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

2012 and 2014 Regional Partnership Grants to Increase the Well-Being of and to Improve the Permanency Outcomes for Children Affected by Substance Abuse:

Fourth Annual Report to Congress

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

ADMINISTRATION FOR CHILDREN & FAMILIES

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EXECUTIVE SUMMARY

In October 2016, the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS) released data showing that the number of children in foster care, after declining for seven years, had increased for the third consecutive year (HHS, 2016a). Over that time (2012 to 2015), the percentage of child removals where parental substance use was cited as a contributing factor increased 13 percent—the largest percentage increase compared to any other circumstance around removal. Recent increases in the misuse of opioids may be causing or contributing to this increase in substance-use related removals.

Although the opioid crisis is an emerging phenomenon, concerns about the effect of parental substance misuse on child welfare is not new. Since 2006, Congress has authorized HHS to make competitive Regional Partnership Grants (RPG) to support partnerships between child welfare agencies and organizations in substance use disorder treatment and other social service systems 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.

- **First round of grants (RPG1).** The Child and Family Services Improvement Act of 2006 (Public Law 109-288) authorized and appropriated $145 million over five years for the first round of RPG funding. HHS made three- to five-year grants to 53 partnerships in 29 states. To support grantees in achieving their program and performance goals, HHS provided technical assistance (TA) to grantees through a federal contract. These grants have ended and are described in three earlier reports to Congress (HHS, 2012a, 2013a, and 2014a).
- **Second round of grants (RPG2).** The Child and Family Services Improvement and Innovation Act of 2011 (Public Law 112-34) reauthorized the RPG program and appropriated $100 million of funding for new grants. In September 2012, HHS awarded new grants to 17 organizations in 15 states. HHS contracted with Mathematica Policy Research to design and conduct a national cross-site evaluation reflecting the goals of the legislation and assessing program effectiveness. In 2012, HHS also awarded eight existing grantees new grants of $500,000 per year for two years to extend their programs (Administration for Children and Families, 2012b). As stated above, these grants have ended and are described in three earlier reports to Congress (HHS, 2012a, 2013a, and 2014a).
- **Third round of grants (RPG3).** In September 2014, HHS awarded another round of five-year grants to four organizations in four states. As in RPG2, these new grantees also participate in the cross-site evaluation and conduct local evaluations (also required for RPG2).

A. Prior reports to Congress

Each year, HHS develops a report to Congress to describe the progress of the overall RPG program and the funded projects, using data from the cross-site evaluation. (For more detail, see Appendix A of this report.)

The first report to Congress (HHS, 2014b) described how HHS made the grants to the 17 partnerships, identified the grantees, and discussed their planned projects and first-year milestones achieved. It showed that:

- **Partnerships included required members.** Each partnership consisted of at least four and as many as 29 partner agencies, including child welfare agencies responsible for the administration of the state's plan under Title IV-B or IV-E of the Social Security Act.
- **RPG projects incorporated evidence-based and evidence-informed program and practice models (referred to in this report as EBPs).** Of 51 distinct program and practice models proposed by all RPGs combined, 37 had been reviewed by at least one of five evidence sources; seven others had been evaluated at least once, and of the seven remaining models, four were described by their developers as based on research or evidence. These evaluations included randomized, controlled trials, quasi-experimental designs, and/or descriptive methods only. Thus the level of evidence varied across the models, and some had not been evaluated among child welfare populations.
- **HHS successfully established a TA system.** HHS established an infrastructure to provide ongoing program- and evaluation-related TA to grantees through the National Center for Substance Abuse and Child Welfare (NCSACW) and Mathematica Policy Research, Inc., respectively.[1] Together, in the first year they received and responded to over 100 requests for TA.
- **Most grantees' initial evaluation designs met HHS goals for levels of evidence.** HHS reviewed the rigor of the designs grantees proposed to evaluate their projects. The review concluded that, if well-implemented, 12 local evaluations could offer strongest, promising, or limited evidence on program effectiveness. The other seven could not provide evidence of effectiveness, but did offer descriptive information, such as change over time.

The second report to Congress (HHS, 2015b) described the progress in the early implementation of the RPG2 projects. This report found:

- **By April 2014, 16 of the 17 grantees had begun enrollment.** The number enrolled at each site by then ranged from 35 to 700, for a total of 3,365 participants, 65 percent of them children. Nearly all grantees had obtained Institutional Review Board approval for their local evaluations, and 13 had begun enrolling families into the cross-site evaluation.
- **Not only their own efforts but also external factors affected grantees' progress implementing their RPG projects.** Fourteen grantees in 12 states described contextual factors that inhibited or spurred RPG implementation. The main factors were related to child welfare, such as changes in child welfare practices that reduced referrals to RPG (11 grantees); (2) substance use, or policies affecting substance use disorder (SUD) treatment or individuals with SUDs (7 grantees); and (3) federal or state economic and fiscal conditions (7 grantees).

[1] The Center for Children and Family Futures, Inc. managed NCSACW, which is funded by the Administration on Children, Youth, and Families and the Substance Abuse and Mental Health Services Administration.

- **Grantees actively requested TA, including help to obtain needed administrative data.** Grantees submitted 77 requests for programmatic TA to NCSACW, and made another 69 inquiries for TA on evaluation-related topics through an RPG help desk operated by Mathematica. Numerous grantees asked for assistance obtaining administrative data (child welfare data on reports of maltreatment, episodes of removal, as well as adult enrollment in state-funded SUD treatment) they needed for their own evaluations and to submit to the cross-site evaluation.[2] While in most instances their requests for data were well-received, as of March 2014 five grantees still did not have agreements to obtain child welfare data, and nine did not have agreements for substance abuse treatment data.
- **HHS launched the cross-site evaluation.** HHS approved the final design of the cross-site evaluation, received OMB clearance for data collection, and completed two web-based systems for grantees to submit enrollment, services, baseline, and outcome data.

