPG partnerships themselves. The figure shows the research questions associated with each element of the framework.

- Inputs to Implementation. Inputs to implementation include the services grantees plan to implement, the characteristics of participants that enroll in RPG projects, members of the regional partnerships and their attributes, and the implementation systems developed to facilitate service delivery.
- Implementation Outputs. The products of the implementation system are service-delivery and partnership outputs. The service-delivery outputs are the services provided by the RPG projects. Partnership outputs include coordination and collaboration among the grantee and its partners, as well as the partners' perceptions of partnership quality.

Figure ES.1. Conceptual Framework for the Cross-Site Evaluation



RQ= Research Question

- Outcomes. The cross-site evaluation will describe outcomes for children, adults, and families enrolled in the RPG projects and the outcomes of the partnerships.
- Community Context. Underlying the entire framework—inputs, outputs, and outcomes—is the context of the state and communities in which the RPG projects operate and participants reside. Aspects of community context that the cross-site evaluation will capture include information on available resources; child welfare; substance abuse treatment; judicial, fiscal, and other policies; competing interests; and other factors that may influence the implementation of the projects and outcomes for program participants.

C. Components of the Cross-site Evaluation

Based on the conceptual framework, and to address the research questions established, the RPG cross-site evaluation has four main components: (1) an implementation study, (2) a partnership study, (3) an outcomes study, and (4) an impact study.

1. Implementation study

The RPG cross-site evaluation will contribute to building the knowledge base about effective implementation strategies by examining the process of implementation in the 17 RPG projects, with a focus on factors shown in the research literature to be associated with quality implementation (Fixsen et al. 2005; Meyers et al. 2012). We will examine activities conducted at different stages of implementation and implementation progress over time, as well as the extent to which structural supports for implementation are in place.

The implementation study will address five of the cross-site evaluation research questions listed in Section A (research questions 2-6). The EBPs selected by grantees are the primary focus of the implementation study. The 17 grantees have proposed to implement a large number of EBPs—51 across all 17 grantees— more than can be feasibly studied by the cross-site evaluation. Therefore, the evaluation team selected a subset of 10 EBPs as the focus of the implementation study (Table ES.2).

To address the implementation study's research questions, we will draw on four sources of data:

- **Grantees' Semi-Annual Progress Reports (SAPRs).** Twice a year, grantees submit a SAPR to CB. The SAPRs will include information from grantees about the infrastructure in place to support implementation, features of the community context that has influenced grantees' implementation plan, and adherence to program developer specified service-delivery requirements for each of the 10 focal EBPs.
- **Staff survey.** The survey will target frontline staff implementing the 10 focal EBPS and provide direct services to children, adults, and families and their supervisors. This group will include staff employed directly by the grantee organization, as well as staff employed by other implementing agencies that are partnering with the grantee. We plan to administer the survey during the second quarter of 2015.

Table ES.2. Focal Evidence-Based Program and Practice Models Selected by Grantees as of January 2014

EBP or Practice	Number of Grantees Implementing	Alternative Opportunities, Inc., Missouri	The Center for Children and Families, Montana	Center Point, Inc., California	Helen Ross McNabb Center, Tennessee	Children's Research Triangle, Illinois	Families and Children Together, Maine	Georgia State University Research Foundation	Health Federation of Philadelphia	Judicial Branch, State of Iowa	Kentucky Department for Community-Based Services	Commonwealth of Massachusetts	State of Nevada Division of Child and Family Services	Northwest Iowa Mental Health Center/Seasons Center	Rockingham Memorial Hospital, Virginia	Oklahoma Department of Mental Health and Substance Abuse Services	Summit County Children Services, Ohio	Tennessee Department of Mental Health and Substance Abuse Services
Celebrating Families!	3		X	X						X								
Child-Parent Psychotherapy	4					X			X		X	X						
Cognitive Behavior Therapy	5		X		X	X					X				X			
Hazelden Living in Balance Programs	4	X	X	X							X							
Matrix Model Program	4	X	X	X	X													
Nurturing Parenting Programs	6	X			X		X	X				X	X					
Parent and Child Interactive Therapy	2	X												X				
Seeking Safety	7	X	X	X	X						X	X						X
Strengthening Families	3									X						X	X	
Trauma-Focused Cognitive Behavior Therapy	6	X			X	X		X					X	X				
Total per Grantee		**6**	**5**	**4**	**5**	**3**	**1**	**2**	**1**	**2**	**4**	**3**	**2**	**2**	**1**	**1**	**1**	**1**

Source: Grantees' applications, personal correspondence, and April 2013 SAPRs.

- **Site visits.** Cross-site evaluation team members will visit each grantee in approximately the third and fourth quarters of 2015. The visits will focus on the RPG planning process, how and why particular EBPs were selected, the implementation system's ability to support quality implementation for the 10 focal EBPs, and the implementation experiences of grantees and their partners.

- **Enrollment and Services Log (ESL).** The ESL, a web-based system, will provide information on implementation outputs. Grantee staff will use this system to record: demographic information about RPG case members at enrollment, enrollment and exit dates for each case that enrolls in the RPG project, enrollment and exit dates for all EBPs that are offered as part of the RPG project, and information on each service delivery contact for any of the 10 focal EBPs implemented by the grantee.

Our analysis will first focus on documenting and describing project implementation. It will then examine patterns and themes related to implementation that can support continuous project improvement activities by the RPG projects and build knowledge on implementing EBPs targeted to the needs of families in the child welfare and substance abuse treatment systems.

2. Partnership study

The need for collaboration to serve families involved with child welfare and substance abuse treatment systems motivated Congress to create the RPG program in 2006. At least two social service systems—child welfare and substance abuse treatment—will be involved in the RPG project in every site. Each has different missions, constituencies, funding sources, legal requirements and restrictions, and institutions. The partnership study will provide a description of the partnerships formed among each of the 17 RPG grantees, agencies in the community implementing RPG services, and organizations who have come together to support the RPG program (research question 1). The partnership study will draw on three main data sources: (1) SAPRs, (2) partner surveys, and (3) site visit interviews with RPG project directors.

- **SAPRs.** The SAPR includes questions about partners involved in the grantee's RPG project, such as their roles in RPG. Grantees will be asked to provide updates in the SAPRs about changes in partnerships, such as termination of relationships and new partnerships formed, throughout the evaluation period.

- **Partner Surveys.** Partners who participate in the RPG projects play a crucial role in planning and coordinating services for families across service-delivery systems. The survey will target the grantees and their primary partners, including those who provide services to RPG families, refer families to the RPG projects, and play other key roles in the RPG projects. We will ask the lead staff member for RPG within each partner organization to respond to the survey. We plan to administer the partner survey during the second quarter of 2015. We will ask all partners actively involved in each RPG project to complete the survey.

- **Site Visits.** Site visitors will conduct an individual interview with the RPG project director that will include discussion of their RPG partnerships. During the visit, the director interview will include a focus on understanding the RPG planning process, how and why particular partners were selected, and how the partnership developed, changes

in partnerships and the rationale for those changes, the director's perceptions of partnership quality, partnership challenges, and lessons learned.

The analytic methods to address the questions include descriptive analysis, social network analysis, and principal components analysis. For example, to describe the levels of communication and collaboration among partners, we will use the social network data from the partner survey. To operationalize the overall "quality" of the partnership, we will use a principal components analysis to distill an overall underlying "quality" score from several survey elements. Data collected from the grantee and partner organizations participating in each RPG project will be analyzed together, and then summarized in a cross-grantee analysis.

3. Outcomes study

The outcomes study provides an opportunity to describe the changes that occur in children, adults, and families who participate in the 17 RPG projects (research question 7). The projects are designed to support families in various ways, including addressing substance use disorders and improving parenting skills, so that children have safe and healthy environments in which to thrive. The outcomes study examines five domains of interest to Congress and CB: child well-being, permanency, safety, adult recovery, and family functioning/stability.

To address the five domains of interest, the outcomes study will use primary data and administrative data collected or obtained by the grantees and their evaluators (Table ES.3). Primary data will be based on self-administered standardized instruments that CB has asked all grantees and their evaluators to administer to RPG participants. The administrative data will include a common set of elements that grantees and their evaluators will obtain from states or providers. To measure change over time, local evaluations are asked to collect data prior to and after receipt of RPG services. Mathematica will use scores created from the instruments, individual items, or constructed variables to examine outcomes.

For the cross-site evaluation, grantees will collect data on one child in each family, even if multiple children in the family receive RPG services. This child is referred to as the "focal child" for data collection. Because projects are offering different services and serving different populations, each local team is in the best position to define the focal child who is of greatest interest to the evaluation. For example, if selected children receive RPG services or live with a parent in residential treatment for substance abuse, the team may want to define the focal child to include one of those children. To allow for flexibility in different grantee designs, each grantee will develop a decision rule for selecting the focal child and apply the rule consistently to all enrolled families. For example, a rule might state that the focal child is always the youngest child in the family. The cross-site evaluation team will document the decision rules and include them in cross-site evaluation reports.

Data from the instruments and administrative sources will be submitted on a biannual basis to the Outcome and Impact Study Information System (OAISIS), an online data collection system, starting in the second year of the evaluation. Grantees will submit the data in April and October of each calendar year, starting in 2014. For the outcomes study, grantee teams will submit data only on project participants. A subset of grantees, who are part of a cross-site impact study, will also submit data on their comparison group members.

Table ES.3. Information on Constructs by Domain, Outcome and Impact Studies

Construct	Source	Inclusion in Outcomes Study	Inclusion in Impact Study
Child Well-Being			
Child trauma symptoms	Trauma Symptoms Checklist for Young Children (Briere et al. 2001)	Yes	No
Executive functioning	Behavior Rating of Executive Function (Preschool or Older) (Gioia et al. 2000)	Yes	Recommended
Child behavior	Child Behavior Checklist (Preschool and School Age) (Achenbach and Rescorla 2000, 2001)	Yes	Yes
Sensory processing	Infant-Toddler Sensory Profile (Dunn 2002)	Yes	No
Social and adaptive behavior	Socialization Subscale, Vineland Adaptive Behavior Scales (Sparrow et al. 2005)	Yes	Yes
Permanency			
Removals from family of origin	Administrative data	Yes	Yes
Placements	Administrative data	Yes	Yes
Type of placements	Administrative data	Yes	Yes
Discharge	Administrative data	Yes	Yes
Safety			
Screened-in referrals	Administrative data	Yes	Yes
Type of allegations	Administrative data	Yes	Yes
Disposition of allegations	Administrative data	Yes	Yes
Death	Administrative data	Yes	Yes
Adult Recovery			
Substance use addiction severity	Addiction Severity Index (McLellon et al. 1992)	Yes	Yes
Parent trauma	Trauma Symptoms Checklist-40 (Briere and Runtz 1989)	Yes	No
Substance abuse services received	Administrative data	Yes	Yes
Type of discharge	Administrative data	Yes	Yes
Family Functioning/Stability			
Depressive symptoms	Center for Epidemiologic Studies-Depression Scale (Radloff 1977)	Yes	Recommended
Parenting skills	Adult-Adolescent Parenting Inventory (Bavolek and Keene1999)	Yes	No
Parental stress	Parenting Stress Index (Abidin 1995)	Yes	Yes
Family composition and relationships between family members	Addiction Severity Index (McLellon et al. 1992) and administrative data	Yes	No

To describe participant outcomes at baseline and program exit, change over time, and results for subgroups of interest, we will calculate means or proportions for each construct. Information will be presented by grantee as well as aggregated across grantees into summary statistics.

4. Impact study

CB is interested in assessing the effectiveness of programs proposed by the grantees (research question 7). To meet this objective, we will conduct a cross-site impact study that examines the effect of the interventions by comparing outcomes for individuals with access to RPG services with those in groups that do not receive the RPG services but may receive a different set of services (business as usual). Each of the RPG sites is charged with conducting a comparison group study, and the impact will include grantees with study designs that are randomized controlled trials or quasi-experiments with primary data collection from both treatment and comparison groups.

Randomized-controlled trials (RCTs) and quasi-experimental designs (QEDs) are rigorous designs for detecting program effects. The strength of both designs is based on baseline equivalence: the similarity of the program and comparison groups at baseline. If the groups are similar at the study's onset, then subsequent differences observed at the end of programming are attributable to the program, rather than to differences in the groups at the beginning of the study. With RCTs, random assignment creates two groups that are equivalent on all characteristics, on average. Factors, such as attrition, however, can erode the strength of the design. With QEDs, in which the program and comparison groups are created non-randomly, such as by self-selection or geographic location, equivalence can be established on measured variables. Because differences can always exist on unmeasured variables, QEDs are less rigorous than RCTs.

Analysis will begin with estimating site-specific impacts of the interventions implemented in the selected sites. We will examine impacts of the programs by comparing the treatment and comparison group at a follow-up time period, controlling for key baseline characteristics. We will use a consistent method across sites and examine the robustness of the results to ensure that the final results are not sensitive to the benchmark methods selected.

We will then create cross-site impact estimates based on aggregated estimates of site-specific impact estimates. This approach provides a more (statistically) powerful test of the effect of interventions. Our approach to aggregation is calculating impacts at varying levels of evidence. Specifically, we will calculate an aggregate impact for three groups of studies: (1) those with the strongest evidence available—that is, the well-implemented RCTs;[1] (2) those with moderate evidence—that is, well-implemented QEDs and RCTs with some issues, such as high attrition; and (3) all studies in groups 1 and 2. We will compare the results from groups 1 and 2 to determine whether the findings are substantively different. The results from group 3 will have the greatest statistical power, but the inclusion of QEDs and RCTs with high attrition may create bias in this pooled impact estimate.

[1] Although this aggregate impact will be based on well-implemented RCTs (for example, RCTs with low attrition rates) it is not necessarily free from bias because studies are being excluded based on factors determined post-randomization (that is, on factors that are endogenous, not exogenous).

Seven grantees are candidates for inclusion in the cross-site impact study. Five of the grantees are proposing RCTs that could provide strong research evidence. These grantees plan to include a total of 1,810 families in their local evaluations over the course of the grant period. In addition, two grantees are proposing QEDs with plans to do primary data collection on key baseline variables across both treatment and control groups. The QED studies will include a total of 700 families over the course of the grant period. We will combine information from sites doing RCTs or QEDs to test the broad effectiveness of the collection of interventions across both sets of studies listed above, for a total of 2,510 families.

We have estimated the smallest effect or impact that will be detectable in the analysis, given expected sample sizes. These are smallest (that is, we have the greatest statistical power to observe program impacts) when we pool information across both RCTs and QEDs to aggregate information across all participating grantees. When we pool the evidence from the RCTs with the QEDs, we expect to be able to detect a difference as small as 5.9 percentage points.

Most of the data needed to conduct the impact analyses will be uploaded by grantees to the OAISIS and ESL systems. For the treatment group, all grantees will submit demographic data to the ESL for the implementation study and outcome data to OAISIS as a component of the outcomes study. Grantees participating in the impact study will provide similar data elements for members of their comparison groups.

To reduce the burden on the grantees and local evaluators, we limited the outcomes that the impact study will include (Table 3). Thus, only a subset of the instruments being used in the outcomes study will be collected from the comparison groups at baseline and at program exit (at the same time periods of data collection for the treatment group).

D. REPORTING

To support program development and improvement and inform stakeholders—including the CB, Congress, and the grantees themselves—results from the cross-site evaluation will be released throughout the evaluation period. Products include annual reports to Congress, annual cross-site evaluation program reports, special topics briefs, and the final evaluation report. To disseminate findings more broadly, the cross-site team, sometimes in partnership with grantees, will also present at professional conferences, brief federal interagency groups, and publish in scholarly journals. We will also prepare a restricted-use data file available to qualified researchers through the National Data Archive on Child Abuse and Neglect at Cornell University, including documentation for users.

I. INTRODUCTION

Adult substance abuse can destabilize families, with potentially long-term negative consequences for children. When mothers, fathers, or other caregivers struggle with addiction, children can experience unresponsive, erratic, neglectful, or abusive care from those responsible for their nurturing. This negligence can in turn interfere with children's physical, social, and emotional development and well-being. A substance use disorder limits a parent's ability to create a safe and stable environment for his or her children, and children of substance-abusing parents have poorer physical, intellectual, social, and emotional health and are at greater risk of abusing drugs or alcohol themselves as adults (U.S. Department of Health and Human Services 1999, 2009; Osterling and Austin 2008; Niccols et al. 2012). Trauma resulting from parental neglect or abuse associated with substance use disorders can be particularly detrimental to young children's development.

The problem of substance use disorders and its effects on children is far reaching. An estimated 9 percent of children live with at least one parent who abuses illicit drugs or alcohol (U.S. Department of Health and Human Services 2009). Most adult participants in substance abuse treatment are parents. One study concluded that about 58 percent of participants in treatment had minor children—69 percent of women were mothers, and 52 percent of men were fathers (Young et al. 2007; Brady and Ashley 2005). Further, it was estimated that 27 percent of parents in treatment had lost custody of one or more children. Indeed, substance use disorders are a prominent cause of family involvement in the child welfare system: 50 to 80 percent of child welfare cases involve a substance-abusing parent (Niccols et al. 2012; U.S. Department of Health and Human Services 1999).

The ability of the child welfare and substance abuse treatment systems to coordinate services to address the needs of these families has been challenging (U.S. Department of Health and Human Services 1999; Semidei et al. 2001). Each system is embedded in different federal and state legal and policy environments, and each has a different position on who the "client" is (the parent or the child) and about issues such as the separation of parents from their children, through removal and reunification or during substance abuse treatment. Ineffective screening by staff in both types of agencies can make early detection of problems difficult, and confidentiality requirements can hinder cooperation and communication across systems, making it hard to identify and address client needs.

Since 2006, Congress has authorized competitive grants to address these problems. The Child and Family Services Improvement Act of 2006 (Pub. L 109-288) provided funding over a five-year period to implement regional partnerships among child welfare, substance abuse treatment, and related organizations to improve the well-being, permanency, and safety outcomes of children who were in or at risk of out-of-home placement as a result of a parent's or caregiver's substance use disorder. With this funding, the Children's Bureau (CB) within the Administration for Children and Families, Administration on Children, Youth, and Families at the U.S. Department of Health and Human Services (HHS) established the Regional Partnership Grant (RPG) program.

Under the first RPG program, CB awarded 53 three- and five-year grants in September 2007. Grantees were located in 29 states and included six Native American tribes. Most grantees provided services to families with children placed out of the home or living at home but at risk of out-of-home placement (U.S. Department of Health and Human Services 2010; U.S. Department of Health

and Human Services 2013b). In addition, most RPG projects[2] included at least 10 partner agencies, such as child welfare agencies, substance abuse treatment providers, courts, health and mental health service providers, criminal justice systems, education and early childhood development agencies, housing providers, and other community-based multiservice agencies. Grantees were legislatively required to collect and report on selected performance indicators; two reports to Congress have been published describing grantees' implementation and performance (U.S. Department of Health and Human Services 2010, 2013b). In addition, each grantee conducted an evaluation of its project.

The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) reauthorized the RPG program and extended funding through 2016. On September 28, 2012, the CB awarded RPG funding under the grant program to 17 partnerships in 15 states (Table I.1).[3] The 2012 RPG funding differs from the original 2007 RPG funding in several ways:[4]

- **Removed emphasis on methamphetamine:** the legislation reauthorizing the RPG program (Public Law 112-34) removed references to methamphetamine, including the requirement that gave weight to grant applications focused on methamphetamine use.
- **Reports:** HHS must evaluate and report on the effectiveness of the grants. The reauthorizing legislation required a report on the first round of RPG funding by December 31, 2012 and the second round by December 31, 2017. These reports must include an analysis of the grantees' success in meeting performance indicators and addressing the needs of families with substance use disorders.

Other noteworthy components of the second round of RPG funding include:

- RPG grantees are required to adopt and implement programs and services that are *trauma-informed*.[5] In response to scientific findings that continue to emerge about the long-term neurological, behavioral, relational, and other impacts of maltreatment on children, CB is urging states and child welfare systems to do more to attend to children's behavioral, emotional, and social functioning (Samuels 2012; Administration for Children and Families 2012b). One component of this process is addressing the impact of trauma and its effect on the overall functioning of children and youth.
- CB required grantees to adopt and implement specific, well-defined program services and activities that were *evidence-based or evidence-informed*. Since the first round of RPG funding, federal leaders and policymakers have increasingly emphasized evidence-based

[2] To distinguish individual grants from the overarching RPG program, we refer to grantees' RPG services as "projects." However, throughout the report, we will occasionally use "program" to refer to grantee activities, when that term is more commonly used. For example, we refer to participants leaving the grantee projects as "program exit."

[3] The number of grantees was larger under the first round of RPG grants because total funding for the first round of the program was significantly higher. Program funding was $145 million in 2006 and $100 million in 2011.

[4] For more information, including the reauthorized legislation and a summary of changes, see http://www.acf.hhs.gov/sites/default/files/cb/im1106.pdf.

[5] Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities of trauma survivors that traditional service-delivery approaches may trigger or exacerbate, so that these services and programs can be more supportive and avoid retraumatizating participants (SAMHSA n.d.(b)).

and evidence-informed practices in their budgeting and program decisions (Haskins and Baron 2011).

- Reflecting the emphasis on evidence-based practices, CB established a cross-site evaluation to test innovative approaches and to develop and disseminate knowledge about what works to improve outcomes for affected children and youth. It also required grantees to conduct well-designed outcome evaluations and to contribute to the cross-site evaluation.
- To support the expanded evaluation requirements, CB added evaluation-related technical assistance to the programmatic technical assistance provided to earlier grantees.

CB has funded Mathematica Policy Research, along with its subcontractor Walter R. MacDonald & Associates (WRMA), to conduct a five-year cross-site evaluation of the grantees' RPG projects. The primary purposes of this evaluation are to (1) describe grantee performance; (2) conduct a national evaluation of the RPG program including a rigorous test of program effectiveness; and (3) furnish evaluation-related technical assistance to grantees to support their local evaluations and their participation in the cross-site evaluation. The cross-site evaluation will document the projects and activities conducted through the RPG program and assess the grantees' success in using funds to address the needs of families with substance use disorders who come to the attention of the child welfare system.

This report describes the design of the cross-site evaluation. In developing the design over the first year of the contract, the cross-site evaluation team worked closely with CB and the 17 grantees and their local evaluators, as well as the National Center on Substance Abuse and Child Welfare (NCSACW). To address the legislative requirements and the evaluation goals established by CB, and reflecting the diversity of grantees, their RPG projects, and their provision of multiple program services and activities, the cross-site evaluation consists of four study components.[6] The introductory chapter identifies the research questions that frame the evaluation and presents a conceptual framework to guide the design of the evaluation. It describes the four components of the evaluation and how we have organized the remainder of the report.

[6] As an example of the diversity in projects, all 17 grantees combined plan to provide more than 50 interventions. Each grantee is providing at least one intervention; some are providing 10 or more.

Table I.1. RPG Grantees

Grantee Organization	State	Organization Type	RPG1 Grantee	Target Population and Project Focus
Center Point, Inc.	California	Substance abuse treatment agency/ provider	Yes	Center Point will provide substance abuse treatment and complementary services to women with diagnosable substance use disorders and their children ages 0–5 who are in or at risk of an out-of-home placement. Pregnant women will also be eligible. The project will include residential substance abuse treatment, on-site parenting/family-strengthening curricula, Head Start and other child development services, employment-preparedness services, and case management. Participants will also receive home visits.
Georgia State University Research Foundation, Inc.	Georgia	Research corporation—nonprofit	No	The grantee and its partners will provide evidence-based parenting and trauma services to adult criminal drug court clients and their children. In addition to "standard" drug court services—such as substance abuse treatment, random drug screenings, and graduated sanctions and incentives—participants will receive adult and child trauma treatment and a parenting/family-strengthening curriculum, which are delivered in an integrated manner.
Judicial Branch, State of Iowa	Iowa	State judicial agency	Yes	Iowa Children's Justice (CJ) will pilot a new service-delivery and care-coordination system for families in one of the state's family treatment courts. The project will serve families with children ages 0–18 in which parents have substance use disorders and children are in or at risk of placement in foster care. Participating families will receive parenting/family-strengthening curricula, and referral for trauma treatment, as needed.
Northwest Iowa Mental Health Center/Seasons Center	Iowa	Community mental health service provider	No	Seasons Center offers trauma treatment programs to families with children ages 0–18 who are referred by the Department of Human Services, juvenile court services, or family treatment court based on their scores on a brief trauma screening instrument. Participating families will receive one of four programs that aim to help parents and children recover from trauma and strengthen their bonds.

Table I.1 *(continued)*

Grantee Organization	State	Organization Type	RPG1 Grantee	Target Population and Project Focus
Children's Research Triangle	Illinois	Child and family services provider	Yes	The grantee will provide comprehensive well-being services for children in out-of-home care due to substance use disorders in their families and who also screen positive for trauma or mental health issues. Participating children receive out-of-home care from SOS Children's Villages, an alternative foster care system, and are assigned to a family support specialist who links them and their families to coordinated, integrated services, as well as an SOS case manager. Services may include trauma treatment, parenting/family-strengthening curricula, or child-caregiver therapy, delivered by an integrated team of clinicians. In addition, foster parents may be able to participate in support groups and other group activities.
Kentucky Department for Community Based Services	Kentucky	State child welfare agency	Yes	Through the Sobriety Treatment and Recovery Teams (START) project, the grantee will provide in-home support and access to wraparound services to families with children ages 0–5 that are at risk of an out-of-home placement due primarily to parental substance use disorders. Participating families will receive case management from a START worker (a specially trained Child Protective Services worker) and additional support from a family mentor (a specialist in peer support for long-term addiction recovery). START workers and mentors visit families in their homes to deliver substance abuse treatment, child-caregiver therapy, parent training, and trauma treatment.
Commonwealth of Massachusetts	Massachusetts	Joint state child welfare/ substance abuse agency	Yes	The Family Recovery Project Southeast will provide coordinated, in-home substance abuse treatment, parenting/family-strengthening curricula, trauma treatment, and case management services. The project will serve families whose children have been removed or are at imminent risk of removal from the home, and in which parents have substance use disorders but have been difficult to engage in treatment. Participating families will receive weekly or more frequent visits from a family recovery specialist who provides services, coordinates with the child welfare case manager, and helps the family transition to community-based services.

Table I.1 *(continued)*

Grantee Organization	State	Organization Type	RPG1 Grantee	Target Population and Project Focus
Families and Children Together	Maine	Child welfare services provider—nonprofit	No	The Penquis Regional Linking Project will provide case management and service linkages to rural families with children ages 0–5 who are in or at risk of an out-of-home placement and who face caregiver substance use disorders. Pregnant women will also be eligible. Participating families will be assigned to a Families and Children Together (FACT) navigator who will assess their needs and may refer them to parenting/family-strengthening curricula and/or substance use disorder screening services. Navigators will also help families build formal and informal supports and work to reduce barriers to accessing services. In addition, families will have access to financial assistance for transportation and child care, and a peer-mentoring program.
Alternative Opportunities, Inc.	Missouri	Substance abuse treatment agency/ provider	No	The grantee will provide the Services, Needs, Abilities, and Preferences (SNAP) approach—which includes case management and customized services—to families with substance use issues and children age 0–21 who are in or at risk of an out-of-home placement. Participating families will take part in family group conferencing and receive specialized case management, recovery coaches, and a customized plan of parenting/family-strengthening curricula, trauma treatment, and substance abuse treatment. In addition, they will receive access and referrals to health care, transportation, and housing and child care support.
The Center for Children and Families	Montana	Child and family services provider	Yes	The Center will offer Family Treatment Matters (FTM)—a comprehensive outpatient substance abuse treatment and family services project—to families with children ages 0–12 who are in or at risk of an out-of-home placement due to parental substance use disorders. Participating families will receive a combination of substance abuse treatment—which is provided in three phases that progressively decrease in intensity—parenting/family-strengthening curricula, life skills development for adults, and child development/resilience-building for children. A caseworker will provide assistance with ancillary services as needed, such as child-caregiver therapy, neuropsychological evaluations, or therapeutic groups. In addition, the grantee has adapted its services to address the needs of Native American populations.

Table I.1 *(continued)*

Grantee Organization	State	Organization Type	RPG1 Grantee	Target Population and Project Focus
State of Nevada Division of Child and Family Services	Nevada	State child welfare agency	Yes	In collaboration with partners, the grantee will provide the Dependency Mothers Drug Court (DMDC) program: enhanced on-site services for low-income women receiving substance abuse treatment in a residential facility and their children ages 0–8 who are in or at risk of an out-of-home placement. Participating families will receive residential substance abuse treatment in a modified therapeutic community, with children under age 8 able to join their mothers in the facility after a 30-day adjustment period. Families will have access to peer mentoring and substance use counseling. In addition, the enhanced services consist of treatment supervision and collaborative case management monitored by the court, as well as on-site counseling/mental health, parenting/family-strengthening curricula, vocational services, assessments, and referrals for children, and transitional services after leaving the facility.
Summit County Children Services	Ohio	County child welfare agency	No	Summit County Children Services will provide the STARS (Summit County Collaborative on Trauma, Alcohol & Other Drug, & Resiliency-Building Services for Children & Families) service coordination and engagement project to families that have child welfare cases with court involvement. Families will receive an in-home alcohol or other drug assessment and will be assigned a STARS coordinator who will coordinate child welfare and substance abuse treatment services, as well as a public health outreach worker who will provide ongoing phone contact and help with service coordination. In addition, families will have access to a recovery coach, participate in a parent/family-strengthening curriculum, and receive trauma treatment for children, youth mentoring/tutoring, and transportation assistance, as needed.

Table I.1 *(continued)*

Grantee Organization	State	Organization Type	RPG1 Grantee	Target Population and Project Focus
Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS)	Oklahoma	State substance abuse agency	Yes	Oklahoma DMHSAS will provide two distinct interventions, both of which serve families affected by parental substance use disorders with children who are in an out-of-home placement. The projects are distinct, and will serve different families: The Strengthening Families Program (SFP) is a highly-structured family skills training project that includes components for parents, children, and both together. Solution-Focused Brief Therapy (SFBT) is a "strengths-based" counseling intervention to support recovery from substance use disorders. The project will also include UNCOPE, a universal substance use assessment, being rolled out statewide.
Health Federation of Philadelphia, Inc.	Pennsylvania	Community health services provider	No	The grantee will provide Child Parent Psychotherapy (CPP) to families seeking services at Achieving Reunification Center (ARC). The intervention will serve families in which parents have substance use disorders and children ages 0–5 who have been placed outside the home. The ARC offers families case management, adult and child mental health services, substance abuse treatment, parenting/family-strengthening curricula, employment services, housing assistance, psycho-educational groups, and on-site child care. CPP, the additional service, is a therapeutic treatment focused on the child-caregiver relationship. It incorporates trauma treatment and includes supervised visits between parents and children in out-of-home placements.
Helen Ross McNabb Center	Tennessee	Substance abuse treatment agency/ provider	Yes	The grantee will provide New Beginnings for Children, Women, and Families (NB), which offers early intervention and wraparound services to substance-addicted parents and their children ages 0–18. Many children served will be at risk of an out-of-home placement. Parents will receive residential, intensive outpatient, or in-home substance abuse treatment, and their families will have access to comprehensive family assessment, parenting/family-strengthening curricula, trauma treatment, housing/help finding housing, and integrated health care. Children ages 0–12 may live with their parents enrolled in residential treatment while they undergo substance abuse treatment.

Table I.1 *(continued)*

Grantee Organization	State	Organization Type	RPG1 Grantee	Target Population and Project Focus
Tennessee Department of Mental Health and Substance Abuse Services	Tennessee	State substance abuse agency	Yes	The grantee will provide Therapeutic Intervention, Education, and Skills (TIES)—a suite of coordinated services—to families with children ages 0–17 who are in or at risk of an out-of-home placement due to parent/caretaker substance use disorders. TIES consists of in-home Intensive Family Preservation Services (which is based on Homebuilders, a family-strengthening and case management model), followed by trauma treatment as needed.
Rockingham Memorial Hospital	Virginia	Community health services provider	No	The grantee will provide substance abuse treatment and complementary services to mothers with substance use disorders and their children who are in or at risk of an out-of-home placement. Families will receive an individualized set of services from substance abuse specialists. In addition to substance abuse treatment, this approach may include parenting/family-strengthening curricula; home visits; trauma treatment; and referrals to additional substance abuse treatment.

A. Research Questions

Through the RPG cross-site evaluation, CB seeks to add to the knowledge base about effective models for improving the well-being, permanency, and safety of children, facilitating adult recovery from substance use disorders, and supporting family functioning and stability for the target groups served by the RPG program. In particular, CB is interested in the factors associated with successful implementation of evidence-based practices (EBPs) and programs, the potential for sustaining them, their suitability for replication, and the effects of the RPG projects on participant outcomes. Taking these goals into consideration, the cross-site evaluation is designed to address the following research questions:

1. Who was involved in each RPG project and how did the partners work together? To what extent were the grantees and their partners prepared to sustain their projects by the end of the grant period?
2. Who were the target populations of the RPG projects? Did RPG projects reach their intended target populations?
3. Which EBPs did the RPG projects select? How well did they align with RPG projects' target populations and goals?
4. What procedures, infrastructure, and supports were in place to facilitate implementation of the EBPs?
5. How were the EBPs implemented? What services were provided? What were the characteristics of enrolled participants?

6. To what extent were the RPG projects prepared to sustain their EBPs at the end of the grant period?
7. What were the well-being, permanency, and safety outcomes of children, and the recovery outcomes of adults, who received services from the RPG projects?