The third report to Congress (HHS, 2016b) updated the status of implementation, and provided an early description of the families being served by the RPG2 projects and the services they were receiving. It also introduced a new cohort of RPG grantees. Findings included:

- **Implementation was progressing despite challenges.** During their third year of implementation, some projects faced challenges related to state level policy or fiscal changes, staff turnover in child welfare organizations, and difficulty meeting enrollment targets. However, projects also demonstrated creativity, innovation, and the use of best practices to meet such challenges.
- **As intended, RPG2 projects were serving at-risk children and adults—and had engaged them in a subset of planned EBPs.** By April 2015, the 17 RPG2 grantees had enrolled a total of 5,517 participants, 59 percent of them children. As intended, RPG2 projects enrolled some children with documented maltreatment or other previous experience with the child welfare system. Of the 567 children in the sample for whom records were received, 31 percent had one or more substantiated episodes of maltreatment in the year prior to enrollment in RPG. At enrollment, 37 percent of the RPG2 adults in the cross-site evaluation sample exhibited high severity of substance use (either drug or alcohol or use of both) in the past 30 days. At least 20 percent of adult RPG2 participants had been in one or more publicly funded substance use disorder treatment programs during the year prior to their enrollment in RPG. In total, RPG2 grantees had enrolled participants in 19 different EBPs.
- **HHS funded a new cohort of grantees.** Under a third round of funding, HHS had awarded five-year RPG grants in September 2014 to four new partnerships.

B. The current report

After Congress reauthorized RPG in 2011, HHS required partnerships applying for grants to propose specific, well-defined program services 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 (HHS, n.d.). Evidence-informed practices use the best

[2] State agencies that provide public funds for SUD treatment, and collect SUD data for the national Treatment Episode Data Set.

available research and practice knowledge to guide program design and implementation (HHS, 2011). As required by the Funding Opportunity Announcement (FOA), all grantees proposed at least one EBP. However, both the number and the types of EBPs offered varied across the partnerships. EBPs included those that address substance use disorders, child and/or adult trauma, parenting skills, and child-caregiver relationships.

Social programs, even ones that research shows to be effective, will fail their clients if they are never implemented as intended (Mead, 2016). Increasing the quality of implementation increases the chances that an EBP will achieve its intended outcomes. However, Wandersman et al. (2016) note that it is important to look not only at the quality of implementation, but also at the settings (context) in which interventions are implemented. "Context" can be defined as the normal conditions into which interventions must be integrated if they are to be workable in practice (paraphrased from May, Johnson, & Finch, 2016). Therefore the cross-site evaluation studied the context in which RPG grantees selected their EBPs, and the implementation quality of selected EBPs. To round out understanding of the context in which RPG partnerships implemented their EBPs (and other services), the evaluation explored challenges grantees experienced. This report covers these topics for RPG2 grantees. It also presents a snapshot of participants enrolled by RPG3 grantees, funded in 2014, at an early stage of their projects.

C. Context: Selecting RPG2 focus and EBPs

RPG projects varied in their structure and focus. The RPG FOAs did not specify any particular program setting, EBPs, or package of services applicants had to include. Thus the projects varied significantly in their structure and content. Some RPG projects were embedded in substance use disorder treatment agencies, others in community-based service agencies, and some within family courts or other settings. Grantees also had discretion to define their project focus, such as whether to serve individuals (either parents or children) or the family to best reach RPG goals. More than one-third of the grantees reported that when deciding upon the focus for the project, they determined that to best to meet the RPG program's goals related to child well-being, safety, and permanency outcomes, they would need to address the needs of the entire family rather than focus exclusively on either the child or the parent.

Across the RPG2 grantees, the number of EBPs offered ranged from 1 to 13. Some grantees provided psychosocial EBPs common in behavioral health, whereas others chose family support services; some partnerships combined both. Some provided substance use disorder treatment as part of their RPG project, and others worked with families after an adult completed treatment. Still others targeted adults not yet diagnosed with a substance use disorder and/or their children.

Most grantees selected EBPs because they or their partners already had experience delivering them. In contrast, some engaged in a thorough research and vetting process before selecting a new model. Grantees also based their decisions on factors such as lessons learned from RPG1, their assessment of the evidence base for the model, or recommendations by a partner.

Grantees adapted some selections to better fit their needs. Despite the process RPG2 grantees used to design their projects and select their EBPs, initially, more than two-thirds of grantees subsequently dropped or added EBPs (with HHS permission). Grantees typically cited multiple reasons for dropping an EBP, but the two most common reasons were that the EBP

required too many sessions to complete or was too costly. Some were inappropriate for the population that enrolled in RPG, and others duplicated existing services. Of the EBPs added to grantees' RPG projects, most were added to replace an EBP that was not working well within the context of the RPG projects.

D. The quality of EBP implementation

In addition to documenting the overall structure of RPG projects, the cross-site evaluation assessed grantees' capacity to deliver these models. For the assessment, the cross-site evaluation collected in-depth data on a subset of 10 "focal" EBPs on factors shown in the research literature to be associated with quality implementation of evidence-based models (Fixsen et al., 2005; Meyers, Durlak, & Wandersman, 2012).[3] Specifically, the cross-site evaluation examined whether providers delivered their focal EBPs using practices thought to ensure or "drive" effective evidence-based interventions. The factors studied were those identified by the National Implementation Research Network (NIRN; Fixsen et al., 2013).[4]

NIRN's implementation drivers are interrelated processes that complement one another to bring about high-quality implementation of EBPs (Fixsen et al., 2010). They fall under three categories: staff competency, organizational supports, and leadership (Fixsen et al., 2009; Metz, Blase, & Bowie, 2007):

- **Staff competency** comprises appropriate staff selection and hiring, training, and coaching processes that build the capacity of staff to deliver the intervention with fidelity.
- **Organizational supports** are structures and systems that create an environment conducive to the successful delivery of EBPs.
- **Leadership** involves guiding staff and identifying and solving barriers to service delivery.

By fall 2015 providers had the NIRN implementation drivers examined by the cross-site evaluation in place to deliver the focal EBPs—though some were in place only partially.[5] As Table 1 shows, focal EBP providers from most grantees had overall staff competency drivers (selecting and hiring, training, and coaching staff appropriately) and organizational supports drivers (data systems and administrative supports available) in place for the focal EBPs (13 and 14 grantees, respectively). The ratings for the three categories (bolded in Table 1) are the averages of each grantee's ratings for the drivers that make up each category. Focal EBP providers from fewer grantees (11)—but still a majority—had leadership in place. Nevertheless, there were some gaps, as Section C describes.

[3] The focal EBPs were selected such that each of the 17 RPG2 grantees was implementing at least one of them.

[4] NIRN studies implementation science, organizational change, and system change, to improve human services outcomes.

[5] All measures and discussions of the implementation drivers presented in this report are summarized at the grantee level. Data was aggregated across all focal EBP providers for each grantee that was interviewed during the site visits. In some cases, the grantee organization itself provided the focal EBP (or one or more of the focal EBPs, if the partnership offered more than one). If more than one organization provided one or more of the focal EBPs, site visitors sought to conduct interviews at up to two focal EBP organizations or locations per partnership.

Table 1. Capacity of EBP providers to deliver focal EBPs as indicated by the implementation drivers, at the grantee-level

	Number of RPG2 grantees at each stage			
	In place	Partially in place	Not in place	Not enough information
Staff competency (overall)	**13**	**4**	**0**	**0**
Staff selection and hiring	9	8	0	0
Training	11	6	0	0
Coaching	9	8	0	0
Organizational supports (overall)	**14**	**3**	**0**	**0**
Data systems to support decision making	13	4	0	0
Administrative infrastructure	14	3	0	0
Leadership	**11**	**5**	**0**	**1**

Source: RPG site visits, fall 2015.

Note: The overall staff competency and organizational supports scores are averages of the average scores for each individual driver in the category. That is, even though no more than 11 grantees had any of the 3 individual staff competency drivers in place, 13 grantees had at least 2 of the 3 individual drivers in place.

1. Staff competency to deliver EBPs

The goal of staff selection and hiring is to identify staff who are equipped to implement an EBP in the way intended by its developers and who possess the skills to build rapport with participants—both of which help bring about the intended outcomes of an EBP consistently (Metz, Bandy, & Burkhauser, 2009). "Staff competency" measures staff qualities such as their education and experience, their openness to implementing EBPs, the types of skills needed to connect with participants, and the training and other support staff receive.

Front-line staff and supervisors had college, graduate, or professional degrees and from 2 to 10 or more years of experience.[6] Data from the staff survey showed the characteristics of people employed by the providers who implemented the 10 focal EBPs. More than 90 percent of staff survey respondents had at least a four-year college degree, and at least 60 percent had graduate or professional degrees.[7] Eighty-one percent of supervisors had a graduate or professional degree. Over 75 percent had at least two years of relevant work experience, and half had five or more years of experience working with RPG target populations (children and families in the child welfare system or adults with substance use disorders).

Staff reported receiving initial but not ongoing training. Training is integral to building staff capacity because it prepares staff to work with participants, introduces them to the EBP's content, and teaches them how to deliver the EBP in the way intended by developers of the program model or practice (Metz, Burkhauser, & Bowie, 2009). Most frontline staff (84 percent)

[6] "Front-line staff" refers to all staff members who work directly with participants, such as therapists, group facilitators, or case managers.

[7] All statistics from the RPG EBP staff survey are reported at the partnership level so that they represent an average across all 17 RPG sites. To compute percentages, the percentage within each site (which sometimes included respondents from multiple providers) was first calculated and then the percentages were averaged across the 17 partnerships. Thus all sites are weighted equally regardless of the number of survey respondents at each site.

reported receiving initial training on the focal EBPs, but less than half (40 percent) received ongoing training, despite feeling the need for it. Although ongoing training on EBPs was not commonly provided, staff desired it. In site visit interviews, supervisors and frontline staff identified training in several specific areas they felt would have benefited them such as:

- Tailoring the EBP content to participants
- Implementing substance use disorder components of EBPs, as applicable
- Addressing cultural diversity
- Dealing with crisis situations
- Working with children and tailoring EBP content for young children

Staff received ongoing supervision and coaching. Although staff must learn the core components of an EBP through training, staff also require ongoing support when delivering an EBP to enhance their skill development and provide them with feedback on their performance (Bertram, Blase, & Fixsen, 2014; Metz, Blase, & Bowie, 2007). Findings from the staff survey showed that a majority of respondents met with their supervisor at least once a month in both one-on-one (79 percent) and group meetings (87 percent). More than 40 percent of staff met with their supervisors one-on-one once a week or more, and about 55 percent reported attending group supervision meetings once a week or more often. Three-quarters of staff interviewed during site visits said they also received coaching on how to deliver their EBPs. Coaching consists of on-the-job observations, instruction, modeling, feedback, debriefings, and emotional support, adapted to fit the individual needs of staff members (Burkhauser & Metz, 2009).