B. The Conceptual Framework for the RPG Cross-Site Evaluation

Before an evaluation could be designed, the evaluation team needed to understand the logic underlying the structure and goals of the RPG program. To guide the evaluation design process, Mathematica/WRMA developed a conceptual framework that illustrates how the 17 RPG projects will implement and support EBPs (Figure I.1). Similar to a logic model, this framework describes and draws connections between inputs to implementation, implementation outputs, and outcomes for children, adults, and families as well as for the RPG partnerships themselves. The figure shows the research questions associated with each element of the framework. This section describes each part of the framework and how we will use it to guide cross-site evaluation.

1. Inputs to Implementation

Inputs to implementation include the services grantees plan to implement, the characteristics of participants that enroll in RPG projects, members of the regional partnerships and their attributes, and the implementation systems developed to facilitate service delivery.

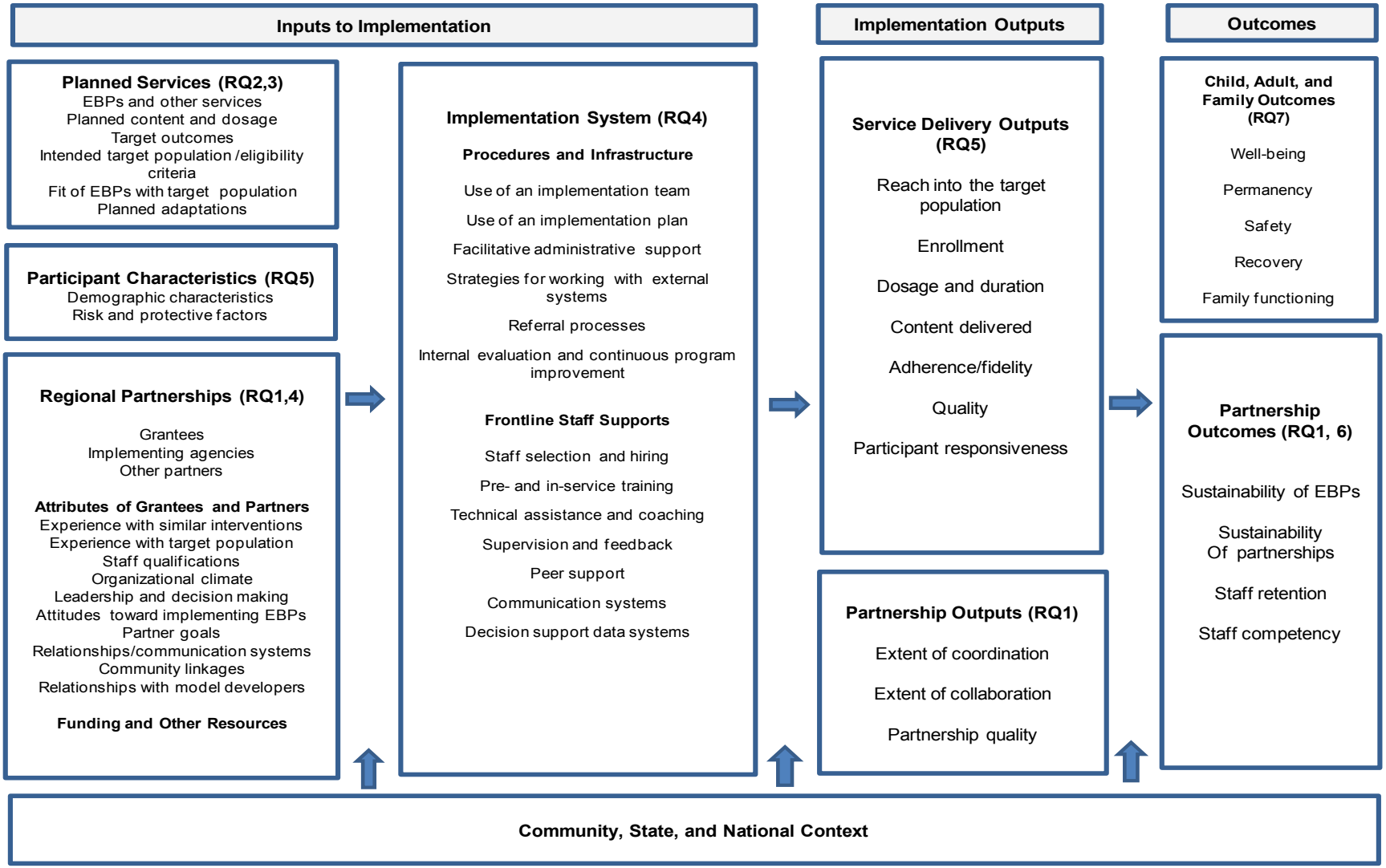
Planned services. Each grantee has selected one or more EBPs to improve child, adult, and/or family outcomes. Grantees may also implement other services, such as assessment, referral to outside services, or case management. The cross-site evaluation will provide information about the features of the EBPs and other services, including the intended target populations and the project's eligibility criteria, the planned content and dosage of the EBPs, and target outcomes. The cross-site evaluation will assess the fit of the EBPs with each grantee's intended target population and any adaptations the grantees plan to make to the EBPs to improve the fit.

Participant characteristics. The RPG projects will enroll children, adults, and families with a range of demographic characteristics and risk and protective factors. The cross-site evaluation will document the characteristics of these participants.

Regional partnerships. The RPG partnerships include all of the entities that come together to support the 17 RPG projects, including the grantees, the agencies implementing the EBPs and other services, and other key organizations (such as funders or advisory groups). The cross-site evaluation will provide information about the entities involved in each of the 17 RPG partnerships. We will document partners' experiences with similar services, programs, and the proposed target population; the qualifications of staff delivering the EBPs; the organizational climate of implementing agencies; leadership and decision making within implementing agencies and among the partners; staff attitudes toward implementing EBPs; the perspectives and goals of partner agencies; relationships and communication systems among partners; other links to the community; and relationships with model developers. Finally, the cross-site evaluation will describe the grant funds and other resources that the grantee and partners bring to the RPG program.

Implementation system. The cross-site evaluation will document the extent to which RPG projects develop procedures, infrastructure, and staff supports that research literature has shown to be associated with quality implementation.

Figure I.1. Conceptual Framework for the Cross-Site Evaluation



RQ= Research Question

- **Procedures and infrastructure.** We will document the use of implementation teams to support initial implementation and the development and content of implementation plans to guide the work of these teams. We will also examine the extent to which administrative processes within agencies facilitate implementation of the EBPs, and strategies for working with external systems (for example, the health care system). In addition, we will document the use of internal evaluation to support continuous quality improvement.
- **Frontline staff supports.** The cross-site evaluation will document the process of selecting and hiring of frontline staff and provision of pre- and in-service training, ongoing technical assistance and coaching, supervision and feedback, and peer support. In addition, we will document communication systems that support frontline staff, and staff use of data systems to support programmatic decision making.

2. Implementation Outputs

The products of the implementation system are service-delivery and partnership outputs.

Service-delivery outputs. These outputs constitute the services provided by the RPG projects. The cross-site evaluation will document each grantee's reach into the intended target population and levels of enrollment into EBPs. For selected EBPs, we will also document dosage and duration of services, content delivered, adherence to developer-prescribed content and service-delivery procedures, and participant responsiveness.

Partnership outputs. The partnership study will document coordination and collaboration among the grantee and its partners, as well as the partners' perceptions of partnership quality.

3. Outcomes

The cross-site evaluation will describe outcomes for children, adults, and families enrolled in the RPG projects and the outcomes of the partnerships. Outcomes of interest to Congress and CB were identified in the RPG funding opportunity announcement, as well as in the statement of work for the RPG cross-site evaluation.

Child, adult, and family outcomes. These outcomes include measures of child well-being (such as executive functioning, sensory processing, and behavior), permanency (such as whether the child was removed from the home, the type of settings he or she was placed in while removed, and whether he was discharged from the state's care), and safety (such as the rates and types of child maltreatment). The study will also describe adults' recovery outcomes as well as family functioning and stability.

Partnership outcomes. The cross-site evaluation will assess the extent to which partnerships are prepared to sustain the EBPs and the partnerships themselves at the end of the grant period. The study will also describe the extent to which partners who deliver services through RPG retain frontline staff, and the perceived competency of staff in their roles as service providers.

4. Community Context

Underlying the entire framework—inputs, outputs, and outcomes—is the context of the state and communities in which the RPG projects operate and participants reside. Aspects of community context that the cross-site evaluation will capture include information on available resources; child

welfare; substance abuse treatment; judicial, fiscal, and other policies; competing interests; and other factors that may influence the implementation of the projects and outcomes for program participants.

C. Components of the Cross-site Evaluation

Based on the conceptual framework, and to address the research questions established, the RPG cross-site evaluation has four main components: (1) an implementation study, (2) a partnership study, (3) an outcomes study, and (4) an impact study.

Implementation study. A growing body of research indicates that the quality of program implementation matters for participant outcomes (Dane and Schneider 1998; Durlak and DuPre 2008; Dusenbury et al. 2005; Fixsen et al. 2005; Berkel et al. 2011). The implementation study will examine the process of implementation, with a focus on factors the research literature shows are associated with quality implementation (Fixsen et al. 2005; Metz and Bartley 2012; Meyers, Katz, et al. 2012; Meyers, Durlak, and Wandersman 2012). It will describe RPG projects' target populations, selected interventions and their fit with the target populations, inputs to implementation, and services provided for a subset of interventions (including their dosage, duration, content, adherence to curricula, and participant responsiveness).

Partnership study. The RPG program requires grantees to develop and sustain partnerships. Organizations from at least two social service systems—child welfare and substance abuse treatment—will be involved in these partnerships; some RPG grantees will involve additional systems such as the courts. Using tools adapted from the literature on complex adaptive systems (Hargreaves 2010; Eoyang 2007) and the Collaborative Capacity Instrument (National Center on Substance Abuse and Child Welfare 2003), the partnership study will examine key attributes of the RPG partnerships—membership in the partnerships, partners' relationships, and partners' perspectives and goals. We will also adapt approaches currently being employed to describe partnerships in the Supporting Evidence-Based Home Visiting Cross-Site Evaluation and the Integration Initiative Evaluation (Cole and Rosenbach 2012). This component of the cross-site evaluation will describe the characteristics of the partner agencies involved in each of the 17 RPG projects, their relationships and communication patterns, the extent of coordination and collaboration, and their potential to sustain the partnerships at the end of the grant period.

Outcomes study. The outcomes study will describe the children and families who participate in the RPG projects, and any changes in selected outcomes after services end. We will provide descriptions of the well-being, permanency, and safety status for children and the recovery and family functioning/stability status for adults enrolled in the RPG projects at enrollment and program exit.

Impact study. To assess the effectiveness of RPG projects for a subset of child, adult, and family outcomes, we will conduct an impact study to include selected grantees. The cross-site evaluation team will assess the rigor of the design and execution of local evaluations to determine the level of evidence that they offer. Grantees selected for the impact study, based on the rigor of their local evaluations, will provide data on their comparison groups, in addition to those in their program or treatment groups. We will estimate site-specific impacts and aggregate impact estimates by pooling across local evaluations to describe the effectiveness of the RPG projects included in the study.

The remaining chapters of the report provide a detailed description of the four cross-site evaluation studies. Each chapter identifies the general and detailed research questions addressed by the study, then describes the data collection and analytic strategy for each, as well as the study's limitations. Chapter II describes the implementation study, Chapter III describes the partnership study, Chapter IV describes the outcomes study, and Chapter V describes the impact study. In Chapter VI, we discuss plans for reporting and dissemination of cross-site evaluation findings. Appendices A through F provide data collection instruments and additional technical information.

II. IMPLEMENTATION STUDY

RPG projects involve coordination between at least two service systems: child welfare and substance abuse treatment. Providers in both systems must also take account of or in some cases work directly with other systems that affect RPG families, such as the family and/or criminal court systems, schools, or health care. Whether they are offering one core intervention or multiple options, grantees and their partners planned to make comprehensive services available to the adults and children in their projects. Many grantees were newly implementing one or more evidence-based programs (EBPs) or practices that might require specialized training for staff or certification by the program developer, or adapting the program model for the groups grantees intended to enroll. All told, grantees proposed 51 interventions. Most grantees plan to offer families at least two interventions, and three grantees will offer 10 or more. Implementing these projects is challenging and an important focus of the cross-site evaluation.

A growing body of research indicates that the quality of program implementation influences the outcomes achieved for program participants across a range of disciplines and services (Dane and Schneider 1998; Durlak and DuPre 2008; Dusenbury et al. 2005; Fixsen et al. 2005; Berkel et al. 2011). However, ample evidence exists of a gap between evidence about effective practices and interventions and their use by practitioners (Clancy and Cronin 2005; Rogers 2003; Saul et al. 2008; Wandersman et al. 2008). In particular, few substance abuse treatment programs embody tested, evidence-based approaches (National Center on Addiction and Substance Abuse at Columbia University 2012). Even when use of EBPs is a requirement of funding, replicating the effects of an intervention requires more than simply deciding to adopt an EBP (Durlak and DuPre 2008). Identifying core components of interventions and understanding what it takes to implement those components with fidelity to program models is critical to successful implementation.

There is growing recognition across disciplines of the importance of implementation research to guide adoption and replication of evidence-based interventions (Berkel et al. 2011; Durlak and DuPre 2008; Gearing et al. 2011; Glasgow et al. 2012). The RPG cross-site evaluation will contribute to building the knowledge base about effective implementation strategies by examining the process of implementation in the 17 RPG projects, with a focus on factors shown in the research literature to be associated with quality implementation. In particular, we will use two implementation frameworks that are based on syntheses of the literature on implementation processes: (1) the Quality Implementation Framework developed by Meyers and colleagues (2012) and (2) the Active Implementation Framework (Fixsen et al. 2005; Metz and Bartley 2012). These frameworks include temporal stages of implementation and structural supports necessary for quality implementation, and provide a framework for the RPG implementation study. In line with the frameworks, we will examine activities conducted at different stages of implementation and implementation progress over time, as well as the extent to which structural supports for implementation are in place. (See Figure I.1 for these components of the implementation system.)

In this chapter, we review research questions for the implementation study and describe our plans for data collection and analysis.

A. Implementation Study Research Questions

The implementation study will address five of the cross-site evaluation research questions listed in Chapter I (questions 2-6). We expect to address the following questions, along with the more detailed sub-questions listed:

- What were the target populations of the RPG projects?
  - To what extent did RPG projects reach their target populations?
- Which interventions did RPG projects select?
  - What is the evidence base for the selected EBPs?
  - What services are offered through the selected EBPs?
  - How did grantees plan to adapt the selected EBPs?
  - How well did the EBPs align with RPG projects' target populations and goals?
- What procedures, infrastructure, and supports were in place to facilitate implementation of the EBPs?
  - What were the qualifications of staff implementing the EBPs?
  - How supportive was the organizational climate of implementing agencies?
  - How supportive were agency leaders and decision making processes?
  - What were staff attitudes toward implementing the EBPs?
  - Did RPG projects create implementation teams?
  - Did RPG projects develop written implementation plans?
  - To what extent did the administrative processes of implementing agencies support implementation?
  - What strategies were used to facilitate implementing agencies' interactions with outside systems (such as health care) necessary to implement the EBPs?
  - What referral systems did RPG projects put in place?
  - Did RPG projects assess implementation? What continuous quality improvement processes were used?
  - What processes were in place for selecting and hiring staff?
  - What pre- and in-service training did staff receive? How helpful was the training from the perspective of frontline staff and supervisors?
  - What kinds of technical assistance and coaching did staff receive? How helpful were these methods from the perspective of frontline staff and supervisors?
  - What kind of supervision and feedback did staff receive?
  - What kind of peer support did staff receive? Did they perceive it to be helpful?
  - How well did communication systems support staff in their work?
  - Did staff use data systems to support programmatic decision making?
  - Which procedures, infrastructure, and supports were most useful for supporting implementation from the perspective of frontline staff, supervisors, and managers?
- How were the EBPs implemented? What services were provided? What were the characteristics of enrolled participants?

  - How many families were enrolled? Did RPG projects meet their enrollment targets?
  - What tools did RPG projects use to assess families' needs and how were the results used?
  - What services were delivered?
  - What dosage of services was delivered?
  - What was the duration of enrollment?
  - How closely did RPG projects adhere to the planned content of the EBPs?
  - How closely did RPG projects adhere to fidelity standards as defined by model developers?
  - How responsive were participants to the services offered?
  - What implementation challenges were encountered, and how were the challenges addressed?
  - What implementation successes were achieved?
- To what extent were the RPG projects prepared to sustain the EBPs at the end of the grant period?
  - What resources and plans were in place to support sustainability?

B. Focal Evidence-Based Programs

In its grant announcement for the RPG program, CB required grantees to select "services or practices that have a demonstrated evidence base, that are appropriate for the population of focus, and that are shown to be effective in achieving the outcomes of the proposed project." Further, CB defined an evidence-based practice as one that is "validated by some form of documented research evidence." The grant announcement provided a list of resource websites that applicants could consult for information about the evidence base for relevant EBPs, and stated that applicants could provide other evidence from the research literature to demonstrate the effectiveness of their selected EBPs. For the purposes of the cross-site evaluation, we refer to the interventions in these CB-approved RPG grant applications as EBPs.[7]

[7] As part of its contract, Mathematica identified all the grantee-proposed interventions and searched for whether they had been included in any of several relevant evidence reviews (Strong et al. 2013).

Table II.1. Focal Evidence-Based Program and Practice Models Selected by Grantees as of January 2014

EBP or Practice	Number of Grantees Implementing	Alternative Opportunities, Inc., Missouri	The Center for Children and Families, Montana	Center Point, Inc., California	Helen Ross McNabb Center, Tennessee	Children's Research Triangle, Illinois	Families and Children Together, Maine	Georgia State University Research Foundation	Health Federation of Philadelphia	Judicial Branch, State of Iowa	Kentucky Department for Community-Based Services	Commonwealth of Massachusetts	State of Nevada Division of Child and Family Services	Northwest Iowa Mental Health Center/Seasons Center	Rockingham Memorial Hospital, Virginia	Oklahoma Department of Mental Health and Substance Abuse Services	Summit County Children Services, Ohio	Tennessee Department of Mental Health and Substance Abuse Services
Celebrating Families!	3		X	X						X								
Child-Parent Psychotherapy	4					X			X		X	X						
Cognitive Behavior Therapy	5		X		X	X					X				X			
Hazelden Living in Balance Programs	4	X	X	X							X							
Matrix Model Program	4	X	X	X	X													
Nurturing Parenting Programs	6	X			X		X	X				X	X					
Parent and Child Interactive Therapy	2	X												X				
Seeking Safety	7	X	X	X	X						X	X						X
Strengthening Families	3									X						X	X	
Trauma-Focused Cognitive Behavior Therapy	6	X			X	X		X					X	X				
Total per Grantee		**6**	**5**	**4**	**5**	**3**	**1**	**2**	**1**	**2**	**4**	**3**	**2**	**2**	**1**	**1**	**1**	**1**

Source: Grantees' applications, personal correspondence, and April 2013 SAPRs.

Note: To maintain a similar level of effort across grantees, some grantees implementing numerous focal EBPs and/or serving many cases will only report service log information on a subset of the focal EBPs. These grantees are: Alternative Opportunities, Inc.; Helen Ross McNabb Center; Kentucky Department for Community-Based Services; and The Center for Children and Families.

The EBPs selected by grantees are the primary focus of the implementation study. The 17 grantees have proposed to implement a large number of EBPs—51 across all 17 grantees— more than can be feasibly studied by the cross-site evaluation. Therefore, the evaluation team selected a subset of 10 EBPs as the focus of the implementation study (Table II.1). As we describe later in the chapter, selected components of the evaluation will focus exclusively on these 10 EBPs. We used the following criteria to select these "focal EBPs:"

- The EBPs should represent to the extent feasible the range of interventions that grantees are implementing.
- Each EBP should be a session-based program for which session information can be collected.
- Each EBP should be implemented by at least two grantees as a primary service of their RPG project.
- All grantees should be implementing at least one of the focal EBPs.

To assess each EBP against these criteria, we identified the EBPs being implemented by more than one grantee. We classified an EBP as "primary" if the grantee or a partner planned to deliver the EBP to most families who enroll in RPG. For all EBPs being implemented as a primary service by at least two grantees, we gathered information about how the EBP is delivered, including prescribed dosage, duration, and content, as well as typical service location. We collected this information from the California Evidence-Based Clearinghouse for Child Welfare, the Substance Abuse and Mental Health Service Administration's National Registry of Evidence-Based Programs and Practices, program model websites, journal articles, and RPG applications. Based on this information, we eliminated EBPs that are not session-based. For example, some interventions lay out a framework for service provision, but they do not specify the services to be provided. Finally, to ensure selection of a range of EBPs that varied by key characteristics, we sought diversity across EBPs along the following dimensions Table (II.2):

- Project focus: child-caregiver therapy, counseling, family strengthening, response to trauma, substance abuse treatment
- Typical service location: home, clinic, residential treatment, correctional facility, other community location
- Target of services: adult, child, family

C. Data Sources and Collection Methods

Data collection for the implementation study will cover constructs delineated in the conceptual framework (Figure I.1). We will use multiple sources and methods to gather both quantitative and qualitative information about RPG implementation: grantees' semiannual progress reports (SAPRs), staff surveys, site visit interviews, and a web-based enrollment and services log (ESL). Table II.3 displays the data sources for each component of the conceptual framework to be measured as part of the implementation study.

Table II.2 Characteristics of Focal EBPs

		Target Population			Service Location				
EBP	Program Focus	Adults	Children	Family	Home	Outpatient Clinic	Residential Facility	Correctional Facility	Other community location
Celebrating Families!	Family strengthening	X	X	X			X		X
Child-Parent Psychotherapy	Child-caregiver therapy			X	X	X			X
Cognitive Behavior Therapy	Counseling	X	X		X	X	X		X
Hazelden Living Balance Program	Substance abuse treatment	X				X		X	
Matrix Model Program	Substance abuse treatment	X				X			
Nurturing Parenting Programs	Family strengthening			X	X		X	X	X
Parent and Child Interactive Therapy	Child-caregiver therapy			X		X			X
Seeking Safety	Response to trauma	X	X			X	X		X
Strengthening Families	Family strengthening	X	X	X	X				X
Trauma-Focused Cognitive Behavior Therapy	Response to trauma	X	X	X	X	X	X		X

Table II.3. Implementation Study Data Sources, by Conceptual Framework Construct

Conceptual Framework Construct[a]	Grantee Semiannual Progress Reports (SAPRs)	Staff Survey	Site Visits to Grantees	Enrollment and Services Log (ESL)
Inputs to Implementation: Planned Services				
EBPs and other services	X			
Planned content and dosage	X			
Target outcomes	X		X	
Intended target population and eligibility criteria	X			
Fit of EBPs with target population	X			
Planned adaptations	X	X	X	
Inputs to Implementation: Participant Characteristics				
Demographic characteristics				X
Risk and protective factors				X
Inputs to Implementation: Regional Partnerships				
Staff experience with similar interventions	X	X		
Staff experience with the target population	X	X		
Staff qualifications	X	X		
Organizational climate		X		
Leadership and decision making		X	X	
Attitudes toward implementing EBPs		X	X	
Community linkages			X	
Relationships with model developers			X	
Inputs to Implementation: Implementation System Procedures and Infrastructure				
Use of an implementation team	X	X	X	
Use of an implementation plan	X	X	X	
Facilitative administrative support		X	X	
Strategies for working with external systems		X	X	
Referral processes		X	X	
Internal evaluation and continuous quality improvement		X	X	
Frontline Staff Supports				
Staff selection and hiring		X	X	
Pre- and in-service training	X	X	X	
Technical assistance and coaching	X	X	X	
Supervision and feedback		X	X	
Peer support		X	X	
Communication systems		X	X	
Decision support data systems			X	
Implementation Outputs: Service Delivery Outputs				
Reach into the target population				X
Enrollment				X
Dosage and duration				X
Content delivered				X
Adherence/fidelity	X		X	X
Quality	X		X	
Participant responsiveness				X
Implementation experiences of staff		X	X	
Partnership Outcomes				
Sustainability of EBPs	X		X	
Staff retention	X			
Staff competency	X	X		
Community Context				
Community context	X		X	

[a]Some constructs displayed in sections of the conceptual framework that are included in this table are not listed here because they will be measured as part of the partnership study discussed in Chapter III.

Data collection will begin following OMB approval, which we anticipate receiving by March 2014. Table II.4 shows the planned timing of data collection for each data source, based on this assumption. Collecting repeated measures over time through the SAPRS and ESL will enable the cross-site evaluation team to examine grantees' progress through temporal stages of implementation as described in the Quality Implementation Framework and the Active Implementation Framework.

Table II.4. Planned Data Collection Timing for the Implementation Study

Data Collection Activity	FY2014				FY2015				FY2016				FY2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
SAPRs		X		X		X		X		X		X		X		X
Staff surveys						X										
Site Visits							X	X								
ESL		X	X	X	X	X	X	X	X	X	X	X	X			

1. Semiannual Progress Reports (SAPRs)

Under our contract, the cross-site evaluation team developed a template for the SAPRs that includes questions about updates and changes to grantees' planned EBPs and other services, target population and eligibility criteria, target outcomes, and planned adaptations (Appendix A). We anticipate most of these updates to be provided in the first two reports in FY13 (not shown), which cover the grantees' planning year and identify when changes to plans will most likely be made. However, grantees will be able to report on these changes at any point during the evaluation period.

The SAPR also collects information from grantees about the infrastructure in place to support implementation, such as the formation of an implementation team, development of an implementation plan, strategies for working with external systems (such as the health care system) required to implement the planned EBPs, referral processes, internal evaluation and continuous quality improvement processes, and communication systems. In addition, the SAPR collects information about features of the community context that has influenced grantees' implementation plans. These could be features of local service delivery systems, the local economy and employment market, and local and state policies affecting children, adults, and families in the target population.

After OMB clears the cross-site evaluation data collection activities, grantees will also report on their adherence to program developer specified service-delivery requirements for each of the 10 focal EBPs. For example, program developers typically specify the type and number of staff required to implement the EBP and provide guidance about the training and ongoing support that staff should receive. The evaluation team will work with the grantees, NCSACW, and developers of focal EBPs as needed to establish a series of performance benchmarks to assess adherence to service delivery requirements in four areas: (1) staffing, (2) initial staff training, (3) ongoing staff support, and (4) service delivery (dosage and content of services). Grantees will report on each benchmark twice yearly by completing a brief adherence form as part of the SAPR.

2. Staff Survey

Staff who deliver EBP services play a crucial role in determining the quality of project implementation. Conducting a survey of frontline and supervisor staff will enable us to collect structured and systematic data from a larger number of staff than would be possible during site visit interviews. The survey will also facilitate collection of information about topics that may be too

sensitive to explore during in-person interviews, such as the quality and supportiveness of supervision or attitudes toward implementing the EBPs.

The survey will be given to frontline staff implementing the 10 focal EBPS and provide direct services to children, adults, and families and their supervisors. This group will include staff employed directly by the grantee organization, as well as staff employed by other implementing agencies that are partnering with the grantee. We plan to administer the survey during the second quarter of 2015 (Table II.4).[8]

Constructs measured. The staff survey will collect information on staff characteristics and attitudes toward implementing EBPs, organizational characteristics, staff supports, and implementation experiences (Table II.5; Appendix B). The survey incorporates several scales used in implementation research: the Evidence-Based Practice Attitudes Scale (EBPAS; Aarons 2004), the Adaptation Scale (Moore et al. 2013), selected subscales of Dickinson and Painter's staff retention survey (Dickinson and Painter 2009), and the Implementation Climate Scale (Panzano et al. 2004, 2006).

Respondent identification and survey administration. We will administer the staff survey in a web-based format using WebSurv, a leading survey development software package. We expect to identify approximately 20 respondents per grantee. To generate a list of respondents, each of the evaluation team's cross-site liaisons (CSLs) will work with his or her assigned grantees to identify all staff who are delivering services to children, adults, and families through one of the 10 focal EBPs. These staff may work directly for the grantee agency, or for a partner agency. CSLs will request for all identified staff contact information including respondent name, email address, and telephone number, along with the name of the EBP the staff member is implementing and the organization that employs the staff member.

Mathematica will email each identified respondent an invitation to participate in the survey. The email will explain the survey's purpose, address confidentiality concerns and the voluntary nature of participation, and describe the intended use of the findings. We will also provide a telephone number and email address whereby respondents can contact us with questions. The invitation will include a personalized hyperlink to the survey in which the respondent's user name and password will be embedded, thus eliminating the burden of a manual log-in. We will email reminders at approximately the third and sixth week of the data collection period, encouraging nonrespondents to complete the survey as soon as possible. Based on pretesting, we estimate it will take respondents on average 30 minutes to complete the survey. Based on similar surveys we have administered, we expect a response rate of approximately 80 percent.

3. Site Visits to Grantees

Cross-site evaluation team members will visit each grantee (Table II.5), in approximately the third and fourth quarters of 2015. The visits will focus on the RPG planning process, how and why particular EBPs were selected, the implementation system's ability to support quality implementation for the 10 focal EBPs, and the implementation experiences of grantees and their partners. Activities will include individual and small group interviews. Visits will be conducted by two-person teams

[8] Timing depends on when OMB clearance is obtained.

consisting of Mathematica researchers and research analysts. In the rest of this section, we describe the site visit topic guide, planned site visit activities and key informants, procedures for site visit planning and scheduling, and procedures for ensuring the quality of data collected during the site visits.

Table II.5. Implementation Study Constructs included in the Staff Survey

Survey Section	Survey Constructs
Staff characteristics and attitudes	Staff role
	Demographic characteristics
	Length of time with organization, working with target population, and working on similar interventions
	Education and relevant experience
	Attitudes about implementing EBPs
Organizational characteristics	Organizational climate
	Organizational support for implementing EBPs
	Engagement of leadership in EBP adoption, planning, and implementation
Procedures and infrastructure	Availability of administrative supports (clerical, database, policies, and procedures)
	Availability of supplies
	Support for intervention with external systems
	Referral processes
	Continuous quality-improvement activities
Staff Supports	Pre- and in-service training
	Technical assistance and coaching
	Individual and group supervision
	Quality and supportiveness of supervision
	Availability of peer support
	Communication systems
Implementation Experiences	Adherence/fidelity to EBPs
	Adaptations to EBPs and reasons for adaptation[9]
	Implementation challenges

a. Site Visit Topic Guide

A master site visit topic guide identifies the range of topics we expect to cover during the site visits. The master topic guide will be used to develop informant- and EBP-specific guides tailored to each of the data collection activities planned for the site visits. Site visit teams assigned to each grantee may, in consultation with site visit team leaders, make additional refinements to the guides to address the circumstances of particular grantees. The master topic guide is organized into five main sections covering 17 topics (Table II.6). Each topic is further divided into subtopics (see Appendix C).

[9] Questions about adaptation will be asked of supervisors only.

Table II.6. Master Site Visit Topic Guide, Topics by Section

Section	Topic
Informant Characteristics	Informant characteristics
Pre-Implementation	Selection of EBPs Referral processes to RPG services Staff selection, hiring, and retention Pre- and in-service training Implementation teams Implementation plans
Early and Ongoing Implementation	Facilitative administrative support Supervision and feedback Technical assistance and coaching Internal evaluation and continuous quality improvement Decision support data systems Referral processes Interventions with external systems
Adherence/Fidelity	Fidelity Staff attitudes toward implementation
State and Community Context	State and community context

b. Site Visit Activities and Key Informants

We will conduct four main activities during each site visit: (1) an individual interview with the RPG project director, (2) a group discussion with the implementation team for each focal EBP implemented by the RPG project, (3) individual interviews with selected managers and supervisors for each focal EBP implemented by the RPG project, and (4) individual interviews with selected direct service staff for each focal EBP implemented by the RPG project.

RPG project director interview. We will conduct a two-hour individual interview with each RPG project director. We will discuss RPG project design, selection of EBPs, referral sources and processes, state and local context, and early implementation experiences. To capture how the projects have evolved, we will also ask about changes to implementation plans, the rationale for the changes, changes in the state and community context, later implementation experiences, and the potential for sustainability of the partnerships and the interventions.

Group discussion for implementation teams of focal EBPs. We will conduct a small group discussion with the managers and supervisors responsible for overseeing implementation of each focal EBP implemented by the grantee's RPG project. These managers and supervisors may be grantee or partner staff. We expect to conduct on average three group discussions during each site visit, each lasting approximately two hours. During these meetings, we will lead the group in discussing each of the implementation drivers included in the active implementation framework (Metz and Bartley 2012). In addition, site visitors will guide the group in reaching a consensus rating of "in place," "partially in place," or "not in place," on individual dimensions of each driver using a modified best practice assessment developed by the National Implementation Research Network (NIRN; Fixsen and Blase 2013). We will also lead the group in assessing the EBPs' fit with their local context and explore the rationale for selecting the EBP for RPG using an adaptation of a planning tool developed by NIRN (Blase et al. 2013).

Individual interviews with supervisors and managers of focal EBPs. We will conduct 60-minute individual interviews with as many as two supervisors and managers of each focal EBP implemented as part of the RPG project. These managers and supervisors may be grantee or partner agency staff. The interview will focus on their satisfaction with implementing the EBP, as well as their perceptions about the consistency with which service delivery adheres to the EBP's service delivery guidelines and the quality of service delivery. The interview guide for these interviews will be based on a framework developed by Keith and colleagues (2010) and tailored to the implementation requirements for each focal EBP.