2. Organizational supports to facilitate the delivery of EBPs

In addition to building staff competency, provider organizations must set the stage for high-quality implementation of their EBPs. Organizational support refers to the structures and systems in place for staff to use delivering EBPs. These structures and systems include implementation teams and written plans to guide the overall work of staff; data systems to track participant data and services provided to participants; adequate funding and facilities (such as office space, session space, or supplies), and a positive organizational climate.

Some staff were aware of implementation teams, but few reported having written plans to guide implementation of their EBPs. The research literature points to the importance of organizations forming teams to guide implementation, maintain institutional knowledge, and sustain relationships. In addition, written guidance helps staff members understand their roles and what is expected of them as part of the larger organization. About half of managers and supervisors interviewed during site visits said there was an initial planning team for the EBP they delivered, and most of these also said that team continued beyond the planning period to provide ongoing support. However, only 12 percent of EBP managers and supervisors (representing 3 out of 12 providers), reported having any written plans available for implementing the EBPs. In contrast, 71 percent of RPG project directors said that they had written plans available to guide the implementation of the RPG project as a whole.

EBP providers had data systems, though the type of data system used, and the purpose of the data, differed for staff and their supervisors and managers. To manage, treat, and monitor cases, staff need a system they can use to accurately track and easily access information on their participants. During the site visits, all focal EBP frontline staff, managers, and supervisors who were asked whether their agency had a data system reported that they had either an electronic or paper-based system. Frontline staff primarily used paper-based data collected on individual participants for planning or monitoring the individual progress of each participant. Managers and supervisors used data maintained in an electronic system, such as a management information system, for program improvement (for example, to identify sessions that were most successful and those that needed additional materials or adjustments).

Staff expressed concern about funding and sustainability. Most EBP staff interviewed during site visits reported that their organizations provided appropriate supplies and session or office space. When asked about the overall capabilities of staff within the organization, interviewees said that staff had appropriate education levels, professional or technical credentials, and cultural competency, and a strong commitment to the organization's mission. Nearly 40 percent of staff felt that the funding for their EBP or agency was inadequate to train and hire staff to deliver services. Staff also felt they needed more funding to pay for additional training or supplies, to hire more staff at all levels, and to sustain their program past the RPG grant period. The staff survey also showed some dissatisfaction with compensation.

3. Leadership that supports high-quality implementation of EBPs

The third category of drivers or best practices deemed important for bringing about high quality implementation of EBPs is leadership. Leadership refers to a core group of individuals who guide the staff providing services and identify and solve everyday and more-complex problems that arise when delivering EBPs. In assessing leadership, site visit interviews asked frontline staff how well-supported they felt by two layers of leadership relevant for RPG: (1) EBP managers and supervisors, and (2) provider organization directors and/or RPG project directors.

Staff thought highly of their supervisors and managers. Most frontline staff reported that they experienced consistent communication with their managers and supervisors—who were also easily accessible to them. This communication made it easy for staff to report any issues they were experiencing in implementing the EBPs. More than 80 percent of frontline staff interviewed reported that their managers and supervisors were responsive to their concerns about barriers to implementing the EBPs with fidelity (such as the lack of session space or needed supplies for the EBP). Similarly, once an issue (such as increasing referrals, increasing participant incentives, and creating a more flexible and safe work environment for staff) was brought to organization directors and RPG project directors, staff reported that these leaders made every effort to respond to the problems. The 40 percent of frontline staff who reported receiving technical guidance on the EBP delivery structure, dosage, and timing of services, said such guidance also came from their supervisors.

Frontline staff did not have the same open communication with the leadership of their organizations or the overall RPG project. Very few frontline staff (less than 10 percent) said their agencies had an open-door policy where they could express concerns directly to organization and project leaders. Instead, organization directors and RPG project directors sought feedback from frontline staff through managers and supervisors. Consistent with this

approach to soliciting feedback, frontline staff mainly heard about policy changes from their own managers and supervisors rather than directly from leaders who made such decisions. Frontline staff noted, however, that changes in the organization's or agency's policies were only communicated to them on a need-to-know basis, and usually communicated to staff after a policy was changed rather than discussing possible changes in advance.

E. Context: Implementation barriers

By April 2016, RPG2 grantees had enrolled 8,298 people in their programs, 57 percent of them children. Although the RPG2 partnerships had many of the implementation drivers in place to support their provision of EBPs to these participants, they experienced other types of challenges implementing their projects—including reaching enrollment goals. The grantees reported challenges related to: (1) obtaining referrals, (2) enrolling participants, (3) retaining participants in EBPs and program services, and (4) recruiting and retaining project staff.

Grantees received fewer referrals than expected. As of April 2016, all RPG2 grantees had been enrolling participants for at least two years. However, nearly all grantees struggled with the preliminary step to enrollment—obtaining referrals of potential clients. Fourteen of the 17 RPG2 grantees reported such recruitment problems.

- **Limited referrals from child welfare.** The most common challenge, cited by nine RPG grantees, was limited referrals from child welfare. Even child welfare agency grantees were not immune to this challenge. Three of the four child welfare agency grantees encountered difficulties securing referrals. Grantees attributed the limited referrals from child welfare to a number of issues, including staffing constraints at child welfare agencies and concerns among child welfare staff about the services offered through RPG and the capacity and sustainability of RPG services.
- **Policy changes.** Five RPG2 grantees reported that policy changes within the child welfare system affected anticipated referrals. For two grantees, child welfare policies limited the pool of potential participants for the project. For example, in one state, the grantee—a family drug court—could not enroll families unless the welfare agency opened a formal court case, which child welfare policy did not require under all circumstances. Thus, the grantee could only serve a subset of the child welfare population. In another state, child welfare policy began to focus on improving the timeliness of permanency determinations. The grantee explained that this shift resulted in a reluctance by child welfare caseworkers to refer clients to a lengthy residential substance use disorder treatment program.
- **Ineligible referrals.** Five RPG2 grantees also reported receiving many referrals for clients that did not meet the criteria set by the grantee for the RPG project. Staff turnover within the child welfare or other referring agencies exacerbated the problem of inappropriate referrals because new staff were not familiar with the grantee's stated eligibility criteria. Some referrals did not meet the eligibility criteria because the universal screening tool being used by community partners was not identifying clients with eligible risk factors, such as low education levels, being a single-parent household, or adult depression.

Once referrals were received, converting those referrals into enrolled participants proved another challenge for grantees. Eleven RPG2 grantees reported difficulty getting potential clients to enroll in RPG. Factors included competing demands on the potential participant's time, or their lack of readiness for services, difficulty engaging biological parents or other family members, and participant's concerns about the potential implications of participation in RPG on their open legal and child welfare cases. Grantees also had difficulties locating potential participants referred to them.

More than two-thirds of RPG2 grantees reported struggling to maintain clients' ongoing participation. Clients failed to engage in services or dropped out before completion for various reasons, including alcohol or drug relapse, termination of parental rights, and lack of stable housing. Additional examples of barriers to retention mentioned by grantees included transportation issues and differing perspectives on clients' progress. In some cases, child welfare caseworkers or probation officers decided that the clients had met their treatment obligation before the client's enrollment in RPG was scheduled to end. In most cases, clients withdrew from RPG once they no longer had an obligation to participate.

Some RPG2 grantees had trouble finding and retaining qualified staff to deliver EBPs. Grantees mostly attributed these challenges to low compensation, the demanding workload of the job, or a shortage of candidates able to meet education or licensing credentials for open positions. Staffing challenges often exacerbated enrollment and retention challenges. For example, grantees operated below enrollment capacity when positions were unfilled, needed time to rebuild rapport with clients when the staff delivering the EBPs changed, and used scarce resources to train new staff.

F. RPG3 cases, children, and adults at early enrollment

In September 2014, HHS funded four additional RPG projects in a third round of grants, referred to in this report as RPG3. The target populations of the four RPG3 grantees varied:

- **Our Kids of Miami-Dade/Monroe Inc.** (Florida) served families with children aged 0 to 11 who were at risk for maltreatment and had a relative with either a suspected or verified substance use disorder.
- **The University of Kansas Center for Research** (Kansas) served families that included a parent with a substance use disorder and a child aged 0 to 3—with a focus on children in foster care or identified as at risk of removal.
- **Montefiore Medical Center** (New York) served families that included a parent with a substance use disorder and children at risk for removal due to abuse and/or neglect.
- **Volunteers of America** (Oregon) served parents in recovery from substance use disorders who were either engaged with or at risk of engagement with child welfare. They emphasized working with African American parents and families.

The cross-site evaluation examined the status of RPG3 adults and children at this early stage of implementation, using a small sample of early enrollees. These data show that RPG3 grantees were indeed enrolling the at-risk populations intended by the RPG program.

Children. RPG3 grantees enrolled cases that included young children (under five years old), a significant portion of whom were at risk of or who had already been removed from their homes. Over half of focal children from RPG3 grantees experienced removals in the year prior to RPG programming, and many had substantiated or unsubstantiated records of abuse or neglect in the same year.

Adults. Adults in the early enrollment sample experienced high levels of financial and emotional strain, which can also affect their children's well-being. Most biological parents were single and had annual incomes below $10,000, and about half reported being unemployed. Above and beyond economic hardship, RPG3 adults expressed more severe symptoms of depression and parenting stress, on average, than nationally representative samples, and many also expressed some attitudes about parenting that placed their children at risk for future maltreatment. RPG3 adults had higher levels of substance use on average than in the general population. Although they had lower levels of substance use when compared instead to a national sample of adults in substance use disorder treatment settings, many reported that they had recently used substances, and many had been in a publicly funded treatment program for substance use in the year prior to RPG enrollment. Together, these findings suggest that RPG3 grantees initially enrolled populations in need of a range of supports for both children and adults to improve children's safety, permanency, and well-being.

G. The fifth report to Congress

HHS will produce one final report on the RPG2 grantees. The five-year period for the 2012 RPG grants comes to a close in September, 2017. At that point, the cross-site evaluation team will develop a report using data collected throughout the evaluation to examine outcomes of the RPG program. The fifth report to Congress will address the following:

- Whether grantees served their intended target populations
- Whether the services that grantees provided aligned with the services they intended to provide
- Whether participants outcomes improved over time

These findings will address the required research questions in the re-authorizing legislation about whether grantees' met their goals and successfully addressed families' needs. Thus, this report will present a targeted set of findings about RPG, intended to communicate key takeaways about grantee performance and whether and how outcomes were achieved.

Separate future reports will also describe implementation and outcomes for the RPG3 cohort of grantees.