Individual interviews with direct service staff of focal EBPs. We will conduct 60-minute individual interviews with as many as two direct service staff for each focal EBP implemented as part of the RPG project. These staff may be grantee or partner staff. The interviews will cover the same topics as the individual supervisor and manager interviews but will reflect the perspectives of frontline staff.

c. Site Visit Planning and Scheduling

To schedule the site visits efficiently with 17 grantees, we will designate a lead member of each visit team to plan and schedule all visit activities.[10] To initiate planning, site visitors will conduct a telephone call with each grantee and furnish a memo describing the scheduling process. This call, which will occur about six weeks before the target date for the visit, will have four main objectives: (1) to review activities planned during the visit and identify the appropriate participants for each activity; (2) to identify the lead grantee staff member who can help the site visit team with scheduling and coordination; (3) to establish a scheduling process; and (4) to identify dates for the visit. Our goal will be to schedule the visit so that we can obtain rich information for the cross-site evaluation while minimizing disruption to grant activities.

After the initial scheduling call, the site visitor will send a memo to the grantee's point of contact, summarizing the discussion, outlining the planned site visit activities, and offering scheduling guidance. Site visitors will continue to coordinate with the point of contact until the site visit agenda is finalized, at least two weeks before the site visit. During the planning process, the lead site visitor will regularly communicate with the site visit team leader to ensure that scheduled activities are appropriate and provide consistency and comparability across grantees, yet allow flexibility in recognition of grantee differences.

d. Site Visit Data Quality

We will take several steps to ensure consistent, high-quality data collection across grantees. Before conducting site visits, we will provide comprehensive training to all site visitors to review the study's objectives, the cross-site evaluation design, and the data collection procedures. At a minimum, training sessions will cover:

- Goals and objectives of the RPG program
- Information about the goals, content, format, and fidelity standards of focal EBPs

[10] Although some CSLs may be part of the site visit team, they will not conduct visits to the grantees for whom they provide TA.

- Cross-site evaluation design and analysis plan
- Guidelines for planning the site visits, including conducting a preparatory telephone call and scheduling activities
- Data collection instruments and activities
- Templates for field notes that ensure consistent reporting and preparation for coding and analysis
- Individual and group discussion moderating techniques

In addition to training site visitors, we will take other steps to ensure consistent, high-quality data collection. After we conduct the first site visit, the site visit team will confer to discuss relevant issues, adjust data collection materials, and ensure that staff are following consistent procedures. The team will continue to have periodic debriefing meetings throughout the data collection period. Senior team members will also review and offer feedback on field notes to ensure coverage of all topics, and will request additional information if gaps are identified. With the informants' permission, we will also audio-record interviews to back up our field notes.

4. Enrollment and Services Log

In addition to documenting the inputs to implementation, as shown in the conceptual framework (Figure I.1), the RPG cross-site evaluation also aims to document implementation outputs. These outputs include reach into the target population, enrollment levels, dosage and duration of services received by families, content delivered, adherence/fidelity to EBP requirements, and participant responsiveness. To facilitate an assessment of service delivery outputs, the cross-site evaluation team is developing a web-based ESL as part of the RPG data collection system. Grantee staff will use this system to record:

- Demographic information about RPG case members at enrollment[11]
- Enrollment and exit dates for each case that enrolls in the RPG project
- Enrollment and exit dates for all EBPs that are offered as part of the RPG project
- Information on each service delivery contact for any of the 10 focal EBPs implemented by the grantee

Table II.7 displays the primary data elements to be collected in the ESL; Appendix D provides a more detailed data dictionary. Data entry into the ESL will begin as soon as the cross-site evaluation receives OMB clearance, likely in the second quarter of 2014 and continuing through the first quarter of 2017 (Table II.4).

[11] For the cross-site evaluation, an RPG case is the group of individuals that present themselves to enroll in an RPG program. An RPG case may be a family or household in which some members are biologically related and some are not. A subset of, who are part of a cross-site impact study, will also submit demographic data on their comparison group members; Chapter V discusses this component of the grantees evaluation.

Table II.7. ESL Sections and Primary Topics

Section	Topic
RPG Enrollment and Exit	Enrollment date Exit date Reason for program exit
Demographics Characteristics of Case Members	Date of birth Gender Race/ethnicity Primary home language Highest education level Income level and sources Employment status (for adults) Relationship status (for adults) Current residence
EBP Enrollment and Exit	Enrollment date Exit date
Service Contact Information (for 10 focal EBPs)	Date of service Case members and others present Session location Session duration Topics covered during the session and length of time Activities completed during the session Participant engagement Extent of session alignment with plan Reasons for missed sessions

a. Strategies for Minimizing Grantee Burden

The web-based ESL designed for the RPG cross-site evaluation will be an important data collection source and will ensure that data are collected uniformly from all grantees. To minimize the time needed for data entry:

- We will use a web-based system that requires no software installation and allows data entry from any computer or device with Internet access. This ease of access will be especially beneficial to grantees operating in more than one location and/or with partners that are implementing focal EBPs.
- Data will be collected continuously in a central database; grantees will not need to periodically upload data or transmit it to Mathematica.
- Users will be automatically directed to relevant data entry screens for any needed entries.
- Data screens will offer checkboxes and dropdown lists as much as possible to reduce the time required for data entry.
- We will design and provide grantees with *optional* hard copy forms to collect information for later data entry.

b. System Users and Supports

The primary users of the web-based ESL will be RPG and partner staff who enroll families and households into the RPG project and individual EBPs, and the direct service staff who deliver services through the 10 focal EBPs. These staff may work directly for the grantee and may work for partner agencies that deliver services through one of the focal EBPs.

Each grantee will designate a single grantee administrator who will then establish permissions for the staff members who will enter enrollment, exit, and service log data. Only this administrator will be able to view all entries for the grantee. Other users will view only their own entries. Grantees will not be able to view the entries of other grantees.

The cross-site evaluation team will provide initial training and ongoing technical assistance to grantees to ensure that staff can effectively and easily enter information into the system throughout the data collection period. We will provide three main types of support: (1) a user's manual and data dictionary, (2) system orientation and data entry training through conference calls and/or webinars for grantees, and (3) ongoing technical assistance from cross-site evaluation staff by telephone or email.

D. Data Analysis for the Implementation Study

We will use a range of methods to address the implementation study research questions identified earlier in the chapter. We will analyze both qualitative and quantitative data to describe inputs to implementation and examine implementation outputs, including the degree of adherence to program models. In this section, we first describe our approach to preparing the data for analysis and constructing variables. We then describe how we will answer the implementation study research questions.

1. Preparing Data for Analysis

Qualitative data. We will use standard qualitative analysis procedures to analyze and summarize qualitative information extracted from the SAPRs and site visit field notes. Analysis will involve coding, triangulation across data sources, and theme identification. For each type of document, we will use standardized templates to organize extracted data and then code it. We will search the coded text to gauge consistency and triangulate across data sources. This process will reduce the data into a manageable number of topics and themes for analysis (Coffey and Atkinson 1996; Ritchie and Spencer 2012).

To code the qualitative data for key themes and subtopics, we will first develop a coding scheme, organized according to key research questions and aligned with the cross-site evaluation conceptual framework. For example, for the SAPRs, we might use the following codes: changes in planned intervention, implementation team, implementation plan, intervention with external systems, referral processes, continuous quality improvement, staff selection and hiring, communication systems, and community context. For individual site visit interviews with managers, supervisors, and direct services staff, we will code their responses according to the core components of the focal EBP under discussion and whether the statement relates to satisfaction with the EBP, consistency of implementation, or quality of implementation.

Senior members of the cross-site evaluation team will refine the initial coding scheme by reviewing codes and a preliminary set of coded data to make adjustments and ensure alignment with the cross-site evaluation conceptual framework. They can capture other themes or topics that may emerge from the data. For each round of coding, a small team of coders will be trained to code the data using Atlas.ti (Scientific Software Development 1997) or a similar qualitative analysis software package. To ensure reliability across coders, all team members will code an initial set of documents and compare codes to identify and resolve discrepancies. As coding proceeds, the lead coder will periodically review samples of coded data to check reliability.

Quantitative data. We will summarize quantitative data using basic descriptive methods. Sources of quantitative data include the staff survey, the implementation driver ratings produced in implementation team discussions conducted during site visits, and the ESL. Analysis for each source will follow a common set of steps involving data cleaning, variable construction, and computing descriptive statistics.

To prepare data for analysis, we will first verify the data values are within the expected ranges. We will run a series of data checking operations to identify invalid character and numeric data values. Also, we will examine frequencies and means for variables to identify outliers, or observations that are numerically distant from the rest of the data. Finally, we will assess the extent of missing data by comparing the number of observations with the expected number of sample members. When we identify missing data, we will review the raw data to confirm that their absence is not due to a data entry or processing error. We will also assess whether data are missing due to nonparticipation or item nonresponse and address any issues accordingly. If missing data are not extensive, we will analyze the data and note what is missing. If a large amount of data are missing for a particular RPG project or a particular source, we will work with CB to determine an appropriate strategy. If missing data are pervasive, we may forgo analyzing certain data or types of data.

To facilitate analysis of each data source, we will create variables to address the study's research questions. Construction of these analytic variables will vary depending on a variable's purpose and the data source being used. Variables may combine several survey responses into a scale, aggregate project participation data from a set time period, or compare responses to identify a level of agreement. For standardized scales, we will examine the psychometric properties of the variables we construct and assess whether they meet the accepted standards in the field (Nunnally and Bernstein 1994).

2. Addressing the Research Questions

To address the implementation study's research questions, we will draw on four sources of data: (1) grantees' SAPRS, (2) surveys of staff, (3) site visits, and (4) project data provided by grantees through the ESL (Table II.8). Our analysis will first focus on documenting and describing project implementation. It will then examine patterns and themes related to implementation that can support continuous quality improvement activities by the RPG projects and build knowledge on implementing EBPs targeted to the needs of families in the child welfare and substance abuse treatment systems.

What were the target populations of the RPG projects? Did RPG projects reach their target populations? We will extract information about each RPG project's target population from the SAPRs, including as much detail as possible about their expected characteristics. We will use this information to create a target population profile for each grantee based on a set of common indicators, such as age ranges of children, characteristics of parents, and risk and protective factors.[12]

[12] Information on protective factors may be collected from additional sources, such as baseline measures of participants. Factors that help protect against child maltreatment that are measured at baseline include knowledge of parenting and child development, parenting stress, and the social-emotional competence of children (ACYF 2013; see chapter IV for more details on participant measures collected at baseline).

Table II.8. Data Sources for Each Implementation Study Research Question

Research Question	SAPRs	Staff Surveys	Site Visits to Grantees	ESL
What were the target populations of the RPG projects? Did RPG projects reach their target populations?	X			X
Which interventions did RPG projects select?	X		X	
What procedures, infrastructure, and supports were in place to facilitate implementation of the planned interventions?	X	X	X	
How were the interventions implemented?	X	X	X	X
To what extent were the RPG projects prepared to sustain the interventions at the end of the grant period?			X	

We will periodically extract information on enrollment and participant characteristics from the ESL and use it to create a set of comparable indicators for describing program participants enrolled in the RPG projects.[13] We will compare the target population and program participant characteristics to assess RPG projects' success in recruiting the target population. For example, an RPG project might target families headed by young, at-risk parents as determined by parent age, education level, and income. However, enrollment data may show that just 50 percent of enrolled families were headed by parents meeting these criteria. Another project might target Latino families, with the enrollment data showing that 90 percent of enrolled families are, in fact, Latino.

If feasible, we will also compare estimates of the size of the target population with enrollment patterns to determine the RPG projects' reach into the target population. For example, community-needs assessment data may show that approximately 200 babies are born each year to teen parents with specific risk factors. The data may show that the RPG project has enrolled 100 teen parents with infants with these risk factors, indicating that it is reaching half of the target population.

Once we characterize each of the 17 RPG grantees, we will also construct indicators to characterize the initiative as a whole, such as the number of grantees that are enrolling families with different characteristics, and the number reaching at least half of their target population. We will repeat this analysis periodically and examine change over time in the characteristics of program participants and in its reach into the target population.

Which interventions did RPG projects select? We have identified the EBPs that RPG projects selected, by reviewing their grant applications and April 2013 SAPRs, and in discussions with the grantees. During site visits, we will explore the reasons the interventions were selected and their associated outcome goals. We will supplement this information as needed to create a profile of each EBP that characterizes its evidence base and target outcomes; the services to be provided, including expected content, dosage, and duration; training and technical support resources available for project implementers; and its fidelity standards along with tools for assessing fidelity and whether the grantee is using them. We will also note any adaptations grantees plan to make and their rationale for the adaptation.

[13] We expect to extract and examine data from the ESL monthly during initial data collection, to verify completeness and quality of data entry. We will extract data less often once we are confident that grantees are entering the data consistently and accurately.

Once intervention profiles are developed, we will compare them with each RPG project's intended target population and goals, to assess fit. For example, does the intervention have evidence of effectiveness with the grantee's target population? Does it target the outcomes that the grantee aims to target? How well do performance measures align with the intervention's target outcomes and capture elements of its fidelity standards?

We will use these comparisons to assess fit between the RPG projects' intended target population and goals and selected interventions. We will conduct this analysis after grantees' have finalized their selection of interventions, perhaps repeating the process if a grantee makes additional changes after the planning year.

What procedures, infrastructure, and supports were in place to facilitate implementation of the planned interventions? Data to address this research question will come mainly from the survey of frontline staff, in combination with information from the SAPRs and data collected during the site visits (Table II.8). We will compute descriptive statistics for all items in the staff survey, and compute scale scores as appropriate.[14] We will also compute scores from assessments of implementation drivers conducted during the site visits. We will supplement these quantitative measures with qualitative descriptions of procedures and infrastructure from the SAPRs and site visit interviews. Using all of these sources, we will create a profile of the implementation system for each implementing agency provider participating in the staff survey. These profiles will describe procedures and infrastructure available to staff (implementation teams and plans, facilitative administration, and so on) and frontline staff supports (such as training, supervision, and peer support).

We will use these profiles to create measures of the potential for these systems to support quality implementation of the 10 focal EBPs. For example, Meyers, Katz, and colleagues (2012) have developed a quality implementation tool (QIT) to translate the results of the quality implementation framework (Meyers, Durlak, and Wandersman 2012) into a practical tool for improving the quality of implementation. This tool can be used to create indicators for specific items in the framework. For example, the QIT contains five measureable steps for creating an implementation team that could be used as indicators for this activity. NIRN researchers have also created measures of implementation drivers that could be used for this analysis. By creating measures for each component of the implementation system, we can assess the potential of each RPG project to achieve high-quality implementation. In addition, we can compare information collected through the staff survey about implementation experiences with these profiles and assess whether gaps in implementation system could account for any challenges identified, or whether additional infrastructure or capacity development might address a challenge.

How were the interventions implemented? We will base the analysis on three main data sources: (1) adherence data collected through the SAPRs, (2) service data from the ESL, and (3) site visit interviews about staff satisfaction with implementing the EBP, their perception of the consistency with which service delivery adheres to its requirements, and the quality of service delivery. We use the first two data sources to compute a series of implementation measures for each

[14] We will examine the psychometric properties of the variables we construct and assess whether they meet the accepted standards in the field (Nunnally and Bernstein 1994).

focal EBP and RPG project. These measures will encompass staffing, staff training and support, enrollment, dosage, content of services and mode of service delivery, duration of enrollment, reasons for program exit, and the proportion of participants that remain in the project through the expected enrollment period.

Once these measures are constructed, we will compare them with profiles of each intervention developed under implementation question 2 to assess adherence or fidelity to the project model. We will focus on the structural aspects of fidelity such as reaching the target population, delivering the recommended dosage, maintaining caseload sizes, and hiring and retaining staff with required qualifications (Daro et al. 2012).

During site visits, we will gather data on staff satisfaction with implementing the EBPs and their perception of the consistency and quality of implementation of the focal EBPs to create ratings of the extent of staff adoption of the focal EBPs. We will also use staff ratings to create grantee-level ratings of fidelity to the focal EBPs. For example, staff adoption ratings may include five levels: (1) nonuse, (2) low compliance use, (3) compliant use, (4) high compliant use, and (5) committed use as described in Keith et al. (2010). We will compare these qualitative fidelity ratings with the quantitative ratings described earlier. The qualitative ratings may help the evaluation team interpret the quantitative fidelity assessment, and identify potential explanations for high or low ratings.

To what extent were the RPG projects prepared to sustain the interventions at the end of the grant period? We will use site visit interview and group discussion data to assess the potential for sustainability at the end of the grant period. For each focal EBP, we will assess the extent to which implementation drivers are rated as "in place" at the time of the second site visit. We will also assess staff satisfaction with the EBPs based on site visit interviews, as well as project director and staff perceptions about the potential for sustainability. We will use these assessments to determine the extent to which implementation systems have been developed to support ongoing implementation of the focal EBPs, and the extent of staff and leadership support.

E. Limitations

There are several limitations to our implementation study approach. First, substantial components of the implementation study data collection are limited to a subset of 10 focal EBPs. Resources for the cross-site evaluation are not sufficient to examine implementation of all components of the RPG program. Further, the data will be limited to those participants who consent to be part of the evaluation. Therefore, we may not have complete information on services provided to all participants in RPG if grantees serve non-consenting families, which will limit some of our analyses. For example, we may not be able to calculate some measures of fidelity such as caseload size. In addition, the study relies primarily on self-reported data from project staff; resources are not sufficient to conduct systematic observations of service delivery to assess implementation quality directly.

In addition, the implementation study is descriptive in nature. We will be able to measure change in the implementation system and implementation outputs over time and associations between dimensions of the implementation and outputs, but this does not imply a causal relationship. Therefore, although the study may provide suggestive evidence about how the implementation system supports high-quality service delivery with fidelity to EBP requirements, we cannot rule out other factors, such as the influence of a dynamic leader in grant implementation.

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III. PARTNERSHIP STUDY

The need for collaboration to serve families involved with child welfare and substance abuse treatment systems motivated Congress to create the RPG program in 2006. The RPG program aims to increase coordination—and, ultimately, improve services for children and families—by fostering "interagency collaboration and the integration of programs, activities, and services" (Administration for Children and Families 2012). As a result, partnerships and collaborative activities are key components of the RPG program—and a focus of the cross-site evaluation.

At least two social service systems—child welfare and substance abuse treatment—will be involved in the RPG project in every site. Each has different missions, constituencies, funding sources, legal requirements and restrictions, and institutions. For some grantees, services will include court-related supports or home visiting. Partners will be drawn from each relevant service-delivery system, families will receive services through each of the systems, and successful integration and coordination of services may require partners to make changes in each respective system.

The partnerships study will provide a description of the partnerships formed among RPG grantees, agencies in the community implementing RPG services, and organizations who have come together to support the RPG program.

Evaluating multisystem initiatives in all their complexity is daunting; service-delivery systems are complicated, constantly evolving, and challenging to measure (Coffman 2007). However, tools from systems theory can be a valuable asset in assessing the RPG projects. We draw on the literature about complex adaptive systems (Hargreaves 2010; Eoyang 2007) to examine three important attributes of the RPG partnerships: (1) boundaries, (2) relationships, and (3) perspectives. Boundaries define which individuals, organizations, and levels of government are involved in the partnerships; relationships are the connections and exchanges that occur among the partners; and perspectives are the partners' points of view, purposes, and goals (Hargreaves and Paulsell 2009; Parsons 2007; Midgley 2007). By incorporating systems theory with social network analysis (Wasserman and Faust 1994), the partnership study will be able to accurately measure and describe these key characteristics of the partnerships for RPG projects. This chapter first reviews the research question to be addressed by the partner study, then discusses data sources to be used and analysis plans, including how the study will address each of the constructs being measured for the study.

A. Partnership Study Research Questions

The partnership study will address the following cross-site evaluation research question:

- Who was involved in each RPG project and how did the partners work together? To what extent were partners prepared to sustain their partnerships at the end of the grant period?

We expect to explore this question further, asking:

- What were the characteristics of the grantees and their partners?
- What were the partners' goals for RPG? Did they share common goals?
- How did members of the partnership communicate with each other?
- What was the quality of collaboration among the partners?

- What types of funding and other resources were available to the grantee and partners?
- How did members of the partnership coordinate services?
- How did members of the partnership collaborate to improve coordination of services?

B. Data Sources for the Partnership Study

The partnership study will draw on three main data sources: (1) semiannual progress reports (SAPRs), (2) partner surveys, and (3) site visit interviews with RPG project directors described in Chapter II. Table III.1 displays the data sources for each part of the conceptual framework that we will examine as part of the partnership study. (See Figure I.1 for the framework.)

Table III.1. Partnership Study Data Sources, by Conceptual Framework Construct

Conceptual Framework Construct	SAPRs	Partner Survey	Site Visits to Grantees
Inputs to Implementation: Regional Partnerships			
Partner characteristics	X	X	
Partner goals for RPG		X	
Relationships and communication systems		X	
Funding and other resources	X	X	
Implementation Outputs: Partnership Outputs			
Extent of coordination		X	X
Extent of collaboration		X	X
Partnership quality		X	X
Outcomes: Partnership Outcomes			
Sustainability of partnerships		X	X

Table III.2 provides an overview of the planned timing of data collection for each data source identified for the partnership study. In the rest of this section, we further detail each data collection method.

Table III.2. Data Collection Timing for the Partnership Study

	FY2014				FY2015				FY2016				FY2017			
Data Collection Activity	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
SAPRs		X		X		X		X		X		X		X		X
Partner Survey						X										
Site Visits							X	X								

1. SAPRs

The SAPR includes questions about partners involved in the grantee's RPG project, such as their roles in RPG. Grantees will be asked to provide updates in the SAPRs about changes in partnerships, such as termination of relationships and new partnerships formed, throughout the

evaluation period. Grantees will submit the SAPRs in the second and fourth quarters of each year throughout the RPG funding period.

2. Partner Survey

Partners who participate in the RPG projects play a crucial role in planning and coordinating services for families across service-delivery systems. The partner survey will collect data from a larger number of partners than would be possible during site visit interviews. The survey is also a better mode for collecting sensitive information, such as about the quality of collaboration and the extent of service coordination.

The survey will target the grantees and their primary partners including those who provide services to RPG families, refer families to the RPG projects, and play other key roles in the RPG projects. We will ask the lead staff member for RPG within each partner organization to respond to the survey. We plan to administer the partner survey during the second quarter of 2015 (see Table III.2). We will ask all partners actively involved in each RPG project to complete the survey.

Constructs measured. The survey will collect information about partner characteristics, partners' goals for RPG and their relationships within the partnership, and outputs of the partnerships (Table III.3; see Appendix E for the full instrument). The first section of the survey collects descriptive information about the partner organizations and their roles in each RPG project.

Table III.3. Partnership Study Constructs Measured in the Partner Survey

Survey Section	Survey Constructs
Partner Characteristics	Organization type Primary organizational activities Implementation of EBPs RPG caseload RPG funding
RPG Goals and Relationships	Goals for RPG Participation on leadership committees Communication frequency Partnership quality Organizational level of collaboration Community linkages
Partnership Outputs	Extent of service coordination Extent of collaboration among partners

The second section on goals and relationships will collection information about the goals partners have for the project. Research suggests that partnerships with better goal alignment are better able to build the necessary infrastructure to support the implementation of evidence-based interventions such as evidence-based home-visiting programs (Hargreaves et al. 2013). Thus, we will assess alignment among partners in their stated goals. This section will also collect information on the ways in which partners are working together. We will collect social network data on the frequency of collaborative activity among organizations in the system. In addition, we will also use a standardized scale—the Working Together survey (Chrislip and Larson 1994)—to assess the quality of the collaborative effort among the partners. The final component of this section of the survey will ask how partners engage with various members of the community.

The third section of the survey will collect information on partnership outputs. One type of output—coordination of services, including, but not limited to case management, data sharing, and service planning—will be assessed using survey items developed by Mathematica as well as selected items from the Collaborative Capacity Instrument (National Center on Substance Abuse and Child Welfare 2003). The extent of collaboration will be assessed by a social network question in which partners will provide information their collaborators on various aspects of service delivery (for example, screening, case management, and substance abuse treatment). With this information, we will be able to accurately assess which types of services are conducted collaboratively across partners.

Respondent identification and survey administration. We will administer the partner survey in WebSurv, a leading survey-development software package. We will survey an average of 25 respondents per grantee. To generate a list of respondents, each of the evaluation team's cross-site liaisons (CSLs) will work with his or her assigned grantees to identify partner organizations that are participating in grant activities as service providers, referral sources, or other key partners. Each partner organization will identify a lead staff person involved in the RPG project who will respond to the survey on its behalf. The CSL will obtain the respondent's name and email address, as well as the organization's name, mailing address, and telephone number.

Mathematica will email each identified respondent an invitation to participate in the survey. The email will explain the survey's purpose, address confidentiality concerns and the voluntary nature of participation, and describe the intended use of the findings. We will also provide a telephone number and email address so that respondents can contact us with questions. The invitation email will include a personalized hyperlink to the survey. The respondent's username and password will be embedded in the hyperlink, thus reducing the burden of a manual log-in. We will email reminders at approximately the third and sixth week of the data collection period, encouraging nonrespondents to complete the survey as soon as possible. Based on pretesting, we estimate it will take respondents 20 minutes on average to complete the survey. Based on similar surveys we have administered, we estimate a response rate of 80 percent.

3. Site Visits

Cross-site evaluation team members will make two multiday site visits to each grantee, in approximately the fourth quarter of 2015 (Table III.2). Site visitors will conduct an individual interview with the RPG project director that will include discussion of their RPG partnership. During the visit, the director interview will include a focus on understanding the RPG planning process, how and why particular partners were selected, and how the partnership developed, changes in partnerships and the rationale for those changes, the director's perceptions of partnership quality, partnership challenges, and lessons learned. Visits will be conducted by two-person teams consisting of Mathematica researchers and research analysts. The site visit topic guide, planned site visit activities and key informants, procedures for site visit planning and scheduling, and procedures for ensuring the quality of data collected during the site visits are described in more detail in Chapter II.

C. Data Analysis for the Partnership Study

We propose to use descriptive methods to answer the partner study research questions. In this section, we describe our approach for preparing the data for analysis and constructing variables. Then, we describe how we will answer the partnership study research questions.

The data collected through the partner survey and the review of annual progress reports will require data preparation steps to facilitate subsequent analysis.

Qualitative data. We will use standard qualitative analysis procedures to analyze and summarize information extracted from SAPRs and site visit field notes as described in Chapter II. We will also code data from the partner survey about partner goals to reduce the number of goals reported into a smaller set of categories. We will assess the inter-rater reliability among coders to ensure high-quality coding of the goals.

Quantitative data. We will prepare all quantitative data for analysis using the same methods described in Chapter II.

1. Addressing the Research Question

To address the partnership study's research question and sub-questions we will draw on information captured through the SAPRs, a survey of RPG partners, and site visits. The analytic methods to address the questions include descriptive analysis, social network analysis, and principal components analysis. Data collected from the grantee and partner organizations participating in each RPG project will be analyzed together, and then summarized in a cross-grantee analysis.

Descriptive analysis. We will compute means and tabulate frequencies of variables of interest and compute scale scores as appropriate to examine differences across the RPG projects and changes over time within RPG projects (noted in the SAPRs).[15] For example, to describe the amount of funding and other resources available for RPG, we will add up or average amounts reported in the SAPRs and partner surveys. Similarly, to examine coordination, we will compute from the partner surveys average scores on the coordination scale. We will also describe the various types of grantee and partner organizations, the types of activities in which they are engaged, the interventions they implement as part of the RPG project, and their work with families, to assess the characteristics of grantees and their partners. We will use data from site visits to describe factors that influenced the formation of partnerships.

To assess the commonality of partners' and grantees' goals, we will back-code the description of RPG goals collected in the partner survey and place them into general categories, then calculate the relative frequency of each goal identified for each RPG project. We will calculate an agreement statistic for each RPG project that indicates the degree to which partners articulated the same goals.

Social network analysis. The partner survey contains a set of network questions in which respondents are asked to report on their relationships as measured by the frequency and type of communications with all other respondents for their RPG project. To describe the levels of communication and collaboration among partners, we will use this social network data from the partner survey. We will create a square sociomatrix, a tabular representation of relationships among responding organizations in which the number of row and columns equals the number of organizations in the partnership, for each grantee. This sociomatrix will also be displayed as a sociogram, a visual representation of relationships within the partnership. In these sociograms, each organization is represented as a node, and connections between two organizations are shown with

[15] As noted earlier, we will examine the psychometric properties of the variables we construct and assess whether they meet the accepted standards in the field (Nunnally and Bernstein 1994).

lines that vary in thickness to represent, for example, the frequency of communication. The sociomatrixes and sociograms will also be used to describe the size of the partnership, and can be used to identify organizations that are isolated from the network.

The evaluation team will also calculate a series of network statistics to examine various aspects of the partnerships. For example, a density statistic will measure the proportion of existing collaborative ties relative to all possible collaborative ties. A reciprocity statistic will measure the degree to which organizations agree on their shared relationships within the partnership.

Principal components analysis. To operationalize the overall "quality" of the partnership, we will use a principal components analysis to distill an overall underlying "quality" score from several survey elements. We will use the observed scores for the degree to which goals align, the density of the communication network, the quality of the collaboration, the extent of coordination, and the density of the collaboration networks as inputs into the overall partnership quality score. The principal components analysis will produce a single score that represents the optimal "average" of all of these various constructs. It will weight some results more than others based on how strongly they are associated with an underlying factor, assumed to be partnership quality.

D. Limitations

The data sources used to answer the key research questions for the partnership study are largely based on self-reported data. When possible, we will attempt to triangulate and validate our findings using information from multiple study participants and data sources.

IV. OUTCOMES STUDY

In all its work, the Children's Bureau (CB), which operates the RPG program, focuses on children's safety and permanency. Increasingly, the Administration on Children, Youth, and Families is also focused on promoting the social and emotional well-being of children and youth who have experienced maltreatment (Administration for Children and Families 2012).

The outcomes study provides an opportunity to describe the changes that occur in children, adults, and families who participate in the 17 RPG projects. The projects are designed to support families in various ways, including addressing substance use and improving parenting skills, so that children have safe and healthy environments in which to thrive. The outcomes study examines five domains of interest to Congress and CB:

1. **Child well-being.** Several studies indicate that children in the child-welfare system suffer from psychological, cognitive, health, and educational deficits or delays (Casanueva et al. 2012; Chernoff et al. 1994; Pilowsky 1995; Wilson et al. 2012; Zima et al. 2000). In addition, traumatic events can elicit mental and physical reactions in children, including hyperarousal and dissociation. If these acute "states" are not treated after children experience trauma, they can become chronic, maladaptive "traits" that characterize how children react in everyday, nonthreatening situations (Perry et al. 1995).
2. **Permanency.** Children who have been removed from their homes by child protective services must develop new attachment relationships with each placement. When these attachment relationships change, children may have difficulty adapting to the new arrangements (Bowlby 1982). In addition, children who experience multiple moves are at risk for diminished academic outcomes, poor socioemotional health, and not developing strong attachments (Gauthier et al. 2004), and may have a weaker capacity to regulate stress than children with consistent caregivers (Dozier et al. 2002).
3. **Safety.** In 2012, an estimated 3.4 million referrals alleged maltreatment of approximately 6.3 million children in Child Protective Services agencies (U.S. Department of Health and Human Services 2013a). More than 2 million were investigated, and almost 700,000 children were found to be victims of maltreatment. Of the substantiated claims, the majority of victims (over 75 percent) suffered neglect; more than 15 percent were physically abused, and almost 10 percent experienced sexual abuse (U.S. Department of Health and Human Services 2013a). The negative impacts of these types of abuse are well documented (cf. Casanueva et al. 2012).
4. **Adult recovery.** Between 50 and 80 percent of child welfare cases involve a substance-abusing parent (Niccols et al. 2012; U.S. Department of Health and Human Services 1999). Further, only one-fifth of parents whose child was involved with the child welfare system successfully completed substance abuse treatment, compared with about half of those seeking treatment in the general population (Choi and Ryan 2006; Brady and Ashley 2005).
5. **Family functioning/stability.** Research suggests that children benefit from stable families, as well as the presence of both parents in healthy relationships (Brown 2004; Cherlin 2004; Osborne and McLananhan 2007; Waldfogel et al. 2010). In contrast, parental stress and depression has been shown to be a contributing factor to childhood

psychological and behavioral disorders and can also influence risk of child maltreatment (Abidin 1992; Assel et al. 2002; Henrichs et al. 2011; Conron et al. 2009).

The primary goal of the outcomes study is to describe the results for those who received RPG services, including change over time. This chapter reviews the research questions for the outcomes study and describes the analytic methods we will use to examine outcomes. It then provides a detailed description of the data sources to measure the constructs for each domain and describes how the data will be collected and prepared for analysis. Finally, it identifies the limitations of the study.

A. Outcomes Study Research Questions

The outcomes study will address one of the cross-site evaluation research questions and several detailed sub-questions:

- What were the well-being, permanency, safety, recovery, and family-functioning outcomes of children and adults who received services from RPG projects?

It will also explore the following sub-questions that fall under this topic:

- How have the outcomes changed from program entry to exit?
- What are the outcomes for selected subgroups of participants, such as those with previous child welfare involvement or by severity of addiction?

B. Data Sources and Constructs for the Outcomes Study

To address the five domains of interest, the outcomes study will use primary data and administrative data collected or obtained by the grantees and their evaluators. Primary data will be based on self-administered standardized instruments that CB has asked all grantees and their evaluators to administer to RPG participants. The administrative data will include a common set of elements that grantees and their evaluators will obtain from states or providers. Mathematica will use scores created from the instruments, individual items, or constructed variables to examine outcomes.

To select standardized measures, the cross-site evaluation team conducted a thorough search for appropriate data collection instruments based on the following criteria:

- Evidence of strong psychometric properties
- Demonstrated sensitivity to similar interventions
- Demonstrated evidence of use with similar populations
- Appropriateness for families and children from diverse cultural, racial, ethnic, and linguistic backgrounds
- Ease in administration (can be used by grantees after minimal training)
- Low burden on respondents
- Low cost of administration

For child well-being and parenting measures, criteria included:

- Covering a wide age range
- Appropriateness for children who have experienced trauma

Using these criteria to guide our search, the cross-site evaluation team identified instruments included in the RPG1 data collection system, instruments proposed by grantees in their applications, and other instruments that are widely used in the field. We compiled information on each instrument to assess fit with our selection criteria and eliminated instruments that were not a good match. For example, we eliminated direct observation and child assessment instruments that require extensive training and in-field reliability checks because of the difficulty and cost of administration. Next, we consulted with measurement experts in each outcome domain to review our recommendations and solicit additional suggestions.

In spring 2013, the cross-site evaluation team hosted a series of conference calls with grantees and local evaluators to discuss our preliminary recommendations for measures in each domain. We also received written comments from grantees and conducted additional phone consultation and in-person consultation at the RPG annual meeting. We reviewed the comments received, examined additional potential measures, and consulted with CB to develop a final set of recommendations, which CB adopted. The rest of this section describes the final set of constructs selected for the cross-site evaluation and data that will be collected to measure them.

1. Child Well-Being

In the domain of child well-being, we will collect measures of executive functioning, social and adaptive behavior, and sensory processing. In addition, trauma symptoms will be assessed at baseline. Each grantee will establish rules to select which child's data will be collected (detailed in Section C). Table IV.1 lists the constructs and instruments used to collect data.

Trauma symptoms. The Trauma Symptoms Checklist for Young Children (TSCYC; Briere et al. 2001) is a standardized and normed trauma measure for children ages 3 to 12 who have been exposed to traumatic events, such as child abuse, peer assault, or community violence. This instrument includes 90 items in three age-specific questionnaires (ages 3–4, 5–9, and 10–12). Focal children's primary caregivers rate each symptom on a 1-to-4 scale according to how frequently the symptom occurred in the previous month. The instrument also contains two scales that assess the validity of the primary caregiver's responses. Clinical scales (anxiety, depression, anger/aggression, post-traumatic stress-intrusion, post-traumatic stress-avoidance, post-traumatic stress-arousal, dissociation, and sexual concerns) and a summary scale provide information about symptoms. Each questionnaire takes 15 to 20 minutes to complete. Questionnaires are written at a 6th-grade reading level and are available in Spanish and other languages. The authors report alpha coefficients ranging from 0.78 to 0.92 and test-retest reliabilities of 0.68 to 0.96. The authors report evidence of good discriminant validity and extensive convergent validity. Further studies have reported evidence of good sensitivity and specificity, discriminant validity, extensive convergent validity, and minimal concurrent validity (Lanktree et al. 2008; Wherry et al. 2008). The TSCYC was standardized on a sample of 750 children from across the United States, with roughly equal numbers in each age level. Demographics closely matched those of the general population.

Table IV.1. Standardized Measures of Child Well-Being, RPG Cross-Site Evaluation

Construct	Instrument	Age Range	Administration Time	Internal Consistency Reliability	Use in Large-Scale Studies/Research with Similar Populations
Child trauma symptoms	Trauma Symptom Checklist for Young Children (TSCYCY; Briere et al. 2001)	3 to 12 years	15 to 20 minutes	0.78–0.92	DVS
Executive functioning	Behavior Rating of Executive Function (BRIEF) and Behavior Rating of Executive Function–Preschool (BRIEF-P; Gioia et al. 2000)	5 to 18 years (BRIEF) 2 to 5 years (BRIEF-P)	10 to 15 minutes	0.80–0.98	MSCEHS
Child behavior	Child Behavior Checklist (CBCL)–Preschool Form and Child Behavior Checklist–School Age Form (Achenbach and Rescorla 2000, 2001)	18 to 60 months (CBCL) 6 to 18 years (CBCL-School Age)	15 to 20 minutes	0.63–0.97	EHSREP; Three Cities; PHDCN; NSCAW
Child sensory processing	Infant-Toddler Sensory Profile (ITSP; Dunn 2002)	Birth to 36 months	15 minutes	0.17–0.83	RDSP
Social and adaptive behavior	Socialization Subscale, Vineland Adaptive Behavior Scales, Second Edition, Parent-Caregiver Rating Form (Vineland-II; Sparrow et al. 2005)	Birth to 90 years	10 to 15 minutes	0.79–0.98	LONGSCAN; NSCAW

Note: DVS = Developmental Victimization Survey (Finkelhor et al. 2009); EHSREP = Early Head Start Research and Evaluation Project (Love et al. 2002); LONGSCAN = Longitudinal Research on Child Abuse; MSCEHS = Mount Sinai Children's Environmental Health Study (Engel 2010); NSCAW = National Survey of Child and Adolescent Well-Being (Dowd et al. 2002); PHDCN = Project on Human Development in Chicago Neighborhoods (Earls et al. 1997); RDSP = Validation Study of the Sensory and Behavioral Criteria for Regulation Disorders of Sensory Processing (Perez-Robles et al. 2012); Three Cities = Welfare, Children, and Families; A Three-City Study (Winston et al. 1999).

Executive functioning. The Behavior Rating of Executive Function and Behavior Rating of Executive Function–Preschool (BRIEF and BRIEF-P, respectively; Gioia 2000) consist of parent and teacher questionnaires designed to assess executive functioning in the home and school environments. To reduce data collection burden for RPG, we will use only the parent questionnaire with focal children's primary caregivers. This instrument is used to evaluate children ages 5 to 18 with a wide spectrum of developmental and acquired neurological conditions, such as learning disabilities, autism, Tourette's disorder, low birth weight, and attention deficit hyperactivity disorder (ADHD). The BRIEF-P assesses executive function in children ages 2 to 5. Each version has 86 items and takes 10 to 15 minutes to complete. The instruments are available in Spanish and other languages. The BRIEF has acceptable internal consistency, with alpha coefficients ranging from 0.80 to 0.98. Test-retest reliability is 0.82 for parents and 0.88 for teachers. Convergent validity on this measure was established with other measures of inattention, impulsivity, and learning skills. The BRIEF-P also has acceptable internal consistency. Normative data are based on ratings from 1,419 parents and 720 teachers for the BRIEF, and 460 parents and 302 teachers on the BRIEF-P. Subjects are from rural, suburban, and urban areas, reflecting 1999 U.S. census estimates for socioeconomic status, ethnicity, and gender distribution. These measures are widely used in clinical settings with similar populations.

Child behavior. The Child Behavior Checklist–Preschool and Child Behavior Checklist–School-Age (CBCL; Achenbach and Rescorla 2001) are part of the Achenbach System of Empirically Based Assessment (ASEBA) and use information collected from parents to assess the behavior and emotional and social functioning of children. We will use two forms: (1) the preschool forms assess children ages 18 months to 5 years and (2) the school-age forms assess children ages 6 to 17 years. Primary caregivers rate children on each item, indicating whether it is not true, somewhat or sometimes true, or very or often true, now or in the past six months. The 99 items in the preschool CBCL are organized into two broad groupings of seven syndromes. The internalizing group includes subscales that assess whether the child is emotionally reactive, anxious/depressive, withdrawn, or has somatic complaints. The externalizing group includes subscales that assess whether the child has attention problems or exhibits aggressive behavior. A third set of items on the preschool version assesses whether the child has sleep problems. The items are also organized into five Diagnostic and Statistical Manual of Mental Disorders (DSM)-oriented scales (American Psychiatric Association 2000). Scales are are normed on a national sample of 700 children.

The school-age form provides information on 20 competencies covering children's activities, social relations, and school performance through 113 items that describe specific behavioral and emotional problems. The items are also organized into six DSM-oriented scales based on factor analyses of parents' ratings of 4,994 clinically referred children; the scales were normed on 1,753 children ages 6 to 18. The school-age normative sample represented the 48 contiguous states for socioeconomic status, ethnicity, region, and urban-suburban-rural residence. Both versions of the CBCL are widely used and have received an assessment rating of "A-Reliability and Validity Demonstrated" from the California Evidence-Based Clearinghouse for Child Welfare.

Sensory processing. The Infant-Toddler Sensory Profile (ITSP; Dunn 2002) provides a standard method for measuring a child's sensory processing abilities and profiling the effect of sensory processing on functional performance in a child's daily life. The profile is designed for children from birth to 36 months. Each item in this primary caregiver-report questionnaire describes children's responses to various sensory experiences. Together, the 58 items assess six types of processing: (1) general, (2) auditory, (3) visual, (4) tactile, (5) vestibular, and (6) oral sensory. Certain patterns of performance are indicative of difficulties with sensory processing and performance. Internal consistency has a wide range, with alpha coefficients from 0.17 to 0.83. Test-retest reliability

ranged from 0.74 to 0.86. Validity is acceptable as measured against the Infant-Toddler Symptom Checklist (ITSC; DeGangi et al. 1995). The ITSP was normed on a sample of 589 children of primary Caucasian descent, with approximately 100 children in each six-month age span. This assessment is used widely with diverse populations and is appropriate for children enrolled in RPG projects, because children who have experienced trauma can display sensory deficits.

Social and adaptive behavior. The Socialization Subscale, Vineland Adaptive Behavior Scales, Second Edition, Parent-Caregiver Rating Form (Sparrow et al. 2005) measures personal and social skills from birth through 90 years and was designed to address special-needs populations. Using the parent/caregiver rating scale form, the focal child's primary caregiver will rate the child as never, sometimes, or usually performing each behavior without help or reminders. An adaptive behavior composite score comprises four areas: (1) communication, (2) daily living skills, (3) socialization, and (4) motor skills. The communication domain measures receptive, expressive, and written communication; the daily living skills area assesses personal, domestic, and community skills; the socialization area measures interpersonal relationships, play and leisure time, and coping skills; and the motor skills area measures gross and fine motor skills. This measure has acceptable internal consistency reliability with alpha coefficients ranging from 0.79 to 0.98. The measure also has good content and concurrent validity. A nationally representative norming sample for the Vineland-II included 3,695 individuals ages birth through 90. The Vineland-II is widely used with diverse populations and is available in Spanish.

2. Permanency

The permanency domain provides information on removal of children from their homes, and their subsequent placements. For example, children may be reunited with their families, adopted through foster care, obtain permanent placements with relatives, or remain in foster care. Above and beyond the location of the last observed placement, the permanency domain provides information on instability in the child's situation. Data elements—for an observation period that includes time before, during, and after RPG services (detailed further in Section C)—will be obtained by grantees from administrative data systems, such as a state child welfare agency State Automated Child Welfare Information System (SACWIS). These data elements/constructs of interest include:

- **Removals from the family of origin.** Indication of whether the focal child was removed from the family of origin for any reason during the observation period
- **Placements.** All placements related to each removal
- **Type of placement.** Setting in which the focal child is placed, such as pre-adoptive home, group home, or foster family
- **Discharge.** Indication of whether focal child is no longer in foster care under the care, responsibility, or supervision of the state agency. Reasons for discharge include reunification with parent or primary caretaker, adoption, and emancipation.

3. Safety

A key outcome for the RPG projects is to ensure the safety of children involved in the child welfare system. Data elements collected from administrative data systems (such as state child welfare data) will represent the following key constructs:

- **Screened-in referral.** Any referral made to child protective services for concerns about maltreatment of the focal child, which the agency decided to investigate during the observation period
- **Type of allegation.** Allegations made in the screened-in referrals, such as physical abuse, neglect, or sexual abuse
- **Disposition of allegation.** For each allegation, the agency's decision on whether it was substantiated or unsubstantiated, or another conclusion reached by the agency
- **Death.** Whether the focal child died during the observation period

4. Adult Recovery

Recovery of parents, an explicit or implicit goal of RPG projects, will be measured by substance use severity, trauma symptoms, and treatment participation. This domain combines data from standardized instruments with administrative data on substance abuse treatment. The administrative data will be similar to that collected for the Treatment Episode Data Set (TEDS; see http://wwwdasis.samhsa.gov/webt/information.htm), but because TEDS data is de-identified, grantees will need to work with the state or local providers to collect the information. Table IV.2 lists instruments and data elements collected from administrative data systems (such as state child welfare data).

Substance use severity. The Addiction Severity Index (ASI), Self-Report Form (McLellan et al. 1992) is a tool widely used in the addiction field and comprises 36 self-report items that assess problems in six areas: (1) medical status, (2) employment/support status, (3) drug/alcohol use, (4) legal status, (5) family/social relationships, and (6) psychiatric status. Most questions ask the parent in a yes/no or open-ended format to report on his or her activities in the past 30 days. Examples of questions on the ASI include "How many days have you experienced employment problems in the past 30?" and "How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30?" Administration time for the ASI Self Report is 10 to 15 minutes, and a paraprofessional can administer the report. Items are comparable to the full ASI, but the self-report version eliminates questions on family history and interviewer ratings.

Internal consistency reliability for the full ASI is generally acceptable across studies, ranging from a low of 0.44 (Luo et al. 2010) to 0.89 (Leonhard et al. 2000). The psychiatric status, medical status, and drug/alcohol use subscales generally have higher reliability than the other subscales (Makela 2004). Makela (2004) also notes that many of the lower reliabilities come from studies of the homeless or patients with mental health issues, or from studies in Europe using translated versions of the ASI. The authors report that concurrent and discriminative validities were demonstrated with respect to a number of other measures for both composite scores and severity ratings. They also note that the ASI demonstrates good specificity and sensitivity (McLellan et al. 1980).

The norming sample was made up of adults and represented a range of socioeconomic and marital statuses, living situations, and ethnicities; the participants abused a range of substances (McLellan et al. 1980). The ASI is widely used in clinical settings and by the Drug Evaluation Network System (DENS), a project that aims to gather clinical information on patients presenting for substance abuse treatment and the treatment programs they attend (Carise et al. 1999). DENS has collected more than 38,000 ASIs from about 100 treatment programs in 20 U.S. states. The ASI was also used in RPG1.

Table IV.2. Standardized Measures of Adult Recovery, RPG Cross-Site Evaluation

Construct	Instrument	Recommended Age Range for Children of Parents/Primary Caregiver Respondents	Administration Time	Internal Consistency Reliability	Use in Large-Scale Studies/Research with Similar Populations
Substance use severity	Addiction Severity Index (ASI), Self-Report Form (McLellon et al. 1992)	Birth to 18 years	10 to 15 minutes	0.44–0.89[a]	None[b]
Parent trauma	Trauma Symptoms Checklist-40 (TSC-40; Briere and Runtz 1989)	Birth to 18 years	10 to 15 minutes	0.89–0.91	None[c]

[a]Alpha coefficients are for the full ASI only.

[b]The ASI, Self-Report Form was used in a validation study with 316 veterans entering substance abuse treatment (Rosen et al. 2002). The study results suggest it is a useful alternative to the full ASI interview for measuring substance abuse treatment outcomes.

[c]TheTSC-40 was used in a study of nearly 3,000 professional women and nearly 7,000 female college students (Elliott and Briere 1992; Gold et al. 1994).

Parent trauma. The Trauma Symptom Checklist-40 (TSC-40; Briere and Runtz 1989) measures aspects of post-traumatic stress and other symptom clusters in adults who have experienced childhood or adult traumatic experiences. The TSC-40 is a self-administered questionnaire for parents/caregivers, and their scores form six subscales: (1) anxiety, (2) depression, (3) dissociation, (4) Sexual Abuse Trauma Index (SATI), (5) sexual problems, (6) sleep disturbance. The questionnaire also tabulates a total score. Parents/caregivers are asked to rate each item based on how frequently it has occurred over the past two months, using a four-point Likert scale ranging from 0 (never) to 3 (often). The adults are asked "How often have you experienced each of the following in the last two months?" and then are asked to identify the frequency with which symptoms such as "headaches," "sadness," or "anxiety attacks" have been occurring. The TSC-40 is a 40-item inventory that requires approximately 10 to 15 minutes to complete.

The subscale alphas range from 0.66 to 0.77, with reliabilities for the full scale averaging between 0.89 and 0.91 (Elliott and Briere 1992). The TSC-40 displays predictive, criterion-related, and convergent validity (Zlotnick et al. 1996; Gold et al. 1994). Elliott and Briere (1992) have studied the TSC-40 in a large sample of professional women (N=2,963). The authors found that the measure discriminates between women who have and have not been abused as children, which held across all subscales and the total scale. Similarly, Gold et al. (1994) administered the TSC-40 to 669 female college students, divided into groups with no sexual assault or abuse (N=438), and those who had experienced sexual abuse or trauma as a child, adult, or both. They found that the measure discriminated between all groups and showed significant differences except on the sleep disturbance subscale.

Substance abuse services received. This data shows whether an adult in the family received treatment in a publically funded facility during the observation period.

Type of discharge. For adults who received treatment, the reason for discharge may be treatment completed, left against professional advice, terminated by facility, transferred to another substance abuse treatment program, incarceration, death, other, or unknown.

5. Family Functioning/Stability

Measures selected for the RPG cross-site evaluation must address multiple dimensions of family functioning and stability. The instruments measure four key constructs in the family functioning domain: (1) primary caregiver depression, (2) primary caregiver stress, (3) primary caregiver parenting skills, and (4) family stability as measured by the composition of the household in which the focal child is living and relationships between family members. The primary caregiver is the adult living with the child who spends the most time taking care of the child. Table IV.3 lists the instruments.

Depressive symptoms. The Center for Epidemiologic Studies–Depression Scale, 12-Item Short Form (CES-D; Radloff 1977) is a screening tool to assess the presence and severity of depressive symptoms occurring over the past week. The 12-item short form of this self-administered questionnaire takes fewer than 10 minutes to complete. Respondents are asked to rate how often each of the items (for example, "I was bothered by things that usually don't bother me") applied to them in the past week, on a four-point Likert scale (from rarely or none of the time to most or all of the time). Alpha coefficients are high for the original CES-D (0.83 to 0.92); concurrent validity by clinical and self-report criteria and substantial evidence of construct validity have been demonstrated (Radloff 1977). The questionnaire is available in Spanish.

Table IV.3. Standardized Measures of Family Functioning/Stability, RPG Cross-Site Evaluation

Construct	Instrument	Recommended Age Range for Children of Parents/Primary Caregiver Respondents	Administration Time	Internal Consistency Reliability	Use in Large-Scale Studies/Research with Similar Populations
Depressive symptoms	Center for Epidemiologic Studies Depression Scale (CES-D), 12-Item Short Form (Radloff 1977)	Birth to 18 years	5 to 10 minutes	0.83–0.92	Baby FACES, ECLS-K; EHSREP; LONGSCAN; PHDCN; SECCYD
Parenting skills	Adult-Adolescent Parenting Inventory (AAPI-2; Bavolek and Keene1999)	Birth to 18 years	10 to 15 minutes	0.86–0.96	EHSREP; LONGSCAN; NSCAW
Parent trauma	Parental Stress Index–Short Form (PSI-SF) (Abidin 1995)	Birth to 11 years	10 to 15 minutes	0.80–0.91	Baby FACES; ECLS-B; EHSREP; SECCYD

Note: Baby FACES = Early Head Start Family and Child Experiences Survey; ECLS-B = Early Childhood Longitudinal Study, Birth Cohort; ECLS-K = Early Childhood Longitudinal Study, Kindergarten Class of 1998–99; EHSREP = National Early Head Start Research and Evaluation Project; LONGSCAN = Longitudinal Studies of Abuse and Neglect; NSCAW = National Survey of Child and Adolescent Well-Being; PHDCN = Project on Human Development in Chicago Neighborhoods; SECCYD = NICHD Study of Early Child Care and Youth Development.

The original instrument was normed on a large sample of patients and generally healthy populations containing racial/ethnic, educational, and gender diversity (Radloff 1977). Since then, the CES-D 12-Item Short Form has been widely used in large-scale research and has demonstrated strong psychometric properties. Researchers have also investigated the reliability and validity of the CES-D with African American, Asian American, French, Greek, Hispanic, Japanese, and Yugoslavian populations (Naughton and Wiklund 1993). The CES-D is widely used in large-scale data collections such as the Project on Human Development in Chicago Neighborhoods (PHDCN) (Earls et al. 1997), the National Early Head Start Research and Evaluation Project (EHSREP; Love et al. 2002), and the Early Head Start Family and Child Experiences Survey (Baby FACES; Vogel et al. 2011).

Parenting skills. We will use the Adult-Adolescent Parenting Inventory (AAPI-2; Bavolek and Keene 1999), which is designed to assess parenting and child-rearing attitudes. Based on the known parenting and child-rearing behaviors of abusive parents, responses to the instrument provide a score that measures parents' risk of practicing behaviors known to be connected to child abuse and neglect. The AAPI-2 produces scores on the following five subscales: (1) expectations of children, (2) parental empathy toward children's needs, (3) use of corporal punishment, (4) parent-child family roles, and (5) children's power and independence. Primary caregivers answer questions based on a Likert scale (strongly agree, agree, and so on) on items such as, "Children need to be allowed freedom to explore their world in safety," and "Time-out is an effective way to discipline children." The AAPI-2 is written at a 5th-grade reading level and is available in Spanish. It takes about 10 to 15 minutes to complete the 40-item inventory.

The AAPI-2 comes in two alternate forms, to reduce the practice effect when repeating the inventory within a short period. Alpha coefficients for the five parenting constructs ranged from 0.86 to 0.96. The authors show evidence of construct and discriminative validity. The AAPI-2 discriminates between abusive and nonabusive parents in samples of adults and in samples of adolescents (Bavolek and Keene 1999). The AAPI-2 was normed on a nationally representative sample of adolescents and adults (abusive and nonabusive adults, abused and nonabused adolescents, and teen parents) referred by agencies from around the country. It has since been widely used with disadvantaged populations, such as low-income families and single mothers (Lutenbacher and Hall 1998; Conners et al. 2006). The AAPI-2 has also been used in large-scale data collections such as the National Survey of Child and Adolescent Well-Being (NSCAW; Dowd et al. 2002) and the Longitudinal Studies of Abuse and Neglect (LONGSCAN; Knight et al. 2008).

Stress. The Parenting Stress Index, Short Form (PSI-SF) is a brief version of the Parenting Stress Index (Abidin 1995), which is a widely used and well-researched measure of parenting stress. The PSI-SF has 36 items from the original 120-item version of the PSI. The PSI-SF yields scores on three subscales: (1) parental distress, (2) parent-child dysfunctional interaction, and (3) difficult child. The instrument takes about 10 to 15 minutes to complete, is written at a 5th-grade reading level, and has been translated into Spanish.

The internal consistency reliabilities of the short-form subscales are high (0.80 to 0.91). Kuendig et al. (2005) indicated that the literature has provided evidence of convergent, concurrent, and discriminant validity and good test-retest reliability. The PSI-SF was developed on a sample of 840 mothers from Virginia. Children's ages ranged from 10 months to 7 years. The children were 47 percent female; 87 percent were Caucasian (Abidin 1995). Since it was developed, the PSI-SF has been used in populations affected by substance use and in families who have had interactions with child welfare (DePanfilis and Dubowitz 2005; Kelley 1998). As of 2010, more than 200 studies had used the PSI-SF (Abidin n.d.). The PSI-SF is widely used in large-scale longitudinal studies, including

Baby FACES (Vogel et al. 2011) and the Early Childhood Longitudinal Study, Birth Cohort (ECLS-B; Najarian et al. 2010).

Family stability. To maximize the efficiency of data collection, we will draw on outcomes collected in other domains to understand family composition and relationships between family members. Although we have categorized outcomes by domain, many are relevant for multiple domains. Parenting, for example, is likely affected by the caregiver's recovery progress. The measures of family stability are:

- **Family/household composition.** Marital status (from the ASI), removal of the focal child from the home (administrative data from the safety domain)
- **Relationships between family members.** Serious problems and conflicts between family members (from the ASI)

C. Data Collection

To facilitate the cross-site evaluation, we have developed recommendations and guidelines for data collection, including timing and selecting the appropriate reporter. In addition, prior to the start of data collection, grantees and their evaluators are expected to pursue and receive IRB clearance for their evaluation. They are also required to obtain consent for any members of the study sample. As part of the consent process, they will inform participants that data will be shared with Mathematica/WRMA for research purposes and archived.

1. Timing of Data Collection

To measure change over time, local evaluations are asked to collect data prior to and after receipt of RPG services. This timing applies to both standardized instruments and administrative data, but will be implemented somewhat differently.

The collection of standardized instruments for the cross-site evaluation study will occur at the following times:

- **Baseline.** Grantees should administer to participants the age-appropriate standardized instruments (Figure IV.1), as soon as possible after each family enrolls in the project but no later than four weeks after enrollment.
- **Program exit.** Grantees should administer to participants the age-appropriate standardized instruments, as close as possible to the family's exit date from the RPG project, up to two weeks before or after the exit date. (If a child is no longer the appropriate age for an instrument at follow-up, that data will not be collected, even if it was collected at baseline.) For families that drop out of the RPG project before completion, it is vital to collect the data as soon as a project staff member learns that the family has dropped out. Drop-out or disenrollment will be defined by the involved agencies' policies.

For the administrative data, grantee teams will be asked to collect data on participants for the period of September 2012 through March 2017. At a minimum, this collection should include data for the 12-month period prior to RPG services through 12 months after the end of services. The longer time frame follows the same principle of pre- and post-service data collection but captures

rare or infrequent events (such as entry into treatment services or a child being removed from the home).

2. Selecting a Focal Child

For the cross-site evaluation, grantees will collect data on one child in each family, even if multiple children in the family receive RPG services. This child is referred to as the "focal child" for data collection. Because projects are offering different services and serving different populations, each local team is in the best position to define the focal child who is of greatest interest to the evaluation. For example, if selected children receive RPG services or live with a parent in residential treatment for substance use disorders, the team may want to define the focal child to include one of those children. To allow for flexibility in different grantee designs, each grantee will develop a decision rule for selecting the focal child and apply the rule consistently to all enrolled families. For example, a rule might state that the focal child is always the youngest child in the family. The cross-site evaluation team will document the decision rules and include them in cross-site evaluation reports.[16]

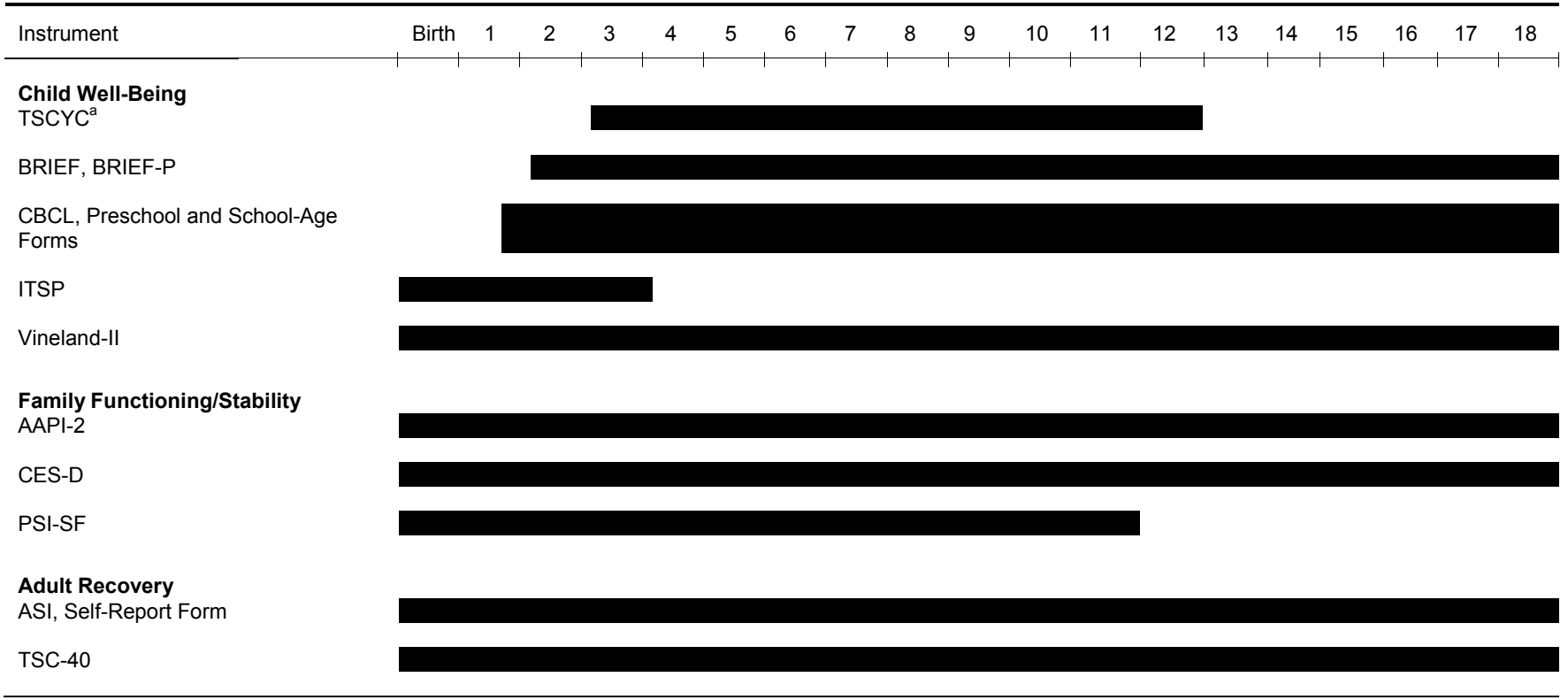
3. Identifying a Reporter for Each Outcome Domain

For each domain, there is both a person who is reported on (the person of interest) and the person who is reporting (the reporter). In some domains, the reporter will report on himself or herself, but the person of interest is not always the reporter. (Table IV.5 includes a summary of the guidelines by outcome.) The outcomes study will include information on as many as three persons of interest:

- **The focal child**. The focal child, who will be defined by grantees, is the child in the family on whom data will be reported on throughout the study.

[16] Grantees may for their local evaluations choose to collect data on additional children, but they will report to Mathematica/WRMA on only the focal child.

Figure IV.1. Age Range for Proposed Instruments for the RPG Cross-Site Evaluation



[a]Administered at baseline only.

Table IV.5. Information on Constructs by Domain

Construct	Source	Focus of Data Collection	Reporter or Data Source	Timing
Child Well-Being				
Child trauma symptoms	Trauma Symptoms Checklist for Young Children	Focal child	Primary caregiver (FFA or out-of-home caregiver)	Baseline only
Executive functioning	Behavior Rating of Executive Function (Preschool or Older)	Focal child	Primary caregiver (FFA or out-of-home caregiver)	Baseline and exit
Child behavior	Child Behavior Checklist (Preschool and School Age)	Focal child	Primary caregiver (FFA or out-of-home caregiver))	Baseline and exit
Sensory processing	Infant-Toddler Sensory Profile	Focal child	Primary caregiver (FFA or out-of-home caregiver)	Baseline and exit
Social and adaptive behavior	Socialization Subscale, Vineland Adaptive Behavior Scales	Focal child	Primary caregiver (FFA or out-of-home caregiver)	Baseline and exit
Permanency				
Removals from family of origin	Administrative data	Focal child	SACWIS	12 months prior to RPG services through 12 months after the end of services
Placements	Administrative data	Focal child	SACWIS	12 months prior to RPG services through 12 months after the end of services
Type of placements	Administrative data	Focal child	SACWIS	12 months prior to RPG services through 12 months after the end of services
Discharge	Administrative data	Focal child	SACWIS	12 months prior to RPG services through 12 months after the end of services
Safety				
Screened-in referrals	Administrative data	Focal child	SACWIS	12 months prior to RPG services through 12 months after the end of services
Type of allegations	Administrative data	Focal child	SACWIS	12 months prior to RPG services through 12 months after the end of services
Disposition of allegations	Administrative data	Focal child	SACWIS	12 months prior to RPG services through 12 months after the end of services

Table IV.5 *(continued)*

Construct	Source	Focus of Data Collection	Reporter or Data Source	Timing
Death	Administrative data	Focal child	SACWIS	12 months prior to RPG services through 12 months after the end of services
Adult Recovery				
Substance use severity	Addiction Severity Index	RDA	RDA	Baseline and exit
Parent trauma	Trauma Symptoms Checklist-40	RDA	RDA	Baseline and exit
Substance abuse services received	Administrative data	RDA	Local treatment providers or state agency responsible for TEDS data	12 months prior to RPG services through 12 months after the end of services
Type of discharge	Administrative data	RDA	Local treatment providers or state agency responsible for TEDS data	12 months prior to RPG services through 12 months after the end of services
Family Functioning/Stability				
Depressive symptoms	Center for Epidemiologic Studies-Depression Scale	FFA	FFA	Baseline and exit
Parenting skills	Adult-Adolescent Parenting Inventory	FFA	FFA	Baseline and exit
Parental stress	Parenting Stress Index	FFA	FFA[a]	Baseline and exit
Family composition and relationships between family members	Addiction Severity Index and administrative data	FFA	FFA	Baseline and exit (Addiction Severity Index) and 12 months prior to RPG services through 12 months after the end of services (administrative data)

Note: CPS = Child Protective Services; FFA = Family Functioning Adult; RDA = Recovery Domain Adult; SACWIS = Statewide Automated Child Welfare Information System; TEDS = Treatment and Episode Data Set.