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I. INTRODUCTION

In October 2016, the Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services (HHS) released data showing that the number of children in foster care, after declining for seven years, had increased for the third consecutive year (HHS, 2016a). Over that time (2012 to 2015), the percentage of child removals where parental substance use was cited as a contributing factor increased 13 percent—the largest percentage increase compared to any other circumstance around removal. Recent increases in the misuse of opioids may be causing or contributing to this increase in substance-use related removals. Over a similar time period, heroin use has more than doubled among young adults ages 18 to 25, many of whom are parents (Centers for Disease Control and Prevention, 2015). Data from the National Survey on Drug Use and Health, administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) show a significant increase between 2002 and 2016 in the numbers of persons who misuse prescription drugs, new users of heroin, and persons with heroin dependence (SAMHSA, 2017).

Although a number of studies have found that many, if not most, child welfare cases involve a parent with a substance use disorder (see, for example, Niccols et al., 2012; Osterling & Austin, 2008), estimates vary widely, and national estimates of the percentage of cases in which opioid use is a factor are not available (Seay, 2015). Some states, however, have issued their own reports. For example, Vermont reported that opioid use is a factor in 80 percent of cases in which a child younger than age 3 was taken into child welfare custody (State of Vermont, 2015). Similarly, Ohio reported that 70 percent of infants in child protection custody are in care due to their parents' addiction to opioids (Public Children Services Association of Ohio, 2016).

A. The Regional Partnership Grant (RPG) Program

Although the opioid crisis is an emerging phenomenon, concerns about the effect of parental substance misuse on child welfare is not new. Since 2006, Congress has authorized HHS to make competitive Regional Partnership Grants (RPG) to support partnerships between child welfare agencies and organizations in substance use disorder treatment and other social service systems 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.

- **First round of grants (RPG1).** The Child and Family Services Improvement Act of 2006 (Public Law 109-288) authorized and appropriated $145 million over five years for the first round of RPG funding. HHS made three- to five-year grants to 53 partnerships in 29 states. To monitor program outcomes as required in the legislation, HHS established performance indicators for the first round of grants that reflected the broad goals of the legislation and aligned with the diverse activities of the 53 regional partnerships. Each partnership was led by an organization that received the grant and led the partnership and its project, and reported on the performance indicators that were most relevant to their specific partnership goals and target populations. In 2012, HHS also offered existing grantees new grants of $500,000 per year for up to two years (Administration for Children and Families 2012b) to extend their programs. To support grantees in achieving their program and performance goals, HHS provided technical assistance (TA) to grantees through a federal contract. These

grants have ended and are described in three earlier reports to Congress (HHS, 2012a, 2013a, and 2014a).

- **Second round of grants (RPG2).** The Child and Family Services Improvement and Innovation Act of 2011 (Public Law 112-34) reauthorized the RPG program and appropriated $100 million of funding for new grants. In September 2012, HHS awarded new grants to 17 organizations in 15 states (Table I.1). HHS contracted with Mathematica Policy Research to design and conduct a national cross-site evaluation reflecting the goals of the legislation and assessing program effectiveness. Mathematica also provides TA to support grantees' submission of common data elements to the cross-site evaluation and to help grantees conduct their own required local evaluations. As part of its contract to manage the National Center for Substance Abuse and Child Welfare (NCSACW), supported through an intra-agency agreement between SAMHSA and the Administration on Children, Youth & Families, the Center for Children and Family Futures provides program-related TA to the grantees.
- **Third round of grants (RPG3).** In September 2014, HHS awarded another round of five-year grants to four organizations in four states (Table I.1). As in RPG2, these new grantees also participate in the cross-site evaluation and conduct local evaluations. They receive similar evaluation- and program-related TA.

RPG2 and RPG3 grants ranged from $500,000 to $1 million annually, with increasing percentages of required grantee matching funds. Eleven of the 21 grantees had received RPG1 funding; the other 10 were new to the RPG program. Grantees are mainly state agencies or local service providers:

- Six grantees are state agencies. Four of these are state child welfare agencies or agencies responsible for administering the Substance Abuse Prevention and Treatment Block Grant (hereafter referred to as state substance use services agencies). In one state, the state child welfare and substance use services agency jointly received the grant. The sixth state-level grantee is a state judicial branch.
- One grantee is a county child welfare agency.
- Ten grantees are local organizations that provide services to individuals and families. Three are substance use disorder treatment providers, two are health or mental health service providers, and five provide child welfare or other child and family services.
- Two grantees are hospitals that provide substance use disorder treatment and related services.
- Two grantees are universities.

The grants were intended to improve collaboration between the substance use disorder treatment and child welfare systems. To do so, they required partnerships between these two systems and other related agencies. Partnerships took different approaches to service provision; some provided a focused suite of services to all participants; others offered a range of customized services depending on each family's needs. Services provided by the partnerships included case management, residential and outpatient substance use disorder treatment, parenting and/or family strengthening programs, treatment for trauma or mental health problems, family drug treatment

courts, counseling and peer support groups, health care, housing support, employment services, and child development services.