[a] The Parenting Stress Index will be administered only if the focal child lives with the family of origin.

- **The family functioning adult.** This person is the primary caregiver—the adult living with the child who spends the most time taking care of the child—from the focal child's family of origin. If the child has been removed from the home, it is the former primary caregiver. In many cases, the family functioning adult will be the child's parent.
- **The recovery domain adult.** If the family functioning adult is receiving RPG services, he or she will also be considered the recovery domain adult. When the family functioning adult is not receiving RPG services *and a separate adult in the family is receiving services*, then the adult receiving services should serve as the recovery domain adult. If no adults in the family are receiving RPG services, the family functioning adult should complete the instruments in the adult recovery domain.

The following guidelines pertain to the reporters in each domain:

- **Reporter for child well-being domain.** A primary caregiver who has been caring for the child for at least 30 days prior to data collection will complete all standardized instruments in the child well-being domain. The reporter will be either the family functioning adult or an out-of-home primary caregiver. At the time of data collection, if the child has been with the current caregiver for fewer than 30 days—for example, the child was placed into the person's care the previous week—then these instruments would not be completed.
- **Reporter for family functioning domain.** Most projects prefer to keep a child with his or her family of origin when it is safe to do so. Therefore, the family functioning instruments will be given to the primary caregiver of the family of origin (the family functioning adult), even if the child has been removed from the home.[17]
- **Reporter for recovery domain.** All projects intend for the family functioning adult to report the recovery instruments. However, in some cases, they rely on a recovery domain adult, who is the individual in the family receiving RPG services when the family functioning adult is not receiving services. The instruments under the adult recovery domain should be administered to either the family functioning adult or the recovery domain adult, whether or not the individual is living with the focal child.

4. Support and Training

In recognition of the difficulties of data collection and the necessity of high-quality data for the local and cross-site evaluations, grantee teams are eligible for multiple supports. Each grantee team has a dedicated cross-site evaluation liaison (CSL), who will provide evaluation technical assistance and support, from planning through execution. We are also conducting trainings via webinars. A webinar on outcome data collection pertaining to the administration of standardized instruments was conducted in August 2013. Additional webinars will be held on obtaining administrative records. Training materials, webinars, data dictionaries, and user guides will be provided to support the collection and submission of outcome data.

[17] The Parenting Stress Index–Short Form should be administered to the family functioning adult only if the child has been in his/her custody for at least the prior 30 days. Otherwise, the PSI-SF should not be administered.

D. Submitting Data

To date, most grantees have proposed using most of the instruments, although none of the instruments have been adopted by all grantees (Table IV.6).[18] Most grantees are also proposing to collect the specified administrative elements, although as of fall 2013, many have not yet developed formal agreements with agencies to provide those data.

Table IV.6. Number of Grantees Using Proposed Instruments with Participants

Standardized Instrument	Number of Grantees
Child Well-Being	
Trauma Symptoms Checklist for Young Children	15
Behavior Rating of Executive Function (Preschool or Older)	13
Child Behavior Checklist (Preschool and School Age)	15
Infant-Toddler Sensory Profile	13
Socialization Subscale, Vineland Adaptive Behavior Scales	13
Family Functioning/Stability	
Adult-Adolescent Parenting Inventory	14
Center for Epidemiologic Studies-Depression Scale	13
Parenting Stress Index	14
Adult Recovery	
Addiction Severity Index	14
Trauma Symptoms Checklist-40	13

Source: Requests for standardized instruments grantees submitted by each grantee in August 2013.

Data from the instruments and administrative sources will be submitted on a biannual basis to the Outcome and Impact Study Information System (OAISIS), an online data collection system, starting in the second year of the evaluation (Table IV.7). Grantees will initially enter information on children and families into their local management information systems at the time of data collection. These data will then be uploaded to OAISIS. Grantees will submit the data in April and October of each calendar year, starting in 2014. For the outcomes study, grantee teams will submit data only on project participants. A subset of grantees, who are part of a cross-site impact study, will also submit data on their comparison group members; Chapter V discusses this component of the evaluation.

Table IV.7. Data Submission Timing for the Outcomes Study

Data Collection Activity	FY2014				FY2015				FY2016				FY2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Participant Outcomes		X		X		X		X		X		X		X		

For administrative data, grantees will need to develop agreements with state, county, or local child welfare and substance abuse treatment agencies to obtain administrative records for the relevant outcomes. They will then need to submit a detailed request for specific records and variables required by Mathematica/WRMA. The requests will identify the individuals for whom data are sought, and identify each person sufficiently to allow the administrative data to be linked to the

[18] By the time the report was finalized, 7 grantees proposed to collect data from all instruments.

primary data collected by evaluators. Data in the permanency and safety domains is likely to come from SACWIS. Data in the recovery domain may be requested from local treatment providers, if they are partners in the RPG projects. It may also come from the state agency responsible for collecting and reporting data on treatment from federally funded providers to the Treatment Episode Data Set (TEDS). Before submission to OAISIS, all identifying information will be removed.

E. Data Analysis for the Outcomes Study

The outcomes data will be analyzed annually. For several of the questions, we will examine means and change over time. For others, we will use correlational models to examine the associations between factors of interest and outcomes. In this section, we describe our approach for preparing the data, constructing variables, and performing analysis.

1. Preparing Data for Analysis

We will prepare for analysis the data submitted by the grantee teams through OAISIS. We will first verify that the data values are within the expected ranges, then run a series of data-checking operations to identify invalid character and numeric data values. Also, we will examine frequencies and means for variables to identify outliers, or observations that are numerically distant from the rest of the data. Finally, we will assess the extent of missing data by comparing the number of observations with the expected number of sample members. When missing data are identified, we review the raw data to confirm that the data are not missing due to a data entry or processing error. We will also assess whether data are missing due to nonparticipation or item nonresponse and address any related issues. If missing data are not pervasive, we will analyze the data and note what is missing. If a large amount of data is missing for a particular RPG project or source, we will work with CB to determine an appropriate strategy for handling the data. If missing data are pervasive, we may exclude certain data from analysis.

We will create variables to examine outcomes for families, parents, and children. Construction of these analytic variables will vary depending on a variable's purpose and the data source being used. Variables may combine several survey responses into a scale, aggregate administrative data elements, or provide a count of events. For standardized measures, we will calculate scores according to the developer's guidelines and examine the psychometric properties of the constructed variables to ensure that they meet the standards in the field (Nunnally and Bernstein 1994).

2. Analyzing Data to Address the Research Questions

The overarching focus of this outcomes study is the well-being, permanency, safety, recovery, and family functioning/stability outcomes of children and adults who received RPG services. Sub-questions under this topic capture changes over time, outcomes for subgroups, and variables that predict participant outcomes.

To describe participant outcomes at baseline and program exit, change over time, and results for subgroups of interest, we will calculate means or proportions for each construct. Information will be presented by grantee as well as aggregated across grantees into summary statistics. Table IV.8 illustrates the framework for presentation, which includes summary statistics for baseline, follow-up, and change over time.

Table IV.8. Example Table Shell Used to Report Descriptive Results for a Given Construct/Outcome for Each Grantee and When Aggregated Across Grantees

	Baseline			Follow-Up			
	Sample Size	Mean (or proportion)	Standard Deviation (if applicable)	Sample Size	Mean (or proportion)	Standard Deviation (if applicable)	Change from Baseline to Follow-Up
Grantee1							
GranteeN							
Cross-grantee Averages							

Data will include primary information collected by grantees and local evaluators and administrative data collected through other sources. Primary data will be collected at baseline and program exit. In most cases, we will have administrative data for participants at least one year after receiving RPG services. However, for participants who enroll and exit the program later in the grant, we may not have a full year of follow-up. If the number of such participants is substantial, we will consider reporting a shorter term follow-up, such as six months after discharge. Similarly, if the number of participants with longer follow-ups is substantial, we will consider reporting those results, as well.

F. Limitations

The approach for the outcomes study has some limitations. First, data must be collected consistently across local evaluations, following procedures for proper administration. To this end, we will be providing trainings, resource materials, and technical assistance through monthly calls. We will also assess the data once it is received and work with grantees to rectify any issues.

A key requirement for the cross-site outcomes study is that the grantees develop the necessary Memoranda of Understanding (MOUs) with administrative data sources to collect certain outcomes (such as those in the safety, permanency, and recovery domains), and to ensure that that data can be linked to information collected locally using the standardized instruments. Because grantees must obtain the data from an external source, they may encounter some difficulties, such as timeliness or reluctance to provide data for identified individuals. We will work with grantees to determine a schedule and approach to increase the likelihood of obtaining the data in a timely fashion.

The final limitation for the outcomes study reflects the descriptive nature of the analysis. We will be able to measure change over time and associations with particular implementation factors, but this ability does not imply a causal relationship. For example, although it may be tempting to interpret an improvement in outcomes from baseline to exit as the result of the project, we cannot rule out other factors, such as natural change over time, participants' characteristics (such as motivation), or other influences in the community (such as heightened enforcement against local drug dealers). However, the impact study, which we explore in the next chapter, will be designed to examine the *effects* of a subset of projects with rigorous local evaluations.

V. IMPACT STUDY

The implementation, partner, and outcomes studies described in the previous chapters include all grantees and provide important descriptive information to address the research questions posed in Chapter I. The Children's Bureau (CB) is also interested in assessing the effectiveness of projects proposed by the grantees. To meet this objective, we will conduct a cross-site impact study that examines the effect of the interventions by comparing outcomes for individuals with access to RPG services with those in groups that do not receive the RPG services but may receive a different set of services (business as usual). Each of the RPG sites is charged with conducting a comparison group study, and the impact study will include grantees with study designs that meet the cross-site evaluation's criteria for rigor (that is, a randomized controlled trial or a quasi-experiment with primary data collection from both treatment and comparison groups).

During the first year of the project, we reviewed grantees' evaluations plans, worked with them to strengthen those plans, and identified likely candidates for the impact study. Implementing a rigorous evaluation can be challenging, however, such as in building support for conducting random assignment and following up with sample members to collect data. The grantees initially identified for the impact study (discussed in Section D) have strong plans and commitment to rigor. Mathematica will provide additional support and monitoring of their evaluation activities throughout the project.[19]

When the evaluations are complete, we will estimate cross-site impacts through three steps. First, we will assess the research design and data provided by each site to determine the level of evidence that can be attained with each local evaluation, given how the evaluations were conducted. Next, for sites that were able to maintain a sufficiently rigorous design, we will estimate site-specific impacts. Finally, we will create aggregated impact estimates by pooling impact estimates across the selected sites to obtain a more powerful and generalizable summary of effectiveness for those RPG interventions.

In this chapter, we first outline the research questions that this study will answer. Next, we describe the review framework that will be used to examine the level of research evidence provided by each site. We then discuss the process that will be used to create consistent estimates of impacts for each site before they are pooled. Following this general description, we include information on the sites we currently anticipate will be able to participate in the study. The chapter ends with a more detailed technical description of the methods and analyses that will be used for the impact study.

A. Research Questions

For each of the child well-being, permanency, safety, recovery, and family functioning outcome domains, the impact study is designed to answer the following research question and sub-questions:

- What were the well-being, permanency, and safety outcomes of children, and the recovery outcomes of adults, who received services from the RPG projects?

[19] For example, at each RPG annual meeting, we will meet with the evaluators from these sites to discuss their progress and challenges.

- What is the site-specific average treatment effect (ATE) of the combination of selected RPG projects?
- What is the aggregated ATE of the RPG-funded projects for sites conducting well-implemented randomized controlled trials?
- What is the aggregated ATE of the RPG-funded projects for sites conducting well-implemented quasi-experiments or randomized controlled trials with some limitations?
- What is the aggregated ATE of the RPG-funded projects for all sites participating in the impact study?

B. Framework for Classifying the Evidence Provided

Grantees that participate in the impact study will vary in terms of the rigor of evidence they can provide—with some planning for randomized controlled trials (RCTs) and others for quasi-experimental designs (QEDs). RCTs can provide stronger evidence of program effectiveness than can QEDs. However, not all studies of each type are equally compelling in terms of their research evidence. For example, a QED that was careful to compare similar groups may provide evidence that is more compelling than an RCT with high attrition. To understand the level of evidence provided by each grantee, after the grantee's final data submission we will conduct a review of the research design and available data for each site. This review will focus on determining our confidence in the level of evidence that each site-specific impact evaluation can produce, and will inform our analytic approach in this impact study.

Random assignment creates two groups of individuals that should be the same, on average, except that one group receives an intervention. In other words, the two groups should be indistinguishable on most, if not all, of their characteristics—both observed and unobserved. This increases confidence that any differences in outcomes between the two groups after an intervention can be attributed to that intervention. Without randomization, individual selection, or characteristics that relate to both program participation and subsequent outcomes, may introduce bias in comparisons made across groups.

The goal of a quasi-experimental design is to overcome selection bias by establishing the "equivalence" of observable characteristics between treatment and comparison groups that is created in an RCT. Equivalence on observable characteristics can be created through matching on observable pre-intervention characteristics. With QEDs, however, we cannot ensure equivalence on *unobservable* characteristics. Given that limitation, the most compelling QEDs are those that establish equivalence on observable pre-intervention characteristics that are highly correlated with outcomes and/or the selection mechanism.[20] To classify the levels of evidence provided by research designs across sites, we will use two well-established review processes and standards. Classifications and standards from the California Evidence-Based Clearinghouse (CEBC)[21] for Child Welfare and the

[20] In practice, it is often impossible to assess the correlation between observable characteristics and the selection mechanism. However, it usually is possible to assess the correlation between observable characteristics and outcomes.

[21] The California Evidence-Based Clearinghouse for Child Welfare uses its Scientific Rating Scale as a basis for measuring evidence-based practices. Details on the Scientific Rating Scale can be found at http://www.cebc4cw.org/ratings/scientific-rating-scale/ (accessed March 12, 2013).

What Works Clearinghouse (WWC)[22] of the Department of Education will be used to classify the level of evidence across sites. Both systematic reviews have well-established standards for rating the level of evidence across each design and provide guidance we can use in classifying site-specific RPG designs. Our approach is to use the labels for evidence rating described in the CEBC, and apply them to the local evaluations based on an assessment using the WWC evidence standards.

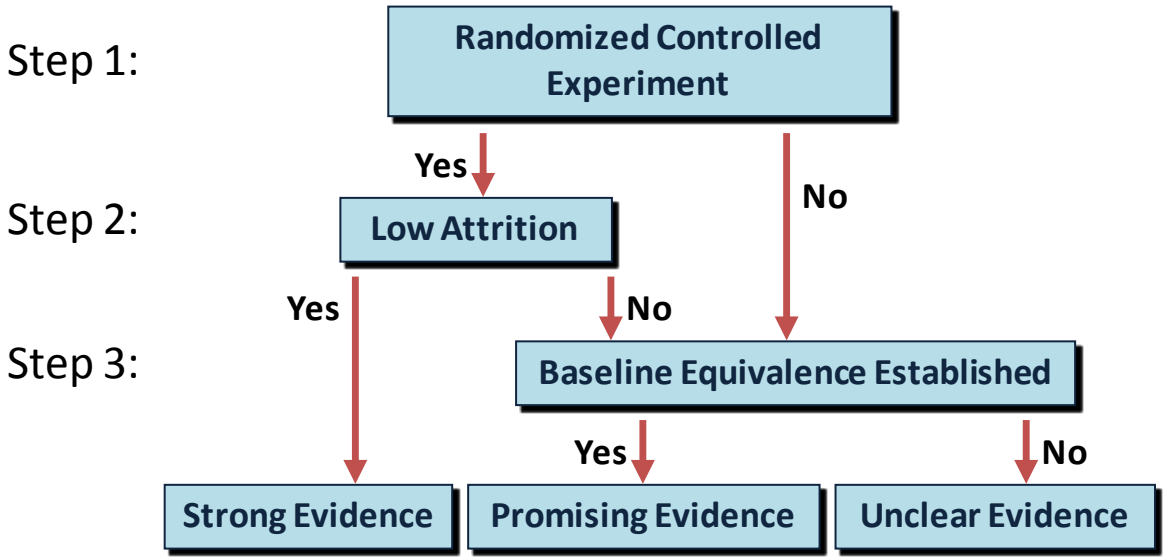
The CEBC is useful for interpreting levels of research evidence. For example, the Scientific Rating Scale established by the CEBC indicates that only RCTs can achieve the highest score on the rating scale, which is indicated by saying that the results are supported by "research evidence." According to this same scale, QEDs can at best provide only "promising research evidence." We will use the same rating scheme in our review: Well-implemented RCTs will be eligible to provide "strong research evidence," and QEDs will be able to provide "promising research evidence." The CEBC rating procedure relies on the peer-review publication process to determine the quality of the evidence, a practice that is not viable in the context of the current local evaluations. As a result, we will use the WWC standards to determine the level of evidence submitted by each grantee.

The WWC provides a well-established framework for assessing levels of research evidence. This overarching framework has been applied to research outside of education, including home visiting interventions to improve children's outcomes (Avellar et al. 2012), responsible fatherhood programs (Avellar et al. 2012), and teen pregnancy prevention interventions (Goesling et al. 2013). We will use the WWC guiding principles (version 2.1 standards) to assess the evidence provided by the evaluations. Figure V.1 highlights the specific principles for assessing each design. Each step is briefly outlined below, with a more substantive discussion of steps 2 and 3 following the overview.

- **Step 1: Assess the design of the study.** The first step in the review process is to establish whether the study is an RCT. Even if the study is an intended RCT, random assignment process must be strictly implemented. For example, assignment to treatment or comparison condition may not be changed. Experimental designs lose credibility if the random assignment process was not followed as intended. If there is evidence of issues with the random assignment process, the study will be assessed as a QED, and the next step (Step 3) is to assess the baseline equivalence of the sample. In RCTs with appropriate assignment procedures, the next step is to examine attrition levels (Step 2).

[22] The What Works Clearinghouse is an evidence-based review process for education research by the Institute of Education Sciences in the Department of Education. The latest procedures for establishing the rigor of ratings for comparison-group designs can be obtained at http://ies.ed.gov/ncee/wwc/DocumentSum.aspx?sid=19 (accessed March 12, 2013).

Figure V.1. Classification of Research Designs for Each Site



- **Step 2: Assess attrition levels in the study.** In an RCT, sample attrition—that is, participants leaving the study and not providing data at follow-up—has the potential to compromise the validity of the evaluation. Determining the level of attrition is described below. If an RCT has a low level of observed attrition, it will receive the "strong evidence" classification. If the study has a high level of sample attrition, it will be assessed as a QED and will need to demonstrate the equivalence of the sample (step 3).
- **Step 3: Assess the equivalence of the analytic sample.** For RCTs with high attrition and QEDs, the sample must be equivalent on key characteristics prior to the intervention (described in detail below). If a study examined in this step shows equivalence of the sample at baseline, it will receive the "promising evidence" classification. If the study cannot demonstrate equivalence of the sample at baseline, the study will receive the "unclear evidence" rating.

1. Determining Attrition Levels of RCTs (Step 2)

Random assignment provides certain safeguards against systematic differences between randomly assigned groups. However, this advantage exists only when analyses are conducted on the initially assigned sample. If participants are missing from the analysis in ways that lead to systematic differences between the treatment and comparison groups, the benefit of random assignment in providing the most rigorous evidence of a program's impact is compromised.

For our review, we will use the WWC attrition standards. Based on criteria presented in the WWC handbook, we will assess attrition as being "low" or "high" from the time of random assignment to the time at which follow-up outcomes are observed. Low levels of attrition suggest that the study has not experienced severe enough attrition to question the validity of the impact findings. In cases of high attrition, the rigor of the experiment is attenuated, so we effectively consider the study as a QED.

2. Establishing Baseline Equivalence for QEDs and RCTs with High Attrition (Step 3)

In the absence of an experimental design, baseline characteristics provide an opportunity to create credible counterfactual groups, based on how similar the groups *would have* been in the absence of an intervention. Therefore, we will assess baseline equivalence on demographic characteristics, standardized instruments, and administrative data that may influence participation in programming and outcomes.

As detailed in the methods section below, our benchmark approach will use observed baseline characteristics to estimate the probability of being in a treatment or comparison group. In the program evaluation literature, this measure is known as a "propensity score" (Rosenbaum and Rubin 1983; Rosenbaum 2002). It quantifies the probability of being assigned to the treatment group, based on background characteristics that influence treatment assignment. This strategy can identify individuals across treatment and comparison groups who appear to be appropriate counterfactuals. The benefit of using propensity scores is that we can pool information across a number of various background characteristics to identify a sample in the treatment and comparison groups that are well matched on key observable characteristics. This approach will allow us to make comparisons that can provide "promising evidence."

Broadly speaking, we will identify individuals who have similar propensity scores across the treatment and comparison groups, to create groups that are substantively similar on key baseline characteristics. For this subsample of participants across the treatment and comparison groups, we will assess baseline equivalence of the characteristics used to create the propensity score, and estimate the impact of each project using this analytic sample. We describe the details of the process used for estimating propensity scores and for showing the equivalence of the groups in the methods section below.

3. Additional Concerns Influencing Rating the Quality of Evidence

Although classifying studies based on decisions outlined in Figure V.1 makes up the bulk of our rating strategy, we will also consider two additional issues that may potentially affect the research design. We based this decision on information learned about each evaluation during the monthly evaluation monitoring calls with CSLs. The two issues of interest are:

- **Data collection confounding factor**. Differences in how or when data are collected for treatment and comparison groups can influence the observed results and weaken the rigor of the comparisons. For example, if data are collected by project staff in the treatment group and researchers in the comparison group, data collector characteristics or relationships with the clients may influence data reporting. Thus, any observed difference across groups at the follow-up period could be a combination of project effects and data collection effects. Because we are interested only in project effects, factors that confound data collection will be highlighted as a limitation of any evidence.
- **Intervention confounding factor**. In some cases, all members of a group may share a common experience, unrelated to the intervention that influences outcomes. For example, all members of the comparison group may come from a neighboring county in which a different set of services are available. Any observed differences between groups may be based on the intervention or other differences across counties—such as differences in services provided, or populations served. Therefore, the research design

cannot distinguish the effect of the intervention from the underlying differences in the two groups. We will flag research designs that may suffer from these types of confounding factors. However, we may still include these comparisons depending on the severity of the issue, noting limitations.

C. Estimating Impacts

Analysis will begin with estimating site-specific impacts of the interventions implemented in the selected sites. We will examine impacts of the projects by comparing the treatment and comparison group at a follow-up time period, controlling for key baseline characteristics. The results may differ from local evaluators' estimates because each site may use models that are not possible in an analysis that combines information across sites. We will use a consistent method across sites and examine the robustness of the results to ensure that the final results are not sensitive to the benchmark methods selected.

We will then create cross-site impact estimates based on aggregated estimates of site-specific impact estimates. This approach provides a more (statistically) powerful test of the effect of interventions. Our approach to aggregation is calculating impacts at varying levels of evidence. Specifically, we will calculate an aggregate impact for three groups of studies: (1) those with the strongest evidence available—that is, the well-implemented RCTs;[23] (2) those with moderate evidence—that is, well-implemented QEDs and RCTs with some issues, such as high attrition; and (3) all studies in groups 1 and 2. We will compare the results from groups 1 and 2 to determine whether the findings are substantively different. If so, this may be because of possible bias and/or the inclusion of different projects, for example, if more intensive projects are in one group. Therefore, in assessing the findings, we will also consider whether other factors are likely to contribute to any substantive difference in findings. The results from group 3 will have the greatest statistical power, but the inclusion of QEDs and RCTs with high attrition may create bias in this pooled impact estimate.

D. Initial Selection of Sites for the Comparison-Group Study

Seven grantees are candidates for inclusion in the cross-site impact study (Table V.1). Five of the grantees are proposing RCTs that could provide strong research evidence. (These grantees will contribute data used to determine the aggregated ATE of the RPG-funded projects for sites conducting well-implemented randomized controlled trials.) Grantees plan to include a total of 1,810 families in these RCTs over the course of the grant period. In addition, two grantees are proposing QEDs with plans to do primary data collection on key baseline variables across both treatment and comparison groups. These grantees could offer promising research evidence, and we will use their data to determine the aggregated ATE of the RPG-funded projects for sites conducting well-implemented quasi-experiments or randomized controlled trials with some limitations. The QED studies will include a total of 700 families over the course of the grant period. We will combine information from sites doing RCTs or QEDs to test the broad effectiveness of the collection of interventions across both sets of studies listed above, for a total of 2,510 families. This analysis will

[23] Although this aggregate impact will be based on well-implemented RCTs (for example, RCTs with low attrition rates) it is not necessarily free from bias because studies are being excluded based on factors determined post-randomization (that is, on factors that are endogenous, not exogenous).

address the aggregated ATE of the RPG-funded projects for all sites participating in the impact study.

Table V.1. Characteristics of Likely Candidates for the Impact Study

Grantee Name	State	Proposed Design	Target Population	Project Services	Proposed Sample Size
Center for Children and Families	MT	RCT	Families with children birth to age 12 who are in, or at risk of placement in, out-of-home care due to parental substance use disorders	Family Treatment Matters (FTM) is a comprehensive outpatient family treatment project based on the Chadwick Trauma Assessment Pathway model.	450 families (225 treatment, 225 comparison)
Nevada Division of Child and Family Services	NV	RCT	Low-income women in a residential substance abuse treatment facility and their children birth to age 8 who have or are at risk of an out-of-home placement	Project offers treatment supervision and collaborative case management monitored by the court; on-site counseling/mental health, family-strengthening, and vocational services; assessments and referrals for children; and transitional services after leaving the facility.	320 families (120 treatment, 200 comparison)
Summit County Children Services	OH	RCT	Families that have child welfare cases (children ages 0–5) with court involvement	STARS (Summit County Collaborative on Trauma, Alcohol, and Other Drug, and Resiliency-building Services for Children and Families) project offers a service coordinator and public health outreach worker.	300 families (150 treatment, 150 comparison)
Oklahoma Department of Mental Health and Substance Abuse Services	OK	RCT	Families with children ages 0–17 affected by parent substance use disorders who have an out-of-home placement	Solution Focused Brief Therapy (SFBT) is a "strengths-based" counseling intervention to support recovery from substance abuse.	240 cases (120 treatment, 120 comparison)
Health Federation of Philadelphia	PA	RCT	Families with parents who have substance use disorders and children ages 0–5 who have been placed outside the home	Child Parent Psychotherapy (CPP) is a relationship-based, trauma-specific EBP that includes weekly sessions for the caregiver/parent-child dyad and supervised visits between parents and their children who are in out-of-home placements.	500 parent-child dyads (250 treatment, 250 comparison)
Kentucky Department of Community Based Services	KY	QED	Families with young children (age 0–5) who are new to the child welfare system in Daviess County Sobriety Treatment and Recovery Teams (START) families	The START project provides in-home support and access to wraparound services. Participants receive case management and service coordination from a specially trained CPS caseworker with a limited caseload, and support from a family mentor, both of whom visit the family at home.	300 families (150 treatment, 150 comparison)
Massachusetts Family Recovery Project	MA	QED	Families whose children (age 0–17) have been removed or are in the home but at imminent risk of removal, and who have substance use issues but have been difficult to engage in treatment	The treatment group will receive weekly or more frequent visits from a family recovery specialist who provides the services; manages the case; coordinates screenings, assessments, and community-based services; works with the child welfare case manager; and helps the family transition to community-based services.	400 families (280 treatment, 120 comparison)

1. The Grantees

The following five sites are currently planning for RCTs:

1. **Montana**. The grantee will examine the effects of Family Treatment Matters (FTM)—a comprehensive outpatient family treatment project based on the Chadwick Trauma Assessment Pathway model—among families with children birth to age 12 who are in, or at risk of placement in, out-of-home care due to parental substance use disorders. The evaluation will use an RCT design with a potential sample of 450 families (225 treatment and 225 comparison). The FTM project combines substance abuse treatment with family-strengthening programs, including resilience-building programs for children, in three phases that progressively decrease in intensity.
2. **Nevada**. The grantee will examine the effects of enhanced on-site services for low-income women in a residential substance abuse treatment facility and their children birth to age 8 who have or are at risk of an out-of-home placement. The evaluation will use an RCT design with a sample of approximately 320 families (120 treatment, 200 comparison). The treatment group will receive treatment supervision and collaborative case management monitored by the court, as well as on-site counseling/mental health, family-strengthening, and vocational services; assessments and referrals for children; and transitional services after leaving the facility.
3. **Ohio**. The grantee will examine the effects of the STARS (Summit County Collaborative on Trauma, Alcohol, and Other Drug, and Resiliency-building Services for Children and Families) project—which offers a service coordinator and public health outreach worker—on families that have child welfare cases (children ages 0–5) with court involvement. The evaluation will use an RCT design with a sample of approximately 300 families (150 treatment, 150 comparison). STARS families will receive coordination of services and outreach/encouragement from STARS workers, access to a recovery coach, and a family-strengthening program.
4. **Oklahoma**. The Oklahoma grantee is conducting two separate outcome evaluations, one examining the Strengthening Families Program (SFP) and the other of Solution Focused Brief Therapy (SFBT). The impact study will include the evaluation of SFBT. The grantee will examine the effects of SFBT (compared with the usual substance abuse treatment) among families with children ages 0–17 affected by parent substance use disorders that have an out-of-home placement. The analysis will use an RCT design with a total sample size of approximately 240 cases (120 treatment, 120 comparison). SFBT is a "strengths-based" counseling intervention to support recovery from substance use disorders.
5. **Pennsylvania**. The grantee will examine the effects of Child Parent Psychotherapy (CPP) on families in which parents have substance use disorders and with children ages 0–5 who have been placed outside the home. The evaluation will use a randomized controlled trial design with a sample of 500 parent-child dyads (250 treatment, 250 comparison). CPP is a relationship-based, trauma-specific EBP that includes weekly sessions for the caregiver/parent-child dyad and supervised visits between parents and their children who are in out-of-home placements.

The sites proposing QEDs with primary data collection have an opportunity to demonstrate that the groups were effectively equivalent at baseline on key observable variables expected to

influence program participation and outcomes (see Appendix F for further details). By collecting baseline assessments of outcomes of interest, more information is available for assessing baseline equivalence relative only to administrative data. The two sites proposing QEDs include:

1. **Kentucky.** Kentucky will evaluate the impact of the Sobriety Treatment and Recovery Teams (START) project—a comprehensive project that provides in-home support and access to wraparound services—for families with young children (age 0–5) who are new to the child welfare system in Daviess County. The evaluation design is a quasi-experiment with a proposed sample of 300 families (150 treatment and 150 comparison). START families receive case management and service coordination from a specially trained CPS caseworker with a limited caseload, and support from a family mentor. Both of these service providers visit the family at home.
2. **Massachusetts.** The Family Recovery Project Southeast will examine the effects of coordinated, in-home substance abuse treatment, parenting/family-strengthening, child trauma, and case management services on families whose children (age 0–17) have been removed or are in the home but at imminent risk of removal, and who have substance use disorders but have been difficult to engage in treatment. The evaluation will use a comparison group design, with comparison families drawn from neighboring counties, and a sample of 400 families (280 treatment and 120 comparison). The treatment group will receive weekly or more frequent visits from a family recovery specialist who provides the services; manages the case; coordinates screenings, assessments, and community-based services; works with the child welfare case manager; and helps the family transition to community-based services.

2. Minimum Detectable Effect Sizes Based on Current Assessment of Research Designs

We have estimated minimum detectable effect sizes (MDEs) and minimum detectable impacts (MDIs) for each of the three research questions that aggregate impacts across grantees. Effect sizes are standard-free measures of impact sizes for continuous outcomes that are in terms of standard deviations of an outcome. They are useful for interpreting the impacts of programs because they represent changes across groups relative to the distribution of outcomes. The MDE is the smallest effect size that we would be able to identify as being statistically distinguishable from 0 at a 95 percent level of confidence and is directly related to expected sample sizes. Similarly, the MDI represents the smallest percentage point difference that we would be able to detect across comparison groups for dichotomous outcomes.

Given the fact that there will be different numbers of grantees and different numbers of families available to answer each of the research questions that focus on aggregated impacts across grantees, we provide one set of MDEs for each research question.

Table V.2 provides estimates for post-intervention impact. As the table shows, the MDEs and MDIs are smallest (that is, we have the greatest statistical power to observe project impacts) when we pool information across both RCTs and QEDs to answer the final research question that aggregates information across all participating grantees. Overall, the effect sizes are able to produce relatively precise estimates, with the exception of the aggregated estimates that may be based on two QED studies used to answer the research question about QEDs or RCTs with limitations. For example, we will have 80 percent power to detect project impacts as small as 0.14 standard deviation units or 6.9 percentage points under the worst scenario for a set of sites conducting RCTs (used to

answer the research question about well-implemented RCTs). When we pool the evidence from the RCTs with the QEDs to answer the final research question that pools information across all grantees, the MDE shrinks to 0.12 standard deviation units, or as little as 5.9 percentage points.

Table V.2. MDE Sizes and MDIs for Outcomes Measured at Different Months

Research Question	N	MDE (Continuous)	MDI (Binary 50 percent prevalence rate)	MDI (Binary 75 or 25 percent prevalence rate)	MDI (Binary 90 or 10 percent prevalence rate)
What is the aggregated ATE of the RPG-funded projects for sites conducting well-implemented RCTs?[a]	1158	0.14	6.9	6.0	4.1
What is the aggregated ATE of the RPG-funded projects for sites conducting well-implemented QEDs or RCTs with some limitations?[b]	448	0.23	11.4	9.8	6.8
What is the aggregated ATE of the RPG-funded projects for all sites participating in the impact study?[a + b]	1606	0.12	5.9	5.1	3.5

Note: The MDE is expressed in standard deviation units. The MDI is expressed in percentage points and assumes various base outcome rates as presented at the top of each column. These values were calculated assuming (1) a two-tailed test; (2) a 0.05 percent significance level, α; and (3) an 80 percent level of power, β. Based on the original sample sizes proposed by the grantees (described above), we assumed that only 80 percent of the originally proposed would contribute data during the grant period (some families served before data collection and some served after the end of the data collection period used for the impact study), and an 80 percent rate of follow-up. We further assumed that baseline covariates explain 30 percent of the variance in the outcome.

[a]The sites conducting RCTs to be included in the estimate used to answer this research question include MT, NV, OH, OK, and PA.

[b]The sites conducting QEDs to be included in the estimate used to this research question include KY and MA.

Based on findings from RPG1, we believe that this impact study is well-powered to detect impacts. Some of the substantive findings (Boles et al 2012) covered the following topics:[24]

- **Safety**. More children in the treatment condition were able to stay at home through case closure (93.5 percent) than in the comparison condition (88.7 percent), a difference of 4.8 percentage points.
- **Permanency**. A greater proportion of clients in the treatment condition were reunified in less than 12 months (70.1 percent), than in the comparison condition (63.8 percent), a difference of 6.3 percentage points.
- **Recovery**. A higher percentage of clients in the treatment condition participated in recovery (73.2 percent) than the comparison group (53.6 percent), a difference of 19.6 percentage points.

[24] The RPG1 study did not require common assessments for the child-well being or family functioning domains.

E. Data

Most of the data needed for the impact analyses will be uploaded by grantees to the RPG Outcome and Impact Study Information System (OAISIS) and the Enrollment and Service Log (ESL). For the treatment group, grantees will submit demographic data to the ESL for the implementation study and outcome data to OAISIS as a component of the outcomes study. Grantees participating in the impact study will provide similar data elements for members of their comparison groups.

To reduce the burden on the grantees and local evaluators, we limited the outcomes that the impact study would include (Table V.3). Thus, only a subset of the instruments being used in the outcomes study will be collected from the comparison groups at baseline and at program exit (at the same time periods of data collection for the treatment group).[25]

Table V.3. Required and Recommended Standardized Instruments and Administrative Records for Comparison Group Members of the Impact Study

Outcome Domain	Required Instruments/Records	Recommended Instruments
Child Well-Being	Child Behavior Checklist–Preschool Form; Child Behavior Checklist–School-Age Form (Achenbach and Rescorla 2000)	Behavior Rating of Executive Function; (Gioia 2000)
	Socialization Subscale, Vineland Adaptive Behavior Scales, Second Edition, Parent-Caregiver Rating Form (Sparrow et al. 2005)	
Permanency	Administrative records on number of placements	None
Safety	Administrative records on child maltreatment	None
Recovery	Addiction Severity Index, Self-Report Form (McLellan et al. 1992)	None
	Administrative records on substance abuse treatment participation	
Family Functioning	Parenting Stress Index, Short Form (Abidin 1995)	Center for Epidemiologic Studies-Depression Scale, 12-Item Short Form (Radloff 1977)

Source: RPG-052 Comparison Group Design Memo.

Note: These measures were those that were most frequently proposed for data collection across treatment and comparison groups by the grantees likely participating in the comparison group study.

Most participating grantees agreed to collect all of the instruments (Table V.4). The exception is the one grantee, which will collect only the Child Behavior Checklist and administrative data.

[25] Following the grantee conference in April 2013, we cross-walked the standardized instruments proposed for the core cross-site evaluation with measures that grantees who are the likeliest candidates for the impact study proposed collecting from both their treatment and comparison groups. We identified the instruments that were the most commonly proposed across grantees, and used this information to determine the best candidates for the impact study. This list of measures was then approved by Children's Bureau and shared with the grantees participating in the impact study.

Table V.4. Number of Grantees Using Proposed Instruments with Treatment and Comparison Groups

Instruments	Number of grantees [a]
Child Behavior Checklist–Preschool Form; Child Behavior Checklist–School-Age Form	7
Socialization Subscale, Vineland Adaptive Behavior Scales, Second Edition, Parent-Caregiver Rating Form	6
Behavior Rating of Executive Function; Behavior Rating of Executive Function–Preschool	5
Parenting Stress Index, Short Form	6
Center for Epidemiologic Studies–Depression Scale, 12-Item Short Form	6
Addiction Severity Index, Self-Report Form	6

Source: The lists of the standardized instruments the grantees were planning on collecting from both treatment and comparison groups were submitted by each grantee in August 2013.

[a] Only the seven likely candidates for the impact study are included.

F. Methods

This section describes our analytic approach for calculating both the site-specific and the cross-site impact estimates for the comparison group study. Although the data elements for the members of the treatment conditions will have already been cleaned and organized for the core outcomes study, a similar approach will have to be applied to the data of comparison group members. As described in the core implementation study, the following general approaches will be used to clean data for the comparison group members.

First, we will verify that the scores for each relevant variable are within the expected ranges, to identify outliers or errors in the data set. When necessary, we will generate scale scores for baseline or outcome variables by combining several items from a survey or other instrument. Approaches for handling missing data are described below.

In the remainder of this section, we first describe the ways that we will address missing data and demonstrate the equivalence of our sample. Next, we describe the benchmark approaches that we will conduct for estimating site specific and cross-site impacts. Finally, we describe sensitivity analyses we will run to demonstrate the robustness of our results to other equally appropriate analytic methods that use different assumptions.

1. Benchmark Approach for Handling Missing Data

We will use a common approach for handling missing baseline data for each local evaluation in our benchmark analyses. We will use casewise deletion to drop all observations for which there is missing outcome data. For missing baseline data, we will use mean imputation with a dummy missing variable indicator for each baseline variable with missing data (Deke 2013). That is, we will replace all missing data for a given variable with the mean of the observed data for that variable, and include a dummy variable to indicate whether the value had been imputed. Under this approach, the relationship between the baseline variable and the outcome is estimated using only nonmissing values of the baseline variable, which improves the precision of the impact estimate. This approach is appropriate in the context of a well-implemented RCT because all baseline variables are expected

to be uncorrelated with treatment status. Thus, missing baseline data can be imputed (and flagged with a dummy indicator) without incurring any statistical bias in subsequent impact estimation.

2. Benchmark Approach for Demonstrating Baseline Equivalence

We will demonstrate the equivalence of the analytic samples differently for RCTs with low attrition versus high attrition. For RCTs with low attrition, we assume that any differences observed at baseline are simply due to random sampling error, and not due to any systematic selection bias resulting from nonresponse. However, we will still assess baseline differences (in particular, the magnitude and statistical significance of the differences), which can occur by chance, as a basic check for the success of random assignment. Regardless of the results, the subsequent impact analyses will include all baseline covariates to increase the precision of the estimates. Table V.5 provides an example of how we will present the information.

Table V.5. Table Shell for Showing Equivalence of the Groups on Baseline Covariates for a Given Site

Characteristic	Treatment Mean (Standard Deviation)	Comparison Mean (Standard Deviation)	Difference (Standard Error)	Effect Size (g)
Char. 1				
Char. 2				
Char. *N*				

Note: * $p < 0.05$, ** $p < 0.01$.

For RCTs with high attrition and QEDs, because of the potential for systematic differences across the treatment and comparison groups, it may not be appropriate to include certain individuals who are particularly dissimilar from their counterfactual member. Our goal is to use estimated propensity scores to determine the appropriate sample members to include in the comparison group impact analyses, and to use these scores to appropriately adjust the impacts.

A propensity score $\lambda(x)$ represents the probability of receiving the treatment ($T = 1$), given a set of covariates x (Rosenbaum and Rubin 1983; Rosenbaum 2002). More formally,

$$\lambda(x) = \Pr(T = 1|x),$$

where x includes key baseline characteristics that are expected to influence an individual's propensity to be included in a certain group, such as those who are eligible for a program, participate in a program, or complete of a program. Importantly, this set of baseline characteristics will include information beyond typical demographic characteristics. As described above, we have included in this impact study the subset of grantees that are conducting primary data collection of key variables (including baseline assessments of all outcomes of interest) for members of the treatment and comparison groups at baseline. These groups will be key covariates used in the propensity score generation process. When appropriate, we will include interaction terms and higher order values of the covariates to achieve balance in the observed samples (more on this below).

The first use of the propensity scores will be to determine the appropriate sample members to include in each site's comparison group study. To exclude very dissimilar individuals, we will eliminate treatment group members with propensity scores higher than the highest propensity score

in the comparison group. Similarly, we will eliminate comparison group members with propensity scores lower than the lowest propensity score in the treatment group. These members' "lack of common support" essentially means that no credible counterfactual individuals existed across groups. By excluding them, we will limit ourselves to individuals that that appear to be reasonably comparable.

The second use of the propensity scores will be to operationalize them as weights for subsequent analyses. Because each observation *i* will have a different propensity score, $\lambda_i(x_i)$, we can use these probabilities to generate weights for each participant, to allow each observation to contribute more or less information to the estimate of interest, based on their propensity score. Individuals who receive the treatment (T_i =1) will receive the weight $\frac{1}{\lambda_i(x_i)}$, and individuals in the comparison condition (T_i =0) will receive the weight $\frac{1}{1-\lambda_i(x_i)}$ (Robins et al. 2000). Under this weighting scheme, the clients in the treatment group would have higher weight if they are less likely to receive the treatment (have lower propensity scores), and the clients that do not receive the treatment would have higher weight if they are more likely to receive the treatment. As a result, this weighting scheme focuses on the strongest overlap (or support) in propensity: clients that received the treatment in spite of having a low propensity with those who did not receive the treatment but had high propensity to get the treatment.

We will assess the equivalence of the two groups by estimating the means and differences in the means for each covariate of interest, after weighting each observation by its respective propensity score. If there are large differences in baseline characteristics, or statistically significant differences observed in any of the baseline covariates, we will re-estimate the propensity scores for the sample members by including interaction terms of the non-equivalent characteristic with other variables to improve balance. As a result of the iterative process, we will achieve an analysis sample that is equivalent on all key covariates at baseline. We will present the results of the baseline equivalence assessment in a format similar to Table V.6, and we will include in our reports a final specification of the propensity model that was used to generate the weights for each site.

Table V.6. Table Shell for Showing Equivalence of the Groups on Baseline Covariates for a Given Site

	Before Adjustment (n_T = XXX, n_C = XXX)				After Adjustment (n_T = XXX, n_C = XXX)			
Characteristic	Treatment Mean (SD)	Comparison Mean (SD)	Difference (SE)	Effect Size (g)	Treatment Mean (SD)	Comparison Mean (SD)	Difference (SE)	Effect Size (g)
Char. 1								
Char. 2								
Char. *n*								

Note: * $p < 0.05$, ** $p < 0.01$. The "Before Adjustment" columns represent the raw data for the full sample, and the "After Adjustment" columns represent the information for the samples within the common support region, after weighting each observation by the inverse of the estimated propensity score.

3. Benchmark Approach for Site-Specific Impact Estimation

We plan on using a common approach for the impact analyses, with the method of weighting as the one major difference in the way that we analyze the data across RCT and QED studies. For the impact estimation approach, we will use an Analysis of Covariance (ANCOVA) framework to

estimate the effect of the offer of treatment on the outcome of interest, after adjusting for baseline covariates. The model specification for a given grantee is:

(1) $Y_i = \beta_0 + \beta_1 * T_i + \beta_2 * X_i + \varepsilon_i$,

where Y_i is the outcome for client i, T_i is an indicator variable that represents the result of the random assignment procedure (the offer of treatment), X_i is a vector of baseline variables that are expected to correlate with the outcome (they will increase the precision of the impact estimate), and ε_i is a client level error term. The impact of the RPG intervention will be identified as the coefficient for the treatment variable $\delta = \beta_1$.

Although we expect that most grantees conducting RCTs will assign clients to condition with a 0.50 probability of receiving the treatment, our analysis will allow for alternate treatment probabilities, by weighting each observation by the inverse of the probability of treatment. (In evaluations where Pr[T_i=1] = 0.50, this weighting scheme gives each observation equal weight.)

The impact estimation approach for studies that provide a moderate level of evidence will be a propensity score technique, to create "equivalent" groups in the treatment and comparison conditions in terms of their observable baseline characteristics. The estimate of project impact will use the inverse of the propensity score as sample weights to obtain a project impact.

We will present site-specific means for each treatment group, the impact estimate measured as the difference, the standard error, and *p*-value for each outcome of interest in a format similar to Table V.7. Thus, this set of results will inform the first research question about site-specific impacts.

4. Benchmark Approach for Pooling Site-Specific Estimates into a Cross-Site Impact

Our general approach will pool the results across sites to obtain a more precise average impact estimate than the estimate obtained in each site. The average impact estimate will be a weighted average of each site-specific impact estimate, in which the weight of each site-specific impact is the inverse of the squared standard error of the impact (Cooper et al. 2009). As such, sites with more precise impact estimates (with larger sample sizes or with baseline variables that are highly correlated with the outcomes) will receive greater weight in the average impact estimate.

Because we have research questions that focus on different types of pooled estimates, we will use two methods to conduct the pooled analysis. The first pooled impact estimate will use information from grantees that contribute the highest level of evidence (well-implemented RCTs) to answer the second research question. The second pooled impact estimates will focus on grantees conducting QEDs or RCTs with some issues. Finally, we will combine the evidence of effectiveness across all grantees in the impact study (both those conducting RCTs and QEDs). The benefits of the pooled analysis—the result of the inclusion of a greater number of grantees—are greater generalizability and improved power. However, as noted above, the inclusion of QEDS and RCTs with high attrition may bias the estimates.

Table V.7. Table Shell for Demonstrating Cross-Site Average Impacts

Site	Mean (Standard Deviation)		Difference (Standard Error)	Effect Size (g)
	Treatment	Comparison		
Outcome 1				
Site 1				
…				
Site 7				
Strong Evidence (Well-implemented RCTs)				
Moderate Evidence (QEDs and RCTs with limitations)				
Combined Evidence (All sites)				
Outcome 2				
Site 1				
…				
Site 7				
Strong Evidence (Well-implemented RCTs)				
Moderate Evidence (QEDs and RCTs with limitations)				
Combined Evidence (All sites)				

Note: * $p < 0.05$, ** $p < 0.01$. The cross-site average impact estimates are estimated as the weighted average of the site-specific impact estimates, where the weight is the inverse of the squared standard error. The cross-site average impact expressed as an effect size is calculated as the aggregated difference, divided by the pooled standard deviation of the outcome, as calculated across all participating sites.

[a]Site is included in Strong Evidence impact estimate.

[b]Site is included in Strong + Promising Evidence impact estimate.

5. Sensitivity Analyses—Baseline Equivalence

To assess the robustness of the weighting method used in the benchmark approach (that is the inverse of the propensity score), we will also present baseline equivalence results using an alternate method. We will estimate the baseline equivalence of the groups giving each observation equal weight, focusing on the sample that exists within the region of common support. We will present the baseline equivalence sensitivity results in a format similar to Table V.8.

Table V.8. Baseline Equivalence Sensitivity Analysis Table Shell

Covariate	Benchmark Analysis			Sensitivity Result 1		
	Treatment Mean (Standard Deviation)	Comparison Mean (Standard Deviation)	Difference (Standard Error)	Treatment Mean (Standard Deviation)	Comparison Mean (Standard Deviation)	Difference (Standard Error)

Note: * $p < 0.05$, ** $p < 0.01$

6. Sensitivity Analyses—Impact Estimation

We will also assess the robustness of the impact estimate using alternate estimation methods. For well-implemented RCTs, the primary impact estimation method used an ANCOVA approach to identify a project impact at a particular time period, after adjusting for baseline characteristics. This specification was used because the inclusion of baseline covariates would improve the precision of the impact estimate (reduce the standard error), but would not substantively change the estimate, because baseline characteristics would be uncorrelated with treatment status. To show that the point estimate is relatively unaffected by the inclusion of baseline covariates, we will estimate an impact that omits all baseline covariates.

We will also check the sensitivity of results based on research design and execution. For RCTs with potential problems (for example, high levels of attrition), we will conduct the analysis as if the study were a well-implemented RCT. That is, we will conduct an ANCOVA analysis on all participants who have outcome data, with mean imputation (and dummy indicators) for missing baseline data. For studies assessed as having a moderate level of evidence, the benchmark approach is using propensity scores as weights in our analysis. As a check, we will also alternatively include the propensity score as a covariate in the estimation model.

All impact sensitivity results will be presented in a table, with the benchmark impact estimates and standard errors as one row, and the alternate estimation methods shown as separate rows (Table V.9). This presentation will allow the reader to compare the magnitude and significance of the observed results to determine the degree to which the site-specific impacts are robust to different estimation procedures.

Table V.9. Impact Analysis Sensitivity Results Table Shell

	Mean (Standard Deviation)			
Method	Treatment	Comparison	Difference (Standard Error)	Effect size (g)
Outcome 1				
Benchmark Sensitivity analysis (propensity score as covariate)				
Outcome 2				
Benchmark Sensitivity analysis (propensity score as covariate)				

Note: * $p < 0.05$, ** $p < 0.01$

7. Sensitivity Analyses—Missing Data

The benchmark missing data approach includes mean imputation and dummy indicators for any missing baseline covariates, deleting all cases with missing outcome data. We will take three additional approaches to test the robustness of the impacts to different missing data assumptions.

For the first approach, we will use multiple imputation (MI). MI will "fill in" the missing data with plausible values for the missing data, based on observed data, and generate multiple versions of the data set with different plausible values. The assumption underlying the MI approach is that data are missing at random (MAR). Stated differently, the underlying values that are missing in the observed data set are correlated with the observed data (Allison 2002; Rubin 1987). The proposed MI process will create 10 data sets with plausible values for the missing data, where this missing-data imputation process will be conducted separately for the participants in each treatment and comparison group (Puma et al. 2009).

The second approach will relax the requirement that the analytic sample needs to have an observed score for the outcome of interest. Instead, we will consider the viable sample to include sample members that have at least a baseline outcome or a follow-up outcome, and we will use MI to impute missing baseline or outcome data. This approach will likely produce a larger analytic sample than the benchmark approach but should result in a substantively similar impact, if the missing outcome data are MAR.

The final sensitivity approach for handling missing data is casewise deletion (deleting observations missing any variable of interest, including either the necessary baseline covariates or the outcome assessments). This analysis sample will likely be smaller than the benchmark sample and have weaker statistical power to detect project impacts. However, the magnitude of the impact should be similar to the benchmark approach.

The results of these sensitivity analyses for missing data will be presented with the other sensitivity results of impact analyses as additional rows (Table V.9). The reader will be able to qualitatively assess each site-specific impact estimate to different approaches for handling missing data (or other estimation methods), relative to the benchmark approach.

8. Sensitivity Analyses—Aggregating Impacts

The benchmark approach for aggregating the impact estimates (for each research question of interest) will weight each site-specific impact by the inverse of its squared standard error. To illustrate the robustness of the aggregation method to other weighting techniques, we will apply two weights to the site-specific impacts: (1) allocating equal weight to each site-specific impact (the procedure currently used for WWC intervention reports), or (2) allocating weight proportional to the sample size of the study. These alternate calculations of the aggregated impact estimates would be presented in a format relative to the benchmark impact estimate for a given outcome (Table V.10).

Table V.10. Aggregated Impact Analysis Sensitivity Results Table Shell

	Benchmark	Sensitivity Analysis 1	Sensitivity Analysis 2
Outcome	Difference (Standard Error)	Difference (Standard Error)	Difference (Standard Error)

Note: * $p < 0.05$, ** $p < 0.01$

G. Limitations

The impact study will estimate the effects of selected grantees' RPG projects on key outcomes of interest. The impact study is built on the local impact evaluations. Thus, any problems in executing the local evaluations will affect the quality of the cross-site impact study. To address this challenge, we will be providing technical assistance and other evaluation monitoring supports, such as resource documents and training.

A second limitation is that participating grantees will collect outcome data from comparison group members on only a subset of the outcomes examined in the core outcomes study. Therefore, we will be able to look at only one or two effects in each domain of interest.

A third limitation, as described in Appendix F, is that the selection process for the local QEDs is likely to be complex. Using the handful of baseline assessments for the impact study is likely to offer limited insight into the true process, constraining the internal validity of the moderate evidence and combined results.

Finally, the impact estimates will aggregate grantees with different projects, fidelity, and target populations. The estimates will provide CB an overall sense of the effectiveness of the included RPG projects but will not be able to identify the elements of the projects that made them successful.

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VI. REPORTING

To support program development and improvement and inform stakeholders—including the Children's Bureau (CB), Congress, and the grantees themselves—results from the cross-site evaluation will be released throughout the evaluation period. Products include annual reports to Congress, special topics briefs, and the final evaluation report. To disseminate findings more broadly, the cross-site team, sometimes in partnership with grantees, will also present at professional conferences, brief federal interagency groups, and publish in scholarly journals. We will also prepare a restricted-use data file available to qualified researchers through the National Data Archive on Child Abuse and Neglect (NDACAN) at Cornell University, including documentation for users. This chapter presents the preliminary plans for reporting and disseminating the cross-site evaluation findings.

A. Reports to Congress

Annual reports to Congress will summarize findings from both the local and cross-site evaluations, describing the performance of each grantee. The content of the reports will depend on the phase of the project and available data. Table VI.1 summarizes the data sources to be used for each report. The data sources are described in detail in previous chapters.

Table VI.1. Data Sources for Reports to Congress

	2013	2014	2015	2016	2017
Semiannual Progress Reports	X	X	X	X	X
Staff Survey					X
Site Visits					X
Partner Survey					X
Enrollment And Services Log		X	X	X	X
Participant Outcomes			X	X	X

Once the reports and data are submitted through the RPG data portal, the Mathematica-WRMA team will review the information carefully for accuracy and completeness. As needed, we will work with the grantees to clarify any inconsistencies or inaccuracies (for example, data out of the specified range) or fill in any missing information.

We will then draft the reports to Congress, focusing on grantees' activities and performance. Following are the current plans for content of the reports:

- The **2013 report** focused on the project structure, including details on the collaboration between the various players, such as Children's Bureau, Mathematica, WRMA, the National Center on Substance Abuse and Child Welfare, the grantees, and local evaluators. The report described the the evidence-based and evidence-informed practices grantees planned to provide. It described cross-site and local evaluation planning and summarized the rigor of the grantees' local evaluations.
- The **2014 report** will describe early enrollment and service delivery, including any changes to grantees' planned projects, program services, or target populations. It will

provide baseline characteristics for initial participants, using initial data grantees will begin submitting after OMB clearance is received.

- The **2015 report** will provide enrollment, service, and baseline and followup outcome measures for participants enrolled and served from the beginning of RPG.
- The **2016 report** will provide information covering at least three years of operations (start-up of services and evaluation may vary somewhat across grantees). This report will update previous results for grantees' progress in attaining their goals for enrollment and service delivery, characteristics of the target population, and change over time in outcomes for a larger sample of families. It will focus on grantee performance.
- The **2017 report** will make use of all data sources, including surveys of frontline staff working with RPG families providing the ten focal EBPs, surveys of agencies that are part of the RPG partnerships, and site visits. It will present findings from all four of the cross-site studies, including the impact study. It will discuss potential implications of the evaluation findings for federal policy and programs addressing the needs of families in which children are in, or at risk of, out-of-home placement as a result of a parent's or caregiver's methamphetamine or other substance use disorder.

B. Final Evaluation Report

During the fifth year of the RPG cross-site evaluation, Mathematica/WRMA will publish a final evaluation report. The final report will summarize the results of all components of the cross-site evaluation: implementation, partnerships, outcomes, and impacts. The document will provide a comprehensive synthesis, including the integration and interpretation of both qualitative and quantitative data. We will craft the document to make it accessible and as useful as possible to practitioners, policymakers, and researchers. The report will touch on all major research topics:

- Partnerships, including agencies involved and success of the collaborations
- Target population and characteristics of families served
- EBPs used and alignment with families served
- Supports for implementation, such as staff training and development, supervision, and implementation teams
- Implementation experiences, including service provision and fidelity
- Sustainability of partnerships and services
- Child and family outcomes for those who participated
- Effects of selected projects on selected child and family outcomes

The report will draw on summary and annual reports, grantee participation, expert input, stakeholder input, and other data. It will include a comprehensive, final evaluation of the RPG program implementation and results. Key sections will include: (1) summary of research questions and purpose of the study, including key conceptual and operational definitions, (2) a description of grantee projects, implementation fidelity, and intervention fidelity, with special reference to the extent to which programs are evidence-based or trauma-informed, (3) summary of key outcomes for

participants, (4) summary of effects on families in child well-being, safety, permanency, family functioning and recovery domains, and (5) suggested areas for future investigation.

A separate impact report will provide detailed information on the effects of selected, including the analytic methods. The impact report will be submitted with the final report. Having a freestanding report on effects will enable a research consortium representing participating grantees to be cited, and contribute their review of study methods and final results.

C. NDACAN Data Restricted-Use Data Files

A goal of the cross-site evaluation is to provide data for use in future research by archiving selected data with the National Data Archive on Child Abuse and Neglect (NDACAN) The Mathematica/WRMA will work with staff from NDACAN to develop a process for data submission. After data collection is complete, the evaluation team will submit cross-site evaluation data files to NDACAN, a regular practice for CB grants to facilitate ongoing research through data collection supported by federal dollars. The data files will include all data collected for the contract, including data submitted by grantees and their implementing agencies through OAISIS and ESL, data from partner and staff surveys, and information from site visits.

The Mathematica/WRMA team will work collaboratively with NDACAN, as well as with the grantees and CB, to coordinate the archiving of the data sets to ensure the format supports NDACAN's mission of providing data to researchers on child abuse and neglect, for secondary analysis. This collaboration includes developing a data structure and variable naming conventions, missing code values, syntax, and a codebook that defines the variables and layout of the data files. The codebook will comply with NDACAN requirements and industry best practices, such as the guidelines issued by the Inter-University Consortium for Political and Social Research.

All data and documentation will be transmitted to NDACAN electronically through Secure Sockets Layer transmission protocol into a secure space on NDACAN servers. All data will be in SAS format, in keeping with NDACAN's preference for SAS or SPSS. There will be no delivery of hard-copy files or documentation. The cross-site evaluation team will work closely with NDACAN staff to ensure that the data are not identifiable. Because of the sensitive nature of the data and the fact that data are being collected in a relatively small number of sites, the data set will be available only to researchers who have an institutional review board approval for their proposed project and sign a data security agreement.

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APPENDIX A

RPG GRANTEE SEMI-ANNUAL PROGRESS REPORT

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RPG GRANTEE SEMI-ANNUAL ACF PERFORMANCE PROGRESS REPORT

Appendix B - Program Indicators

ACF-OGM-SF-PPR

SF-PPR-OGM-B

Appendix B of the semi-annual ACF performance progress report provides information on the programmatic and evaluation activities conducted by the grantee during the reporting period as well as activities planned for the next reporting period. Information from the report will be used by the Children's Bureau to meet grants management requirements and to inform the first annual report to Congress. Semi-annual progress reports are due within 30 days of the end of each 6-month reporting period.

Reporting Period 1: October 1 – March 31; Report Due: April 30

Reporting Period 2: April 1 – September 30; Report Due: October 31

Grantees are to submit their original Semi-Annual Progress Report electronically to the Grants Management Specialist (GMS) and their Federal Project Officer (FPO) through Grant Solutions.

An electronic courtesy copy (in either Word or PDF) of the report is to be submitted to your Cross-site Evaluation Liaison (CSL) and Program Management Liaison (PML) when you submit the electronic copy through Grant Solutions.

Suggested Report Format:

Grantee Name and Address:

Grant Number:

Period Covered by Report: through

Principal Investigator or Project Director:

Report Author's Name and Telephone Number:

Name of Federal Project Officer:

Name of Grants Management Specialist:

B-01. Major Activities and Accomplishments During This Period

1. When (month/day/year) did or when do you plan to enroll your first client in RPG program services?

2. In Table 1, list your enrollment goals for the reporting period; the number of participants enrolled in the services delivered as part of your RPG project or through your partnerships during this reporting period; and the total number of participants enrolled in the services delivered as part of your RPG project or through your partnerships to date.

Table 1. Enrollment Goals and Actual Enrollment

	Enrollment Goals During the Reporting Period	Actual Enrollment During the Reporting Period	Total Enrollment to Date
Adults			
Children			
Families			

3. In Table 2, list the number of participants that have exited services, by exit reason (select the primary reason), during this reporting period and the total number of participants that have exited to date. *Specify the unit (e.g., families, children, biological mothers, etc.)*

Table 2. Reasons Participants Have Exited Services during this Reporting Period and To Date

Exit Reason	Exits During the Reporting Period	Total Exits To Date
Program Completed		
Declined Further Participation		
Moved Out of Service Area		
Unable to Locate		
Excessive Missed Appointments		
Child No Longer in Custody		
Other (please specify)		

4. Have you added, changed, or dicontinued any new evidence-based programs or practices (EBPs) since the last reporting period? If so, please use the table(s) in Attachment B-01a to provide information about any new EBPs you plan to implement or are implementing. Complete one table for each new or changed EBP. Please use the list of EBPs previously included in your semi-annual progress reports, provided by Mathematica (Attachment B-01a, Table 1a).

5. Do you plan to or have you added, changed, or discontinued any other services, such as screening or case management, since the last reporting period? If so, please use the table(s) in Attachment B-01b to provide information for any additional services you plan to provide or are providing. Complete one table for each new or changed additional service. Please use the list of other services previously included in your semi-annual progress report, provided by Mathematica (Attachment B-01b, Table 1b).

6. Please describe whether you engaged in any of the following activities during this reporting period. After reporting period 1, please describe any updates regarding these activities.

   - a. If you have an implementation team to support RPG implementation, describe their key activities during this reporting period. [26]
   - b. To facilitate implementation of your project, did you have to engage with systems beyond your partner agencies (such as health care or early care and education)? If so, with what systems did you engage and why, and how did you coordinate services with these systems (if they provide services or otherwise work with your RPG participants)?
   - c. Did you monitor program implementation to determine if the project is being carried out as planned? For example, did you collect and analyze quality assurance or fidelity data? If so, please describe your monitoring process. Did you provide updates/briefings to your Steering or Oversight Committee or other leadership or partner group?
   - d. Have you added any new partners this reporting period? If so, please add information about each new partner to Table 1. Please use the list of partners included in your previous semi-annual progress reports, provided by Mathematica (Attachment 3).
   - e. Did you establish formal agreements (such as MOUs or data sharing agreements) with any agencies during this reporting period? If so, please add information about each agency with whom you established a formal agreement to Table 3.

Table 3. Changes in Regional Partnership Membership and Formal Partnership Agreements Established This Reporting Period

Name of Agency (list agency name, not individual person)	Is this is a new or existing partner?	Primary contribution(s) to the RPG project	Did you establish a formal agreement with this agency?	Type of formal agreement (such as MOU, data sharing agreement)	Description of the content of the formal agreement

[26] An implementation team is a team of individuals focused on supporting the implementation of the EBP. The team may help increase the buy-in and readiness of staff, coordinate the supports staff may need to implement the EBP with fidelity, assess the fidelity of the implementation of the EBP, and problem-solve implementation challenges. (Metz, Allison and Leah Bartley. "Active Implementation Frameworks for Program Success: How to Use Implementation Science to Improve Outcomes for Children."*Zero to Three*, March 2012, pp. 11-18).

- f. Have any partners discontinued their involvement in the RPG project since the last reporting period? If so, describe why they are no longer involved and whether these changes will affect referrals, service delivery, or access to services in any way.
- g. Describe how leadership (county, regional, and /or state) from substance use, child welfare, and the courts support or are engaged in the implementation of your project. How do you keep them informed (such as joint meetings, individual briefings, memos)? Do you have a process for addressing cross-system challenges and barriers? If so, please describe it.
- h. Have you engaged in any other significant programmatic activities during this reporting period? If so, please describe them.

7. Have the organizations or programs from whom you receive referrals for RPG changed since the last reporting period? Has the enrollment process changed since the last reporting period? If so, please describe these changes.
8. Has the list of other community agencies or services to which you refer participants changed since the last reporting period? If so, please describe the changes. Do you track these referrals? Has your process for tracking referrals changed? If so, please describe the changes.
9. Have the instruments or forms used to assess the needs of children, adults, or families who participate (or are targeted to participate) in your RPG program changed since the last reporting period? If so, please describe the changes. Has the organization that does the assessments changed since the last reporting period, or the way assessment information or results are used? If so, please describe these changes.
10. Please describe any programmatic implementation successes (such as engaging and retaining families, expanding access to the services array to better address children and family needs, improving family functioning and child well being, implementing trauma-specific services, and providing access to recovery support services) you have experienced during the reporting period. What innovations have you developed?