Table I.1. Grantees and the geographic areas and congressional districts they serve

Grantee	Geographic area	Congressional district
2012 (RPG2)		
Center Point, Inc.	Located in San Rafael, CA. Serving Alameda, Contra Costa, Marin, San Francisco, and Sonoma counties	CA-2, 5, 11,12, 13
Georgia State University Research Foundation, Inc.	Located in and serving DeKalb County and Atlanta, GA	GA-4, 5, 6
Judicial Branch, State of Iowa	Located in Des Moines, IA, and serving Wapello County	IA-2, 3
Northwest Iowa Mental Health/Seasons Center	Located in Spencer, IA, and serving Buena Vista, Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola, Palo Alto, and Sioux counties	IA-4
Children's Research Triangle	Located in Chicago, IL, and serving the Tri-county Chicagoland region of Cook, Will, and Kankakee counties	IL-1, 2, 3, 7
Kentucky Department for Community Based Services	Located in Frankfort, KY, and serving Daviess County	KY-2
Commonwealth of Massachusetts	Located in Boston, MA, and serving Fall River and New Bedford	MA-4, 8, 9
Families and Children Together	Located in Bangor, ME, and serving Penobscot and Piscataquis counties	ME-2
Preferred Family Healthcare	Located in Springfield, MO, and serving Greene, Barry, Lawrence, and Stone counties	MO-7
The Center for Children and Families	Located in Billings, MT, and serving all Montana counties	MT-1
Nevada Division of Child and Family Services	Located in Carson City (agency) and Clark County (grant site), NV, and serving Las Vegas	NV-1, 2
Summit County Children Services	Located in Akron, OH, and serving Summit County	OH-11, 13, 14, 16
Oklahoma Department of Mental Health and Substance Abuse Services	Located in Oklahoma City, OK, and serving all Oklahoma counties	OK-1, 2, 3, 4, 5
Health Federation of Philadelphia, Inc.	Located in and serving Philadelphia, PA	PA-1, 2
Helen Ross McNabb Center	Located in Knoxville, TN, and serving three Tennessee Department of Children's Services regional catchment areas: Knox, East Tennessee, and Smoky Mountain	TN-1, 2, 3
Tennessee Department of Mental Health and Substance Abuse Services	Located in Nashville, TN, and serving Bedford, Cannon, Coffee, Davidson, Marshall, Maury, Rutherford, and Warren counties	TN-4, 5, 6
Sentara RMH Community Health	Located in Harrisonburg, VA, and serving Harrisonburg, Staunton, and Waynesboro and Bath, Highland, Page, Rockingham, and Shenandoah counties	VA-6
2014 (RPG3)		
Our Kids of Miami-Dade/Monroe, Inc.	Located in Miami, FL, and serving Miami-Dade County	FL-27
University of Kansas Center for Research, Inc./School of Social Welfare	Located in Lawrence, KS, and serving all Kansas counties	KS-1, 2, 3, 4
Montefiore Medical Center	Located in the Bronx, NY, and serving Bronx Borough	NY-15
Volunteers of America Oregon	Located in Portland, OR, and serving Multnomah County	OR-3

Between October 2012 and April 2016, the RPG grantees enrolled nearly 8,700 adults and children (Table I.2). Enrollment grew by 69 percent from April 2015 to April 2016, due to both increasing enrollment in RPG2 projects and the addition of the RPG3 grantees that were funded in late September 2014 and began enrollment in May 2015. Total enrollment in RPG projects ranged from 11 people (Montefiore Medical Center, New York) to 1,621 people (Tennessee Department of Mental Health and Substance Abuse Services). All grantees enrolled adults and children, but in different proportions. By 2016, just 10 percent of Georgia State University Research Foundation enrollees were children, while 82 percent of those enrolled by Children's Research Triangle were children.

Table I.2. Cumulative enrollment in RPG, by grantee

Grantee and state	Reported in April 2015		Reported in April 2016	
	Total adults and children enrolled	Percentage of total enrollment who are children	Total adults and children enrolled	Percentage of total enrollment who are children
RPG2 Grantees				
Center Point, California	170	54	215	55
Georgia State University Research Foundation	58	5	71	10
Judicial Branch, State of Iowa	146	62	315	60
Northwest Iowa Mental Health Center/Seasons Center[a]	36	53	73	51
Children's Research Triangle, Illinois	244	82	279	82
Kentucky Department for Community Based Services	131	37	290	54
Commonwealth of Massachusetts	316	62	490	37
Families and Children Together, Maine	541	55	749	54
Alternative Opportunities, Missouri	670	67	882	65
The Center for Children and Families, Montana	120	65	190	66
State of Nevada Division of Child and Family Services	124	35	200	44
Summit County Children Services, Ohio	593	53	978	51
Oklahoma Department of Mental Health and Substance Abuse Services	158	48	595	65
Health Federation of Philadelphia	44	50	130	48
Helen Ross McNabb Center, Tennessee	1,130	63	660	52
Tennessee Department of Mental Health and Substance Abuse Services	368	52	1621	62
Sentara RMH Community Health formerly Rockingham Memorial Hospital), Virginia	308	60	560	55
RPG3 Grantees				
Our Kids of Miami-Dade, Florida	n.a.	n.a.	90	68
University of Kansas Center for Research	n.a.	n.a.	179	47
Montefiore Medical Center, New York[b]	n.a.	n.a.	11	NA
Volunteers of America Oregon[b]	n.a.	n.a.	117	NA
Total	**5,157**	**59**	**8,695**	**56**

Source: April 2016 RPG semiannual progress reports filed by grantees.
[a] Although families participate in treatment with their children, Seasons Center's focus is primarily on the outcomes and well-being of the child. Therefore, they initially counted all program enrollment on the basis of the number of children enrolled in their services. In 2015 they reported total enrollment in the RPG cross-site evaluation rather than cumulative enrollment from commencement of RPG services.
[b] These grantees track enrollment only by adult.
NA = not available.
n.a. = not applicable (these grantees have not yet begun enrollment).

B. The cross-site evaluation

HHS developed a conceptual framework to guide the design of the cross-site evaluation of the RPG program. The framework illustrates how the RPG partnerships would implement and support their programs and services. It connects implementation inputs and outputs to the desired RPG outcomes, as shown in Figure I.1.