B-04. Dissemination Activities

11. What dissemination activities were conducted during the reporting period? Dissemination activities may include kickoff meetings or program launches; earned media such as a story in the local paper or other report in a news outlet that is not a paid advertisement or public service announcement; press release or public service announcement developed by your partnership; items on grantee's or partnership's website or in own publications; informational presentations or meetings with local organizations; other direct outreach to local organizations (e.g., emails, calls, delivery of brochures); or policy advocacy. How were your partners involved in these dissemination activities? Please place the information about each activity into Table 4.

Table 4. Dissemination Activities

Activity	Target audience	Number of target audience members reached/ materials distributed	Purpose	Results (Was your goal achieved? If so, describe.)	Partners involved?	Additional comments

B-06. Activities Planned for the Next Reporting Period

12. Using Table 5, please list the key activities you plan to engage in over the next six months. In particular, please indicate if you plan to hire, train, or provide professional development to EBP staff, hold partnership meetings or activities, establish MOUs or other formal agreements with other organizations, or modify your RPG program. For each activity listed, please describe the activity and the organization(s) responsible.

Table 5. Planned Activities for Next Six Months

Activity	Description	Organization(s) Responsible for This Activity

B-02. Problems

13. Please describe whether your project faced any of the following programmatic challenges or barriers that affected your ability to provide services as planned. For each describe how you addressed the barrier and your progress in resolving it.

- a. Lower referrals than expected
- b. Inability to enroll intended target population (please describe how the population you are reaching differs from your intended target population)
- c. Longer than anticipated program enrollment periods due to the complex needs of families or other reasons

- d. Staffing challenges, such as finding or retaining qualified grantee or partner agency staff (particularly for implementing EBPs).
- e. Challenges implementing EBPs (please indicate which EBP(s))
- f. Challenges sharing information or data with partners or other issues related to engagement with partners
- g. Challenges coordinating case management or services with partners or other entities
- h. Challenges collaborating with RPG partners
- i. Other challenges

B-05. Other Activities

14. Describe any project changes that require federal approval (such as a change in budget, project director, or other key staff that were made during this reporting period and the reason for the change. Include changes you have discussed with your FPO or GMS.

15. If applicable, describe how you have used (or plan to use) information and knowledge gained from the most recent RPG Grantee Meeting, including any pre-conference meetings (such as evaluators meeting or clinical workshops), to enhance or strengthen your partnership or program. Include, for example, how information was used to improve services for your clients, enhance client engagement and retention, expand or strengthen your cross-systems collaborative relationships, enhance the measurement of your program's performance and outcomes, develop or advance sustainability planning, improve program management, or enhance any other related efforts to affect overall program results.

16. Please answer the following two questions related to evaluation activities:

- a. What main activities for your local evaluation or the cross-site evaluation did the project engage in during the reporting period?
- b. Using Table 6, list the key evaluation activities you plan to engage in over the next six months. For each activity listed, provide a description of the activity and the organization(s) responsible.

Table 6. Planned Evaluation Activities for Next Six Months

Evaluation Activity	Description	Organization(s) Responsible for This Activity

- c. Please describe any evaluation challenges or barriers encountered during the reporting period and their effect on the evaluation. For each please describe how you addressed the barrier and your progress in resolving it.
- B-03. Significant findings and events.

- 17. Describe any significant changes in your state or service area that have affected or may affect your project or the program outcomes you are measuring in your evaluation. (This could include things such as the implementation of other child welfare or substance abuse treatment initiatives, policies or programs; events in the community such as a child death or high profile case that might impact caseloads; changes in judicial officers who hear dependency cases if relevant to your program); changes in agency or community leadership; implementation of other new legislation, policies or procedures that affect your program or target population; changes in child welfare or substance use trends; or other related community developments.
- 18. Has your program experienced any significant challenges during the reporting period as a result of the current fiscal environment? If so, please provide specific examples of how the fiscal environment has adversely impacted your program (such as reductions or changes in child welfare, substance use treatment or other staffing that affects service delivery, decreased referrals to your program, reductions or loss of funding sources, etc.).
- 19. Has your program gained any new sources of funding during the reporting period? If yes, please list the new sources of funding and describe how the funds will be used to support your RPG project.
- 20. In Table 7, indicate whether your program became involved in any other federal initiatives during the reporting period. If your agency is the lead grantee, enter "G;" if the activity involves one of your key partners, enter "P."

Table 7. Involvement in Other Federal Initiatives

G/P	Initiative	G/P	Initiative
	Comprehensive Support Services for Families Affected by Substance Abuse and/or HIV/AIDS		Tribal Court Improvement
	Family Connection Grants: Child Welfare/TANF Collaboration in Kinship Navigation Programs		Partnerships to Demonstrate the Effectiveness of Supportive Housing for Families in the Child Welfare System
	Family Connection Grants: Comprehensive Residential Family Treatment Projects		Initiative to Improve Access to Needs-Driven, Evidence-Based/Evidence-Informed Mental and Behavioral Health Services in Child Welfare
	Family Connection Grants: Combination Family Finding/Family Group Decision Making		Integrating Trauma-Informed and Trauma-Focused Practice in Child Protective Service (CPS) Delivery
	Child Welfare-Education System Collaboration to Increase Educational Stability		Abandoned Infants Assistance Act: Comprehensive Support Services for Families Affected by Substance Abuse and/or HIV/AIDS
	Child Welfare-Early Education Partnerships to Expand Protective Factors for Children with Early Child Welfare Involvement		Child Welfare Waiver Demonstration Projects
	Tribal IV-E Plan Development Grants		Other Children's Bureau or other federally-funded initiative. Please specify.

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APPENDIX B

STAFF SURVEY

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OMB No.: xxxx-xxxx
Expiration date: xx/xx/xxxx

MATHEMATICA Policy Research

Staff Survey

Regional Partnership Grants National Cross-Site Evaluation

November 5, 2013

INTRODUCTION

The Children's Bureau within the U.S. Department of Health and Human Services, Administration for Children and Families (ACF) has contracted with Mathematica Policy Research to complete the national cross-site evaluation of the Regional Partnership Grants (RPG) program. The evaluation will describe the interventions that were implemented, the nature of the partnerships, the types of services provided, and their impacts.

You are asked to complete this survey because you were identified as a front-line staff member who works directly with RPG participants. Your participation is important to helping us understand the characteristics of the staff and organizations implementing RPG-funded programs.

The length of this survey is different for different people, but on average it should take about 25 minutes. Not all response options may apply to you or your organization. Please choose the best answer to each question. You may also choose not to answer any question.

The evaluation focuses on specific evidence-based programs (EBPs), and many questions in the survey will reference a specific EBP. Please answer the questions about the specific program that is listed and not other programs that your organization may operate.

Your responses will be kept private and used only for research purposes. They will be combined with the responses of other staff and no individual names will be reported. Participation in the survey is completely voluntary.

If you have any questions about the survey, please contact the team at Mathematica by calling 1-xxx-xxx-xxxxx (toll-free) or emailing xxxxxxx@mathematica-mpr.com.

Before starting the survey, please read and answer the statement below.

i1. I have read the introduction and understand that the information I provide will be kept private and used only for research purposes. My responses will be combined with the responses of other staff and no individual names will be reported.

1 ☐ I agree with the above statement and will complete the survey

0 ☐ I do not agree with the above statement and will not complete the survey → **END**

i2. Could you please confirm whether you work for *[RPG PROGRAM]* at [ORGANIZATION]?

MARK ONE ONLY

1 ☐ Yes, I work for *[RPG PROGRAM]* at [ORGANIZATION]

0 ☐ No

d ☐ Don't know

→ **END**

A. YOUR WORK ROLE AND EXPERIENCE

A1. Which of the following is closest to your job title?

MARK ONE ONLY

1 ☐ Mental health counselor, therapist, or psychologist
2 ☐ Early intervention or child development therapist
3 ☐ Substance abuse counselor
4 ☐ Family advocate
5 ☐ Child welfare case manager
6 ☐ Other case manager
7 ☐ Social worker
8 ☐ Recovery coach
9 ☐ Child development specialist
10 ☐ Other *(Specify)*

_____

A2. How long have you been employed at [ORGANIZATION]?

Please include the total time you have been employed at the organization, not just the time you have been in your current position.

|__|__| MONTHS OR |__|__| YEARS

A3. The next questions are about your work activities at [ORGANIZATION]. Which of the following activities do you take part in on this job at least once every two weeks?

Please answer thinking about your job as a whole, not just activities related to implementing RPG.

		MARK ONE PER ROW		
		AT LEAST ONCE EVERY TWO WEEKS	**NOT AT LEAST ONCE EVERY TWO WEEKS**	**DON'T KNOW**
a.	Screen or assess potential participants for program eligibility	1 ☐	0 ☐	d ☐
b.	Conduct participant intake	1 ☐	0 ☐	d ☐
c.	Conduct substance abuse screening	1 ☐	0 ☐	d ☐
d.	Conduct substance abuse assessment	1 ☐	0 ☐	d ☐
e.	Conduct risk assessment for child abuse, neglect, and other risk factors	1 ☐	0 ☐	d ☐
f.	Screen children for prenatal substance exposure, developmental delays, emotional or mental health problems, or substance use disorder	1 ☐	0 ☐	d ☐
g.	Provide parenting education	1 ☐	0 ☐	d ☐
h.	Provide case management services	1 ☐	0 ☐	d ☐
i.	Develop coordinated care plans	1 ☐	0 ☐	d ☐
j.	Monitor the implementation and the quality of screening and assessment protocols	1 ☐	0 ☐	d ☐
k.	Conduct group therapy sessions	1 ☐	0 ☐	d ☐
l.	Conduct individual therapy sessions	1 ☐	0 ☐	d ☐
m.	Conduct motivational interviewing sessions (conversations to elicit and strengthen motivation for change)	1 ☐	0 ☐	d ☐
n.	Conduct parent-child therapy sessions	1 ☐	0 ☐	d ☐
o.	Coordinate services for participants with other partner agencies	1 ☐	0 ☐	d ☐
p.	Manage or supervise other individuals at your organization	1 ☐	0 ☐	d ☐
q.	Train other staff at your organization	1 ☐	0 ☐	d ☐
r.	Hold family team conferences, multidisciplinary team meetings, or joint client staffing	1 ☐	0 ☐	d ☐
s.	Work with clients to accomplish designated treatment goals (for example, job searching, housing applications)	1 ☐	0 ☐	d ☐
t.	Conduct administrative activities (for example, paperwork)	1 ☐	0 ☐	d ☐
u.	Other activities *(Specify)* _____	1 ☐	0 ☐	d ☐

A4. How long have you been providing services to child welfare involved children and families?

Please account for all work you have done for current and past organizations related to providing services to child welfare involved children and families.

d ☐ I have not done any work related to providing services to child welfare involved children and families

|__|__| MONTHS OR |__|__| YEARS

A5. How long have you been providing substance abuse assessment or treatment services?

Please account for all work you have done for current and past organizations related to substance abuse assessment or treatment services.

d ☐ I have not done any work related to substance abuse assessment or treatment services

|__|__| MONTHS OR |__|__| YEARS

B. IMPLEMENTING AN EVIDENCE-BASED PROGRAM

B1. The following statements are about feelings someone might have about using new types of therapy, interventions, or treatments. To what extent do you agree with each statement?

Manualized therapy, intervention, or treatment refers to any intervention that has specific guidelines and/or components that are outlined in a manual and/or that are to be followed in a structured or predetermined way.

MARK ONE PER ROW

	NOT AT ALL	TO A SLIGHT EXTENT	TO A MODERATE EXTENT	TO A GREAT EXTENT	TO A VERY GREAT EXTENT
a. I like to use new types of therapy/interventions to help my clients	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
b. I am willing to try new types of therapy/interventions even if I have to follow a treatment manual	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
c. I know better than academic researchers how to care for my clients	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
d. I am willing to use new and different types of therapy/interventions developed by researchers	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
e. Research based treatments/interventions are not clinically useful	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
f. Clinical experience is more important than using manualized therapy/interventions	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
g. I would not use manualized therapy/interventions	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
h. I would try a new therapy/intervention even if it were very different from what I am used to doing	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

B2. If you received training in a therapy or intervention that was new to you, how likely would you be to adopt it if…

	MARK ONE PER ROW				
	NOT AT ALL	TO A SLIGHT EXTENT	TO A MODERATE EXTENT	TO A GREAT EXTENT	TO A VERY GREAT EXTENT
a. it was intuitively appealing?.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
b. it "made sense" to you?.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
c. it was required by your supervisor?.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
d. it was required by [ORGANIZATION]?.	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
e. it was required by your state?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
f. it was being used by colleagues who were happy with it?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
g. you felt you had enough training to use it correctly?.....	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

B3. Organizations have a "personality" that is reflected in the day to day operations of the organization and the way staff members view their work. These items ask about some dimensions that relate to the use of [EBP NAME] in organizations. For each item, please indicate the extent to which you disagree or agree the statement is true for [ORGANIZATION]. Within the past six months…

MARK ONE PER ROW

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	DOES NOT EXIST IN OUR ORGANIZATION	DON'T KNOW
a. Staff members are adequately trained to implement [EBP NAME] at this organization	1 ☐	2 ☐	3 ☐	4 ☐	n ☐	d ☐
b. Top administration strongly supports the implementation of [EBP NAME]	1 ☐	2 ☐	3 ☐	4 ☐	n ☐	d ☐
c. Staff members get positive feedback and/or recognition for their efforts to implement [EBP NAME]	1 ☐	2 ☐	3 ☐	4 ☐	n ☐	d ☐
d. Top administrators minimize obstacles and barriers to implementing [EBP NAME] at this organization	1 ☐	2 ☐	3 ☐	4 ☐	n ☐	d ☐
e. This organization established clear and specific goals related to the implementation of [EBP NAME]	1 ☐	2 ☐	3 ☐	4 ☐	n ☐	d ☐
f. There are performance-monitoring systems in place to guide the implementation of [EBP NAME]	1 ☐	2 ☐	3 ☐	4 ☐	n ☐	d ☐
g. Training and technical assistance are readily available to staff members involved in implementing [EBP NAME]	1 ☐	2 ☐	3 ☐	4 ☐	n ☐	d ☐
h. Adequate resources are available to implement [EBP NAME] as prescribed	1 ☐	2 ☐	3 ☐	4 ☐	n ☐	d ☐
i. Staff members have been encouraged to express concerns that arise in the course of implementing [EBP NAME]	1 ☐	2 ☐	3 ☐	4 ☐	n ☐	d ☐

If you are not a supervisor, please go to question C1.

If you are a supervisor, please continue to question B4. The next questions in this section are about your experiences implementing [EBP NAME].

B4. When implementing a program, it often happens that changes get made to meet the needs of participants, the timeline, organizational resources, or some other factor. Has [ORGANIZATION] adapted [EBP NAME] for any reason?

1 ☐ Yes

0 ☐ No →**GO TO C1**

d ☐ Don't know →**GO TO C1**

B5. What kinds of adaptations to [EBP NAME] were made?

MARK ALL THAT APPLY

1 ☐ Changed procedures
2 ☐ Changed the sequence of sessions
3 ☐ Increased the number of sessions
4 ☐ Decreased the number of sessions
5 ☐ Changed the length of sessions
6 ☐ Changed the target population
7 ☐ Changed program content
8 ☐ Changed for cultural relevance
9 ☐ Other *(Specify)*

_____

d ☐ Don't know

B6. There are several possible reasons why an organization might choose to make changes to a program. To what extent did the following factors contribute to any changes being made to [EBP NAME]?

MARK ONE PER ROW

	NOT AT ALL ← → PRIMARY REASON FOR CHANGE					DON'T KNOW
a. Difficulty recruiting participants	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	d ☐
b. Difficulty retaining or engaging participants	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	d ☐
c. Difficulty finding adequate staff	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	d ☐
d. Lack of or limited resources (such as space or time)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	d ☐
e. Lack of time or competing demands on time	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	d ☐
f. Resistance from implementing staff	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	d ☐
g. Need for a more culturally appropriate program	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	d ☐
h. Requests for changes by participants	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	d ☐

C. SUPERVISION AND SUPPORT

The next questions ask about supervision you may receive as a staff member for [RPG PROGRAM]. If you have more than one supervisor, please answer these questions about the supervisor you work with the most in the [RPG PROGRAM].

C1. Is there at least one person at [ORGANIZATION] whom you regard as your supervisor?

MARK ONE ONLY

1 ☐ Yes

0 ☐ No → **GO TO C5**

d ☐ Don't know → **GO TO C5**

C2. In the past 12 months, how often did you have formal, one-on-one supervision meetings?

MARK ONE ONLY

1 ☐ Never

2 ☐ Daily

3 ☐ Weekly

4 ☐ Twice per month

5 ☐ Monthly

6 ☐ Once every few months

7 ☐ Yearly

d ☐ Don't know

C3. In the past 12 months, how often did you have group supervision meetings with other staff members?

MARK ONE ONLY

1 ☐ Never

2 ☐ Daily

3 ☐ Weekly

4 ☐ Twice per month

5 ☐ Monthly

6 ☐ Once every few months

7 ☐ Yearly

d ☐ Don't know

C4. In the past 12 months, how often did you participate in meetings, trainings, or other joint activites with staff from RPG partner agencies?

MARK ONE ONLY

1 ☐ Never

2 ☐ Daily

3 ☐ Weekly

4 ☐ Twice per month

5 ☐ Monthly

6 ☐ Once every few months

7 ☐ Yearly

d ☐ Don't know

C5. Please read the following statements and decide how strongly you disagree or agree with each statement. My supervisor…

MARK ONE PER ROW

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	DON'T KNOW
a. encourages staff to spend time mentoring new employees?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
b. encourages staff to help each other with work problems?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
c. cares about me as a person?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
d. provides emotional support to me in difficult situations with RPG program participants?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
e. is appropriately flexible when it comes to applying rules?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
f. has an attitude that helps me be enthusiastic about working in social services?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
g. supports me in balancing the demands of my job with my personal life?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
h. provides the help I need to do my job?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
i. knows effective ways to work with RPG program participants?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
j. is willing to help me complete difficult tasks?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
k. encourages creative solutions?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
l. reinforces the training I receive?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
m. helps me learn and improve?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
n. is available when I ask for help?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
o. has expectations for my work that are challenging but reasonable?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
p. gives me clear feedback on my job performance?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
q. has helped staff develop into an effective team?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐

C6. Overall, how supported do you feel by the other staff working at [ORGANIZATION]?

MARK ONE ONLY

1 ☐ Very supported
2 ☐ Somewhat supported
3 ☐ Not very supported
d ☐ Don't know

C7. How strongly do you agree or disagree that overall, the staff at [ORGANIZATION] works as a team?

MARK ONE ONLY

1 ☐ Strongly agree
2 ☐ Agree
3 ☐ Disagree
4 ☐ Strongly disagree
d ☐ Don't know

C8. How strongly do you agree or disagree that overall, the your organization's RPG program and its partners work as a team?

MARK ONE ONLY

1 ☐ Strongly agree
2 ☐ Agree
3 ☐ Disagree
4 ☐ Strongly disagree
d ☐ Don't know

C9. Please read the following statements and rate how dissatisfied or satisfied you are with each with regard to [EBP NAME]. Overall, how satisfied are you that...

MARK ONE PER ROW

	VERY DISSATISFIED	SLIGHTLY DISSATISFIED	NEITHER SATISFIED NOR DISSATISFIED	SLIGHTLY SATISFIED	VERY SATISFIED
a. the information you received during your hiring process reflects the work you are being asked to do?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
b. the training you are receiving is preparing you to work effectively with families and children?.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
c. the coaching you are receiving is improving your skills and abilities to work effectively with families and children?.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
d. the challenges you encounter in providing effective services are understood in your organization?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
e. the challenges you encounter in providing effective services are being actively addressed by your organization?.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
f. the challenges you encounter in providing effective services are understood by the RPG program leadership?.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
g. the challenges you encounter in providing effective services are being actively addressed?.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
h. your immediate supervisor helps you develop your [EBP NAME] skillset?.....	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
i. your organization's administrators effectively develop the supports and conditions that make it possible for you to work effectively with children and families?	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

D. ORGANIZATIONAL CLIMATE

D1. Please read the following statements and decide how strongly you disagree or agree with each statement with regard to [ORGANIZATION].

MARK ONE PER ROW

	STRONGLY DISAGREE	DISAGREE	SOMEWHAT DISAGREE	SOMEWHAT AGREE	AGREE	STRONGLY AGREE	DON'T KNOW
a. The mission of this organization is clear to me	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
b. My work reflects the organization's purpose	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
c. I feel good about what this organization does for RPG participants	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
d. In this organization, there is more emphasis on the quality of services than on the number of participants served	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
e. I am satisfied with the salary I receive from this organization	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
f. I am paid fairly considering my education and training	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
g. I am paid fairly considering the responsibilities I have	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
h. I am satisfied with the physical work environment at this organization	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
i. I am proud to tell others that I am part of this organization	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
j. The administration shows concern for staff	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
k. Employees of this organization are respected by other community professionals	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
l. This organization is committed to my personal safety in the office	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
m. This organization is committed to my personal safety when working off-site	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
n. My professional opinions are respected in this organization	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
o. I have sufficient input in formulating policies that govern my work	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
p. There are strong, positive relationships between this organization and other community resource providers	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
q. I have the support to make work-related decisions when appropriate	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
r. Organizational management shares leadership roles with staff	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐
s. This organization effectively responds to public criticism when it occurs	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	d ☐

E. DEMOGRAPHICS

These next questions ask about your background.

E1. Are you Hispanic or Latino?

MARK ONE ONLY

0 ☐ No

1 ☐ Yes

d ☐ Don't know

E2. What is your race?

MARK ALL THAT APPLY

1 ☐ American Indian or Alaska Native

2 ☐ Asian

3 ☐ Black or African American

4 ☐ Native Hawaiian or other Pacific Islander

5 ☐ White

6 ☐ Other *(Specify)*

_____

d ☐ Don't know

E3. What is the highest level of education you have completed?

MARK ONE ONLY

1 ☐ Did not complete high school or General Educational Development

2 ☐ High school diploma

3 ☐ General Educational Development

4 ☐ Some college/some postsecondary vocational courses

5 ☐ 2-year or 3-year college degree (Associate's degree)

6 ☐ Vocational school diploma

7 ☐ 4-year college degree (Bachelor's degree)

8 ☐ Some graduate work/no graduate degree

9 ☐ Graduate or professional degree (for example, MA, MBA, Ph.D., JD, or MD)

d ☐ Don't know

E4. What is your profession or area of work?

MARK ALL THAT APPLY

1 ☐ Substance abuse counseling

2 ☐ Other counseling

3 ☐ Education

4 ☐ Vocational rehabilitation

5 ☐ Juvenile justice

6 ☐ Psychology

7 ☐ Social work/human services

8 ☐ Medicine

9 ☐ Administration

10 ☐ Student

11 ☐ Other *(Specify)*

_____

12 ☐ None of these

d ☐ Don't know

E5. Are you male or female?

1 ☐ Male

2 ☐ Female

E6. Is there anything else about your experiences implementing RPG that you would like to add?

_____

_____

_____

(End of survey for those who opt out in the first screen)

Thank you for considering participation in this survey. Please click the "Submit survey" button in the lower right hand corner so that we have a record of your desire NOT to participate. This will result in your removal from our contact list.

(End of survey for those who are ineligible in the first screen)

Thank you for considering participation in this survey. Please click the "Submit survey" button in the lower right hand corner and we will remove you from our contact list.

(End of survey for respondents)

Thank you for completing the Regional Partnership Grant Staff Survey! Please click the "Submit survey" button in the lower right hand corner to submit your completed survey.

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APPENDIX C

TOPIC GUIDE FOR IMPLEMENTATION STUDY SITE VISIT INTERVIEWS

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REGIONAL PARTNERSHIP GRANTS (RPG) CROSS-SITE EVALUATION

TOPIC GUIDE FOR IMPLEMENTATION STUDY SITE VISIT INTERVIEWS

The core implementation study for the Regional Partnership Grants (RPG) cross-site evaluation will include a site visit to each grantee in 2015. Researchers will interview grantee project directors, managers, supervisors, and frontline staff who work directly with families during the site visits. Interviews will be conducted either one-on-one or in small groups, depending on staffing structure, roles, and the number of individuals in a role.

Topic	Sub-Topic
Informant Characteristics	
Informant Characteristics	Job title Education background/licensing qualifications Years in current position and with agency Role on RPG Relevant prior experience with the RPG program, target population, and evidence-based programs (EBPs) being implemented by the grantee
Pre-Implementation	
Selection of EBPs	Grantees' prior experience with similar programs and how prior experience informed the RPG design Knowledge of evidence-based practices (EBPs) Involvement of partners and other community organizations/stakeholders in the planning and decision-making processes, and how concerns were addressed Involvement of frontline staff in the planning and decision-making processes, and how concerns were addressed Key design decisions made during the planning phases and rationale for those decisions Process by which grantees selected the planned interventions, including: • Community need to be addressed by the EBP • Needs and resource assessment (including need for and availability of: space, technology, financial and other resources, including in-kind contributions by grantee and/or partners) • Alignment with planned target population • Assessment of organization capacity/readiness • Whether other programs were considered • Champions for certain EBPs • Need for adaptation • Alignment with grantee and partners' goals and mission Challenges encountered during the planning process and steps taken to address them

Appendix Table C *(continued)*

Topic	Sub-Topic
Referral Processes to RPG services	How and when grantee determined referral pathways Sources of referrals, length of relationship with these referral sources, and how relationships were established, relative size of enrollment from each referral source Referral sources that consistently refer individuals that meet eligibility criteria and engage in the RPG project Process used by other agencies to refer potential participants to RPG Any changes to outreach and referral strategies and why Barriers and facilitators to establishing pathways and translating referrals into participation Sustainability of referral pathways
Staff Selection and Hiring and Retention	Staffing structure for the RPG project, including frontline staff and those who support their implementation (project directors, managers, and supervisors) Responsibilities and expectations for each staff role Timeline and process for hiring new staff or reassigning staff to fill RPG roles Re-assignment of existing staff to implement RPG services and/or support implementation Whether job postings specified specific qualifications required for implementation of EBPs selected; recruitment methods used to identify likely qualified candidates; protocols and criteria used to identify qualified candidates Number of full-time equivalent (FTE) staff in RPG pro devoted to administration and direct service provision Extent to which staff in the RPG project had other responsibilities in addition to RPG Current staff vacancies; length of vacancies; efforts to fill vacancies Extent of staff turnover since initiating project operations; reasons for staff turnover (or staff retention); effects on remaining staff when turnover occurs; length of process to replace departing staff Effect of staff turnover on enrollment and service delivery; programmatic adjustments and accommodations as a result of turnover Efforts to prevent future turnover and retain current direct service staff and supervisors Expectation of continued rate of turnover for sustainability Likelihood of identifying individuals with necessary qualifications for sustainability and/or scale-up
Pre- and In-service Training	Plan for and approach to providing supervision and training to direct service staff, including the intended frequency, duration, and focus Initial and in-service training plan for new and ongoing RPG project staff, including the frequency, content, length, and format of training, and individual or organization providing the training (includes whether the EBP's developer or purveyor was involved in training, whether training covers key components of EBPs and whether trainees were given time to practice implementation with feedback) Grantee's ability to provide sufficient training to all necessary staff, at start-up and for sustainability and/or scale-up Staff perception on extent to which training(s) provided necessary information on theory of intervention(s), goals of RPG, as well as competencies needed to implement Whether staff received the planned level of initial and ongoing training and guidance

Appendix Table C *(continued)*

Topic	Sub-Topic
Implementation Teams	Organizational structure for the RPG project Development of implementation team; timing of development, relative to project implementation How grantee determined members of implementation team; qualifications established for team membership; member characteristics Roles and responsibilities of team and its members Strongest advocate for RPG project and how demonstrated; role of advocate and how individual emerged as advocate Existence and role of advisory committee and/or steering committee Duration of operation of implementation team; frequency of meetings; forms of communication by team members; Turnover of team membership; reasons for turnover; impact on implementation Barriers and facilitators to fully installing implementation team in RPG project Accomplishments of implementation team Staff perception of usefulness of team Sustainability of team for scale-up
Implementation Plans	Development of plans and procedures used to ensure that all staff carry out project activities as planned and in a consistent manner; what details were included in plan (e.g. types of tasks, timeline for activities, staff responsible for tasks) Modifications to the grantee's RPG implementation plan that have occurred since implementation began; reasons for modifications; whether they were planned or unplanned Development of strategies to address barriers to the project's ability to deliver high-quality services Staff perceptions of whether implementation plan was communicated sufficiently, executed successfully, and useful in proactively identifying roadblocks to implementation Barriers and facilitators to success of implementation plan Sustainability of implementation plan as RPG projects adapt
Early and On-Going Implementation	
Facilitative administrative support	Grantee oversight of RPG activities and partner services Changes in the demonstration's organizational structure Changes in grantee, partner, or RPG project leadership staff that occurred during the demonstration and may have impacted the direction of the RPG project Strategies to reduce administrative barriers, develop communication and feedback protocols, implement project improvement based on data or staff suggestions Staff perception of availability of these strategies Staff perception of administration's commitment to supporting the implementation of EBPs Sustainability of leadership approach Facilitators and barriers to providing administrative support
Supervision and Feedback	Whether protocols were established for providing feedback Use of staff performance assessments for frontline staff Sources of data for performance assessments Facilitators and barriers to supervisory and feedback mechanisms

Appendix Table C *(continued)*

Topic	Sub-Topic
Technical Assistance and Coaching	Grantee and partners' capability to provide ongoing TA for duration of RPG and beyond Use of external TA providers, including curriculum developers, Children's Bureau, and other entities; whether staff have accessed these resources and, if so, helpfulness of the technical assistance Extent to which grantee believed TA providers were aware of and receptive to goals for RPG Whether TA and coaching led to further adaptation of project model Whether TA and coaching led to need for further training sessions Topics on which staff needed more training and technical assistance Plans for when, how, and why TA or coaching would be provided Sustainability of TA and coaching networks, including financial and other resources
Internal evaluation and continuous quality improvement	Grantee expectations about the quality of services delivered through RPG; how grantee defines high quality delivery for core services, and why project defines service quality in this manner Efforts to monitor service quality, adherence to curricula or other programming, client engagement, participation, and participant outcomes; who completes monitoring; what is monitored and how often; how information is used by staff Strategies for identifying successes and challenges to implementation for purposes of continuous project improvement Use of improvement cycles or other continuous quality improvement strategies Dissemination of RPG implementation to policymakers: frequency of exchanges, extent to which such exchanges are purposeful and part of usual practice Dissemination of RPG implementation to partners: frequency of exchanges, extent to which such exchanges are purposeful and part of usual practice Dissemination of RPG implementation to researchers, other practitioners: plans to publish findings Facilitators and barriers to ongoing evaluation and project improvement Sustainability of systems needed to monitor and improve project implementation
Decision Support Data Systems	Use of data systems to monitor progress toward goals and partner performance Plan for monitoring project performance and for tracking service delivery and quality, adherence to curricula or other programming, client engagement and participation, and participant outcomes Data sources and frequency of data collection and analysis How staff use the data to make project decisions Dissemination plans for: partners/stakeholders, administrators, support staff, frontline staff; perception of purpose of feedback dissemination Staff perception of the relevance and usefulness of project data, management information system Sustainability of data systems Barriers and facilitators to using systems and conclusions derived from data
Referral Processes from RPG services	Types of community services to which RPG project staff refer participants Extent to which needed services are available and accessible in the community Plan for conducting initial and ongoing assessments of participants' needs and linking them to appropriate services Extent to which participants follow up on referrals and take up the services Process for tracking referrals, how often progress is monitored, and who is responsible for monitoring
Interventions with External Systems	Strategies to engage external systems in provision of financial, organizational, or other resources Types of external systems/organizations engaged Staff perception of alignment of organizations with grantee's goals for RPG services
Adherence/Fidelity	

Appendix Table C *(continued)*

Topic	Sub-Topic
Fidelity	How grantee defines high quality delivery of core components of the EBP, and why grantee defines quality in this manner The extent to which staff adhere to the EBP guidelines (during service delivery) Consistency with which services are provided, per EBP guidelines Grantee expectations about the quality of services delivered through the EBP Attitudes expressed by staff towards the use of the EBP Extent to which project staff think that the EBP will improve outcomes Staff understanding of EBP's theory of change (how project services are linked to desired outcomes)
Staff Attitudes Toward Implementation	Staff perceptions as to whether these multiple roles had an effect on their ability to implement the project as designed Extent to which RPG project staff "bought in" to the idea that providing substance abuse treatment, family strengthening, parenting education, and/or in an integrated package would improve participant outcomes Staff perceptions of the EBP's fit to the target population, strengths, and weaknesses Staff perceptions about how well the model has worked in practice; benefits and challenges of this approach to demonstration leadership Staff perceptions of the strengths and weaknesses of the demonstration's approach to leadership Staff perceptions of the utility of an integrated approach to the provision of core services
Community, State, and National Context	
State and Local Context	State or local policies and policy climate, and how they impeded or supported project development Other state or community organizations providing parenting or employment services; how the services provided by these organizations differ from the RPG project; whether and how these services may have affected the RPG project; and use of these other services by participants Role of the courts and willingness of family court judges to support and participate in RPG Physical, social, and economic characteristics of communities in which RPG is offered Unexpected events that altered RPG project activities; how they affected the project and how they were addressed

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APPENDIX D

ESL DATA ELEMENTS

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#	Data element	Description
A.	**Grantee Information**	
A.1	Grantee ID	Grantee identification number provided by the Children's Bureau to the grantee
A.2	Grantee Name	Name of grantee
B.	**RPG Case Enrollment**	
B.1	Case ID	Identification number assigned to each case
B.2	RPG Case Surname	Last name of case or other identifiable information
B.3	RPG Enrollment Date	Date that case enrolled in RPG program
C.	**Demographics**	
C.1	Individual ID	Each individual with be assigned a unique ID. An individual present in more than one case will have the same ID across cases.
C.2	Individual Name	First name of individual or other identifying information such as initials or a pseudonym
C.3	Date of Birth	Date of birth of individual
C.4	Gender	Sex of individual
C.5	Person Type	Whether person is an adult or child. A flag will indicate if the person type is the family functioning adult and/or the recovery domain adult. Similarly, a flag will indicate if the child is the focal child.
C.6 - C.10	Race	Race(s): • American Indian or Alaska Native (C.6) • Asian (C.7) • Black or African American (C.8) • Native Hawaiian or Other Pacific Islander (C.9) • White (C.10)
C.11	Ethnicity	Ethnicity identification of individual: • Hispanic or Latino • Not Hispanic or Latino
C.12	Primary Language Spoken at Home	Language that is primarily spoken at home: • English • Spanish • Other
C.13	Primary Language Spoken at Home Specification	Specification if primary home language is “Other”

Appendix Table D *(continued)*

#	Data element	Description
C.14	Current Type of Residence	Current type of residence for individual: • Primary residence of case member(s) • Treatment facility • Correctional facility/prison • Homeless/shelter • Foster parent's residence • Foster/group home • Other
C.15	Current Type of Residence Specification	Specification if current residence is “Other”
C.16	Highest Education Level	Highest/last level of education attained: • Up to 8th grade • Some high school • High school diploma/GED • Some vocational/technical • Vocational/technical diploma • Some college • Associate's degree • Bachelor's degree • Some graduate or professional school • Master's degree • Doctorate degree • Professional degree (M.D., J.D., D.D.S., etc.)
C.17	Annual Income (past 12 months)	Annual monetary amount received by individual: • $0-9,999 • $10,000-19,000 • $19,001-24,999 • $25,000-34,999 • $35,000-49,999 • $50,000 or higher
C.18 – C.23	Income Source Wage Salary	Source(s) of individual's income: • Wages/salary (C.18) • Public assistance (C.19) • Retirement/pension (C.20) • Disability (C.21) • Other (C.22) • None (C.23)

Appendix Table D *(continued)*

#	Data element	Description
C.24	Income Source Wage Salary Specification	Specification if income source is "Other"
C.25	Employment Status	Individual's Employment Status: • Full-time employment • Part-time employment • Self-employed • Unemployed • Not in labor force
C.26	Relationship Status	Individual's domestic relationship status upon enrollment: • Single (unmarried and not cohabiting) • Married to focal child's biological parent • Married to other individual • Cohabiting with focal child's biological parent • Cohabiting with other individual • Divorced/separated/widowed
C.27	Treatment Assignment	Treatment assignment for grantees participating in the impact study: • Treatment group • Comparison group
D.	**Flags for Specific Types of RPG Case Members**	
D.1	Focal Child	Child is the focal child. Focal child is selected based on defined parameters set forth at grantee level
D.2	Relationship to Focal Child	The relationship between individual and focal child: • Biological parent • Adoptive parent • Step-parent by marriage • Foster parent • Grandparent • Aunt/uncle • Parent's partner • Biological sibling • Adopted sibling • Other step-sibling by marriage • Cousin • Self • Other
D.3	Relationship to Focal Child Specification	Specification if relationship to focal child is "Other"
D.4	Family Functioning Adult	Adult is the family functioning adult

Appendix Table D *(continued)*

#	Data element	Description
D.5	Recovery Domain Adult	Adult is the recovery domain adult
E.	**RPG Case Closure**	
E.1	RPG Case Closure Date	Date case was closed
E.2 – E.10	Reason for Case Closure	Reason for closing the case: • Successfully completed RPG program (E.2) • Family moved out of area (E.3) • Unable to locate (E.4) • Excessive missed appointments/ unresponsive (E.5) • Family declined further participation (E.6) • Transferred to another service provider (E.7) • Miscarriage or fetal/child death (E.8) • Parental death (E.9) • Other (E.10)
E.11	Reason for Case Closure Specification	Specification if closure reason is "Other"
F.	**Enrollment and Exit into Specific EBPs**	
F.1	EBP Name	Name of EBP
F.2	EBP Enrollment	Date case members enrolled in EBP
F.3	EBP Exit Date	Date case members exited EBP
F.4	Case Members Participating in EBP	Individual IDs of case members participating in EBP
F.5	Caseworker for EBP	Name of caseworker for EBP, or initials or a pseudonym
F.6	Caseworker Start Date	Date caseworker began assignment with EBP
F.7	Caseworker End Date	Date Caseworker completed assignment with EBP
G.	**Service Contact Information**	
G.1	Date of Service	Date service was rendered
G.2	EBP Service	EBP delivered during session: • Celebrating Families! • Child-Parent Psychotherapy (CPP) • Cognitive Behavior Therapy (CBT) • Hazelden Living Balance Programs (LIB) • Matrix Model • Nurturing Parenting Programs (NPP) • Parent and Child Interactive Therapy (PCIT) • Seeking Safety • Strengthening Families • Trauma Focused Cognitive Behavior Therapy (TF-CBT)

Appendix Table D *(continued)*

#	Data element	Description
G.3	Session Location	Location where services were provided: • Residential treatment facility • Outpatient clinic • Primary residence of case member(s) • Community site • Local government site • School • Court • Adult's workplace • Correctional facility • Hospital • Other
G.4	Session Location Specification	Specification if session location is "Other"
G.5	Session Length	Session length in minutes
G.6	Case Members Present	Individual IDs of case members attending the session
G.7 – G.15	Other Individuals in Session	Other individuals present in session: • Foster parent/guardian (G.7) • Interpreter (G.8) • Other grantee staff member (G.9) • Other relatives of case member(s) (G.10) • RPG partner staff (G.11) • Staff conducting fidelity observation (G.12) • Health professional (nurse, early interventionist / Part C staff) (G.13) • Supervisor (G.14) • Other (G.15)
G.16	Other Individuals in Session Specification	Specification if others present is "Other"

Appendix Table D *(continued)*

#	Data element	Description
H.	**Activities Conducted During Service Contact**	
H.1 – H.19	Activities Conducted in Session	Activities conducted during service contact: • Group discussion (H.1) • One-on-one discussion (H.2) • Case activity/interaction (H.3) • Family meeting (H.4) • Role playing (H.5) • Re-enactments (H.6) • Exposure to trauma-related triggers (H.7) • Games/play (H.8) • Worksheets (H.9) • Watching videos (H.10) • Goal setting/planning (H.11) • Guided practice (H.12) • Coaching/feedback (H.13) • Provision of emotional support (H.14) • Crisis intervention (H.15) • Parenting skills screening (H.16) • Child development screening (H.17) • Health assessment (H.18) • Mental health/substance use disorder screening (H.19)
I.	**Session Alignment with Session Plans**	
I.1	Session Alignment with Plans	Assessment of how session accomplishments aligned with plans: • Very well aligned • Somewhat aligned • Not well aligned
I.2 – I.8	Reason Session Not Well-Aligned	Reason visit was not well-aligned with intended accomplishments: • Crisis among case members (I.2) • Participants not engaged in activity (I.3) • Participants interested in topic other than one planned (I.4) • Presence of other individuals inhibited session activities (I.5) • Participant(s) were sick (I.6) • Physical space constraints (I.7) • Other (I.8)
I.9	Reason Session Not Well-Aligned Specification	Specification if reason not aligned is "Other"

Appendix Table D *(continued)*

#	Data element	Description
J.	**Topics Covered During Service Contact**	
J.1	Parents'/Other Adults' Substance Use Disorder Treatment	Substantive areas covered with adult in session – Substance Use Disorder Treatment
J.2	Parents'/Other Adults' Parenting Skills	Substantive areas covered with adult in session – Parenting Skills
J.3	Parents'/Other Adults' Personal Development	Substantive areas covered with adult in session – Personal Development
J.4	Youth Therapy and Development	Substantive areas covered with child in session – Therapy and Development
J.5	Education of Youth on Substance Use Disorders and Recovery	Substantive areas covered with child in session – Education on Substance Use Disorders and Recovery
J.6	Education of Other Relatives (Not in RPG Case) on Substance Use Disorders and Recovery	Substantive areas covered with other family members in session – Education on Substance Use Disorders and Recovery
K.	**Substance Use Disorder Treatment, Parents, or Other Adults in RPG Case Subtopics**	
K.1 – K.13	Parents'/Other Adults' Substance Use Disorder Treatment Topics	Whether the following topics were primary, one of the several main topics, touched on, or not discussed : • Acknowledging a substance use problem (K.1) • Discussing readiness to change (K.2) • Discussing past successful behavioral changes (K.3) • Identifying and preventing destructive behaviors (K.4) • Identifying triggers and cravings (K.5) • Enacting plan for change and recovery (K.6) • Developing a relapse plan (K.7) • Fostering honesty and responsibility (K.8) • Fostering self-help skills (K.9) • Providing information on abuse and trauma (K.10) • Developing understanding of substance use disorders and their effects (K.11) • Addressing guilt, loss, and grief (K.12) • Developing support networks (K.13)

Appendix Table D *(continued)*

#	Data element	Description
L.	**Parenting Skills, Parents or Other Adults in RPG Case Subtopics**	
L.1 – L.11	Parents'/Other Adults' Parenting Skills Topics	Whether the following topics were primary, one of the several main topics, touched on, or not discussed : • Fostering parent's ability to effectively communicate with child (L.1) • Teaching parent how to develop child's communication and social skills (L.2) • Teaching parent about child growth and development (L.3) • Teaching parent how to establish care-giving routines (L.4) • Teaching parent to serve as a secure emotional base for child (L.5) • Fostering parent's understanding of and ability to develop child autonomy (L.6) • Teaching parent strategies to promote positive family interactions (L.7) • Teaching parent to manage child's misbehavior, foster positive behavior, and set developmentally appropriate rules and consequences (L.8) • Educating parent about pre-teen and teen sex and STIs (L.9) • Educating parent about child/adolescent substance use (L.10) • Educating parent on child/adolescent depression and suicide (L.11)

Appendix Table D *(continued)*

#	Data element	Description
M.	**Personal Development, Parents or Other Adults in RPG Case Subtopics**	
M.1 – M.9	Parents'/Other Adults' Personal Development Topics	Whether the following topics were primary, one of the several main topics, touched on, or not discussed : • Fostering communication and social skills (M.1) • Fostering resiliency (M.2) • Fostering empathy and kindness (M.3) • Learning to identify and express feelings (M.4) • Fostering skills to manage emotions (M.5) • Developing life management skills (M.6) • Fostering ability and commitment to making healthy choices (M.7) • Fostering healthy, safe relationships and boundaries (M.8) • Processing trauma and developing a trauma narrative (M.9)
N.	**Youth Therapy and Development, Youth in RPG Case Subtopics**	
N.1 – N.11	Youth Therapy and Development Topics	Whether the following topics were primary, one of the several main topics, touched on, or not discussed : • Fostering communication and social skills (N.1) • Fostering resiliency (N.2) • Fostering empathy and kindness (N.3) • Learning to identify and express feelings (N.4) • Fostering skills to manage emotions (N.5) • Developing life management skills (N.6) • Fostering ability and commitment to making healthy choices (N.7) • Fostering healthy, safe relationships and boundaries (N.8) • Processing trauma and developing a trauma narrative (N.9) • Developing honesty, responsibility, and cooperation (N.10) • Developing a positive support network (N.11)
O.	**Education on Substance Use Disorders and Recovery, Youth in RPG Case Subtopics**	
O.1 – O.5	Education of Youth on Substance Use Disorders and Recovery Topics	Whether the following topics were primary, one of the several main topics, touched on, or not discussed : • Discussing risk factors for youth developing substance use disorder (Q.1) • Discussing impact of substance use disorders on family, friends, and relationships (Q.2) • Discussing relapse prevention (Q.3) • Educating on biology of addiction (Q.4) • Educating on medical effects of substance use (Q.5)

Appendix Table D *(continued)*

#	Data element	Description
P.	**Education on Substance Use Disorders and Recovery, Other Relatives Not in RPG Case Subtopics**	
P.1 – P.4	Education of Other Relatives (Not in RPG Case) on Substance Use Disorders and Recovery Topics	Whether the following topics were primary, one of the several main topics, touched on, or not discussed : • Discussing impact of substance use disorders on family, friends, and relationships (P.1) • Discussing relapse prevention (P.2) • Educating on biology of addiction (P.3) • Educating on the medical effects of substance use (P.4)
Q.	**Engagement Rating (after second service contact and EBP exit)**	
Q.1	Participant Engagement Scale	Rating of the specified case's engagement to date in EBP: • Participants were consistently highly involved in services: The participant(s) kept most appointments and actively participated in discussions and activities. If homework was assigned, the participant(s) completed it. • Participants' involvement varied: The participant(s) sometimes kept appointments and sometimes actively participated in discussions and activities. If homework was assigned, the participant(s) sometimes completed it. At other times, the participant(s)' involvement was low. • Participants' involvement was consistently low: The participant(s) kept some appointments but missed or cancelled frequently. The participant(s) rarely actively participated in discussions and activities. If homework was assigned, the participant(s) frequently did not complete it. • Participants were minimally or not involved at all: The participant(s) kept few appointments. The participant(s) did not actively participate in discussions and activities. If homework was assigned, the participant(s) did not complete it.

Appendix Table D *(continued)*

#	Data element	Description
R.	**Service Contact Check if No Contact Data Entered for Two Weeks**	
R.1	Contact with Case Since Last Service Date	Whether contact with case since the last recorded service log
R.2	Contact in Person	Whether in-person services provided since last recorded service log
R.3 – R.6	Contact Type with Case Members	Type of contact with case: • Provided referral services (R.3) • Tried to schedule appointment (R.4) • Checked in on family by phone/email/other of contact not in person (R.5) • Other (R.6)
R.7	Contact Type with Case Members Specification	Specification if contact type = "Other"
R.8	Reason No Case Contact	Main reason no contact made with case since last service date: • Exited from EBP • Scheduled visit did not occur • No scheduled contact
R.9	Count of Missed Scheduled Visits	Scheduled visits that did not occur since last service date
R.10	Ability to Schedule Appointment	Whether caseworker able to schedule an appointment

APPENDIX E

PARTNER SURVEY

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OMB No.: xxxx-xxxx
Expiration Date: xx/xx/xxxx

MATHEMATICA Policy Research

Partner Survey

Regional Partnership Grants National Cross-Site Evaluation

November 5, 2013

INTRODUCTION

The Regional Partnership Grants (RPG) program supports interagency collaborations and program integration designed to increase the well-being, improve the permanency, and enhance the safety of children who are in, or at risk of, out-of-home placements as a result of a parent or caretaker's substance abuse. The Children's Bureau within the U.S. Department of Health and Human Services, Administration for Children and Families (ACF) has contracted with Mathematica Policy Research to complete the national cross-site evaluation of the program. The evaluation will describe the interventions that were implemented, the nature of the partnerships, the types of services provided, and their impacts.

You are being asked to complete this survey because you were identified as a representative of a partner organization working with the RPG grantee, [RPG GRANTEE]. Representatives from partner organizations are asked to complete this survey to provide information about their own organizations, relationships with the grantee and other collaborating organizations, and program implementation. The length of this survey is different for different people, but on average it should take about 20 minutes.

Your participation in this survey is important and will help us understand more about the partnerships implementing RPG-funded programs. Please provide responses for your organization, [ORGANIZATION]. If you represent a specific branch or program within your organization that is engaged with the RPG partnership, rather than the organization as a whole, please provide information about that branch or program rather than the organization as a whole. If you are unsure of how to answer a question, please give the best answer you can rather than leaving it blank.

Your responses will be kept private and used only for research purposes. They will be combined with the responses of other staff and reported in the aggregate; and no individual names will be reported. Participation in the survey is completely voluntary and you may choose to skip any question.

If you have any questions about the survey, please contact the team at Mathematica by emailing xxxxxxx@mathematica-mpr.com or calling xxx-xxx-xxxx (toll-free).

Please read and answer the statement below and then click the "Next" button in the lower right-hand corner to begin the survey.

i1. I have read the introduction and understand that the information I provide will be kept private and used only for research purposes. My responses will be combined with the responses of other staff and no individual names will be reported.

1 ☐ I agree with the above statement and will complete the survey

0 ☐ I do not agree with the above statement and will not complete the survey → **GO TO END**

A. YOUR ORGANIZATION

The first questions are about your organization, [ORGANIZATION].

1. Which of the following best describes your organization?

MARK ONE ONLY

1 ☐ Child welfare services provider
2 ☐ Substance abuse treatment provider
3 ☐ Mental health services provider
4 ☐ School district, school, or early childhood education or services provider
5 ☐ Housing/homeless services provider
6 ☐ Medical or dental services provider
7 ☐ University
8 ☐ Court/judicial agency
9 ☐ Corrections or law enforcement agency
10 ☐ Home visiting services provider
11 ☐ Department in state or tribal government
12 ☐ Department in local government
13 ☐ Foundation
14 ☐ Research/evaluation organization
15 ☐ Other *(Describe)*

_____

2. What are the main activities your organization conducts <u>in general</u>?

MARK ALL THAT APPLY

1 ☐ Regulation and oversight
2 ☐ Child welfare services
3 ☐ Substance abuse treatment
4 ☐ Family therapy
5 ☐ Medical or dental services
6 ☐ Education or early childhood intervention
7 ☐ Legal processes
8 ☐ Law enforcement
9 ☐ Home visiting
10 ☐ Funding
11 ☐ Evaluation
12 ☐ Program planning and policy development
13 ☐ Advocacy
14 ☐ Other *(Describe)*

_____

3. Does your organization currently provide program or other services or plan to serve RPG program clients?

MARK ONE ONLY

1 ☐ Currently provides services to RPG clients
2 ☐ Plans to provide services to RPG clients
3 ☐ No → **GO TO Q.6**

4. Approximately how many RPG program clients does your organization currently serve or plan to serve each year?

Your best estimate is fine.

|__|__|__| , |__|__|__| CLIENTS

5. Which of the following programs does your organization provide or plan to provide <u>to RPG program clients</u>?

MARK ALL THAT APPLY

1 ☐ 24/7 Dad
2 ☐ Alternatives for Families-Cognitive Behavioral
3 ☐ Attachment, Self-Regulation, and Competence (ARC)
4 ☐ Celebrating Families!
5 ☐ Centering Pregnancy
6 ☐ Child-Parent Psychotherapy (CPP)
7 ☐ Cognitive Behavior Therapy (CBT)
8 ☐ Dialectical Behavior Therapy (DBT)
9 ☐ Family Behavior Therapy (FBT)
10 ☐ Family Group Conferencing
11 ☐ Family Treatment Drug Court (FTDC)
12 ☐ Guiding Good Choices (GGC)
13 ☐ Hazelden Co-Occurring Disorders Program
14 ☐ Hazelden Living Balance Programs
15 ☐ Helping Men Recover
16 ☐ Head Start
17 ☐ Healthy Families
18 ☐ Homebuilders Intensive Family Preservation Services
19 ☐ Incredible Years Parenting Class
20 ☐ Kelly Bear
21 ☐ Keys for Interactive Parenting (KIPS)
22 ☐ Lifespan Integration
23 ☐ Matrix Model Program
24 ☐ MindUP
25 ☐ Modified Therapeutic Community (MTC)
26 ☐ Moral Reconation Therapy
27 ☐ Motivational Enhancement Therapy
28 ☐ Motivational Interviewing
29 ☐ Multisystemic Family Therapy (MST)

MARK ALL THAT APPLY

30 ☐ My Baby and Me (Ages 0-3)
31 ☐ Nurse-Family Partnership (NFP)
32 ☐ Nurturing Parenting Programs
33 ☐ Parent and Child Interactive Therapy
34 ☐ Parent Child Assistance Program (PCAP)
35 ☐ Parents and Children Together (PACT)
36 ☐ Parents as Teachers Curriculum
37 ☐ Partners in Parenting
38 ☐ Prolonged Exposure
39 ☐ Recovery Coach
40 ☐ Relapse Prevention Therapy (RPT)
41 ☐ Resource Mothers
42 ☐ SafeCare
43 ☐ Sanctuary Model
44 ☐ Screening, Brief Intervention, and Referral to Treatment (SBIRT)
45 ☐ Seeking Safety
46 ☐ Solution Focused Brief Therapy (SFBT)
47 ☐ Staying Connected with Your Teen
48 ☐ Strengthening Families
49 ☐ Strong Kids
50 ☐ Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
51 ☐ Supportive Education for Children of Addicted Parents
52 ☐ Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
53 ☐ Untangling Relationships
54 ☐ Other *(Describe)*

_____

55 ☐ None of these

6. Approximately how much funding from the Regional Partnership Grants program did your organization receive this fiscal year, if any? *If your organization did not receive RPG funding this fiscal year, please answer $0.00.*

$ |__|__|__|,|__|__|__|.00 AMOUNT OF FUNDING RECEIVED FROM RPG PROGRAM

d ☐ Don't know

7. Which of the following in-kind resources is your organization is contributing to the RPG program this fiscal year?

MARK ALL THAT APPLY

1 ☐ Staff time

2 ☐ Office space

3 ☐ Volunteers

4 ☐ Office supplies

5 ☐ RPG program materials

6 ☐ Computer/Internet, telephone, or fax service

7 ☐ Other *(Describe)*

_____

8 ☐ None of these

B. PERSPECTIVES ON GOALS AND RELATIONSHIPS IN THE PARTNERSHIP

Partner Goals

8. **In your own words, what are the main goals of the RPG partnership?**

____

____

____

Relationships/Communication Systems

9. **Do you currently serve on a steering, implementation, governance, or some other committee for the RPG grant?**

1 ☐ Yes

0 ☐ No

10. **Other than formal RPG partnership meetings, how frequently does your organization communicate about RPG with the organizations listed below?**

First, please indicate if you were previously working with a member of the RPG partnership prior to the beginning the RPG grant in 2012. Next, please indicate if you do not communicate at all, if you communicate infrequently (a few times each month), or if you communicate regularly (every day or nearly every day) with that partner. Please choose the answer that best represents the frequency of communication. *Please ignore the row that contains your organization.*

Organization	Were you previously working with this partner prior to receiving the RPG grant funds? (MARK IF YES)		We do not communicate at all outside of RPG partnership meetings	We communicate infrequently (a few times each month) outside of RPG partnership meetings	We communicate regularly (every day or nearly every day) outside of RPG partnership meetings
	Yes	No			
[ROSTER OF ORGANIZATIONS]	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐
____________	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐
____________	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐
____________	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐
____________	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐
____________	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐
____________	1 ☐	0 ☐	1 ☐	2 ☐	3 ☐

11. To what extent do you disagree or agree with each of the following statements about the current status of the collaboration among RPG partner organizations?

	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Our collaborative effort was started because we wanted to do something about an important problem	1 ☐	2 ☐	3 ☐	4 ☐
b. Our RPG program's top priority was having a concrete impact on the real problem	1 ☐	2 ☐	3 ☐	4 ☐
c. The organizations involved in our RPG program included those organizations affected by the issue	1 ☐	2 ☐	3 ☐	4 ☐
d. Participation was not dominated by any one group or sector	1 ☐	2 ☐	3 ☐	4 ☐
e. Our partner organizations have access to credible information that supports problem solving and decision making	1 ☐	2 ☐	3 ☐	4 ☐
f. RPG partner organizations agree on what decisions will be made by the group	1 ☐	2 ☐	3 ☐	4 ☐
g. Partner organizations agree to work together on this issue	1 ☐	2 ☐	3 ☐	4 ☐
h. Organizations involved in our RPG program have set ground rules and norms about how we will work	1 ☐	2 ☐	3 ☐	4 ☐
i. We have a method for communicating the activities and decisions of the group to all partner organizations	1 ☐	2 ☐	3 ☐	4 ☐
j. There are clearly defined roles for RPG partner organizations	1 ☐	2 ☐	3 ☐	4 ☐
k. Partner organizations are more interested in getting a good decision for the RPG program than improving the position of their own organization	1 ☐	2 ☐	3 ☐	4 ☐
l. Staff who participate in RPG program meetings are effective liaisons between their home organizations and the group	1 ☐	2 ☐	3 ☐	4 ☐
m. Partner organizations trust each other sufficiently to honestly and accurately share information, perceptions, and feedback	1 ☐	2 ☐	3 ☐	4 ☐
n. Partner organizations are willing to let go of an idea for one that appears to have more merit	1 ☐	2 ☐	3 ☐	4 ☐
o. Partner organizations are willing to devote whatever effort is necessary to achieve the goals	1 ☐	2 ☐	3 ☐	4 ☐
p. Divergent opinions are expressed and listened to	1 ☐	2 ☐	3 ☐	4 ☐
q. The openness and credibility of the process helps partner organizations set aside doubts and skepticism	1 ☐	2 ☐	3 ☐	4 ☐
r. Our group sets aside vested interests to achieve our common goal	1 ☐	2 ☐	3 ☐	4 ☐
s. Our group has an effective decision making process	1 ☐	2 ☐	3 ☐	4 ☐
t. Our group is effective in obtaining the resources it needs to accomplish its objectives	1 ☐	2 ☐	3 ☐	4 ☐
u. The time and effort of the collaboration is directed at achieving our goals rather than keeping the collaboration in business	1 ☐	2 ☐	3 ☐	4 ☐

12. Using the two columns below, please indicate the organizational levels at which collaboration most often occurs among all of the organizations in the partnership to fill in the following statement: Generally speaking, collaboration among organizations in the partnership typically occurs at the following levels: (column A) to (column B).

MARK ONE ONLY IN COLUMN A	MARK ONE ONLY IN COLUMN B
1 ☐ Administrators/organization leaders	1 ☐ Administrators/organization leaders
2 ☐ Front-line staff/mid-level supervisors	2 ☐ Front-line staff/mid-level supervisors

13. Indicate the degree to which you disagree or agree with each of the following statements about RPG programming:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does not apply/ Don't know
a. We developed strategies to recruit community participation	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
b. Community members are included in program planning and development	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
c. We developed formal mechanisms to solicit support and input from community members and consumers	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
d. Front-line staff have up-to-date resource directories for family support centers and resources	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
e. Community-wide accountability systems are used to monitor substance abuse and child welfare issues	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
f. Consumers, patients in recovery, and program graduates have active roles in planning, developing, implementing, and monitoring services	1 ☐	2 ☐	3 ☐	4 ☐	d ☐

C. PARTNERSHIP OUTPUTS

14. Indicate the degree to which you disagree or agree with each of the following statements about clients receiving RPG programming:

	Strongly Disagree	Disagree	Agree	Strongly Agree	Does not apply/ Don't know
a. Services provided to families are coordinated across multiple partners	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
b. Case management is coordinated across both substance abuse treatment providers and child welfare agencies	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
c. Families receiving joint case management receive regular cross-agency assessments	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
d. Staff from both substance abuse treatment providers and child welfare agencies participate in joint case management activities such as family team conferences, case plan reviews, or intake or permanency staffings	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
e. Judicial officers and attorneys are viewed as partners in developing new approaches to serve families with substance use disorders in the child welfare system	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
f. Substance abuse and child welfare agencies and the courts have negotiated shared principles or goal statements	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
g. Region/partnership developed responses to conflicting time frames associated with child welfare services, substance abuse treatment, Temporary Assistance for Needy Families, and child development	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
h. Substance abuse treatment and child protective service case plans are coordinated	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
i. Formal working agreements have been developed on how courts, child welfare, and treatment agencies will share client information	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
j. Data tracking child welfare and substance abuse clients across systems is used to monitor outcomes	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
k. Substance abuse agencies, child welfare agencies, and court systems have developed shared outcomes for families and agree on how to use information on outcomes with families	1 ☐	2 ☐	3 ☐	4 ☐	d ☐
l. Joint training programs for the three main systems staff have been developed to help staff and providers work together effectively	1 ☐	2 ☐	3 ☐	4 ☐	d ☐

15. Below is a list of organizations identified as part of your RPG partnership. Which RPG-related services does your organization coordinate with or collaborate on with each organization? If you do not coordinate or collaborate with the organization on any of the listed activities, leave the row blank. *Please ignore the row that contains your organization.*

Organization	Screening and/or Assessment	RPG Program Referrals	Case Management or Coordination	Substance Abuse Treatment	Mental Health / Trauma Services	Other Social or Family Services
[ROSTER OF ORGANIZATIONS]	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
______________________	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
______________________	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
______________________	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
______________________	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
______________________	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
______________________	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
______________________	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐
______________________	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐

END OF SURVEY

16. Thank you for your participation in this survey. If there is anything else that you would like to tell us about your work on the RPG program or about the partnership as a whole, please share it here.

_____

_____

_____

_____

(End of survey for those who opt out in the first screen)

Thank you for considering participation in this survey. Please click the "Submit survey" button in the lower right hand corner so that we have a record of your desire NOT to participate. This will result in your removal from our contact list.

(End of survey for respondents)

Thank you for completing the Regional Partnership Grant Partner Survey!

Please click the "Submit survey" button in the lower right hand corner to submit your completed survey.

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APPENDIX F

ADDITIONAL INFORMATION ON SELECTION IN QEDS

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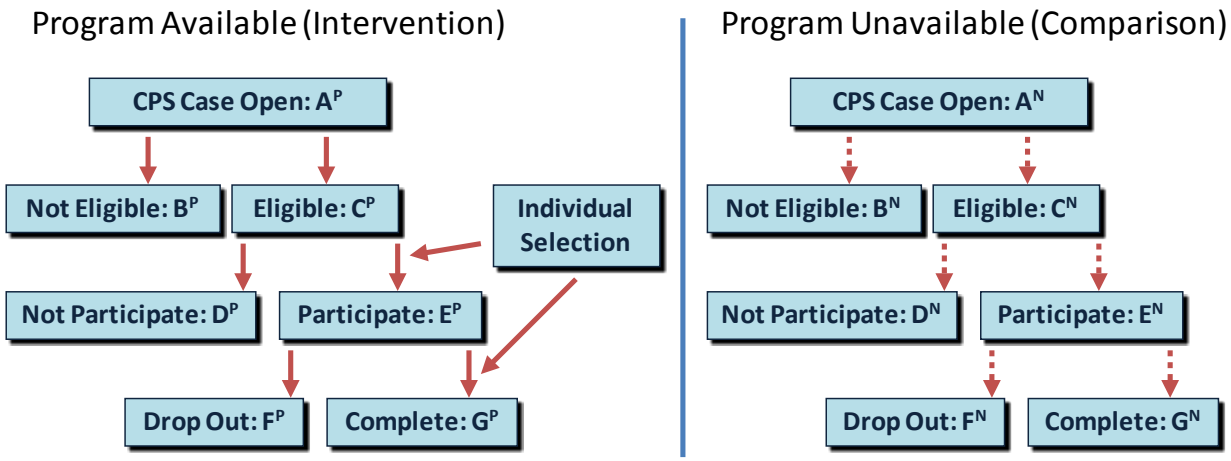
Quasi-experimental designs (QEDs) can provide a causally valid impact estimate of an intervention if the treatment and comparison groups are equivalent on baseline variables that influence the outcomes of interest. Ideally, the only difference between the groups is that the treatment condition experiences the intervention, while the comparison group does not. If this were true, then the difference in outcomes at the end of the intervention can be attributed to the intervention, rather than underlying differences across groups.

In practice, it is impossible to know whether the treatment and comparison groups are equivalent at baseline on all variables that might influence program outcomes. In particular, it is difficult to establish equivalence on variables that might influence the decision to participate, or "select" into a program. Figure F.1 presents a simplified example of individual selection. The left side of the figure represents potential groups for families who have a program (P) available to them. The right side represents potential groups for families who do not have the program available (N)—the dashed arrows indicates we cannot observe these choices because the families do not have access to the program. In the example, families are identified for participation through open CPS cases (Box A) and have certain characteristics to be eligible for the program (B and C). After they are determined eligible, they can choose to either not participate (D) or participate (E). Of those who participate, they can either drop-out (F), or complete the program (G).

For a QED to provide compelling evidence, it is necessary for the samples used in the analysis to have the same experiences (i.e. groups with the same capital letter in Figure F.1). For example, if follow-up data are only collected for intervention families that have completed the program, then a valid comparison would be between group G^P and G^N. This is a valid comparison because the groups G^P and G^N would be similar at baseline in terms of their likelihood of completing a program. The primary problem for QEDs is that we do not know who would have been in G^N. Thus an assumption of the QED is that the researcher has enough information to place comparison group families in the appropriate groups to make a valid comparison.

Figure F.1 Sorting Across Treatment Categories in the Absence of Random Assignment



Baseline equivalence for quasi-experimental designs is most credible when we observe baseline characteristics that strongly predict the paths chosen at each decision level. Because the requirements for participation in the impact study included collecting baseline assessments of each outcome of interest, we have reason to believe that we can ensure that the groups are equivalent on these key variables of interest. That is, we believe that the baseline assessments of the key outcomes of interest, coupled with the administrative data on permanency and safety, will provide enough information to determine the types of individuals that will end up in each pathway. With this information, we can make credible comparisons of the effects of the RPG interventions using QEDs.

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