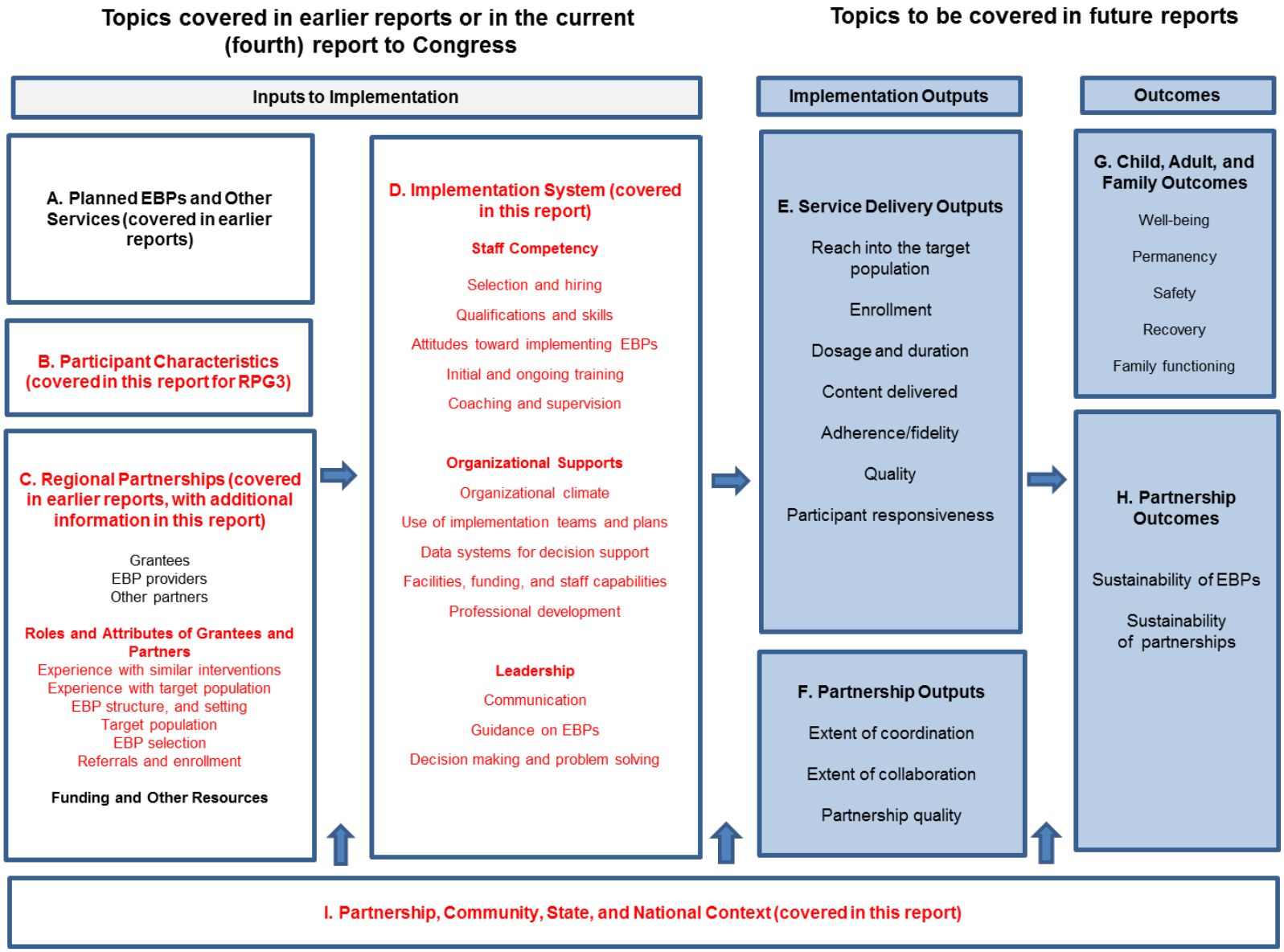
Inputs. Inputs to implementation, shown in the first two columns of Figure I.1, are the partnerships' resources, participants, and activities. Along with RPG grants and other funding, they include the services grantees planned to implement (box A), the characteristics of participants that enroll in RPG projects (box B), members of the regional partnerships and their attributes (box C), and the implementation systems (staff, their organizations, and organization leadership) developed to facilitate service delivery (box D). Partnerships combine these elements to produce outputs.

Outputs. Outputs, shown in the third column of Figure I.1, are the direct products of program activities. The two types of products of the RPG implementation system are service-delivery and partnership outputs. The service-delivery outputs (box E) are the services provided by the RPG projects—services designed to improve outcomes for children, adults, and families. Partnership outputs (box F) include coordination and collaboration among the grantee and its partners, as well as the partners' perceptions of partnership quality—factors that can help sustain RPG programs and the partnerships themselves after grant funding ends.

Outcomes. Outcomes, shown in the last column in Figure I.1, are the specific changes desired by programs. RPG aims to achieve outcomes for children, adults, and families enrolled by the partnerships (box G), as well as outcomes for the partnerships themselves (box H).

Context. Affecting every element in the conceptual framework are partnership, local, state, and national environments or factors. These are referred to as "context" and are shown in the bottom row of Figure I.1 (box I). The recent increase in opioid misuse is an example of one such factor. Other possible contextual factors include public policies, fiscal trends, and local community characteristics.

Figure I.1. RPG conceptual framework



Note: For unshaded boxes, items in red text are addressed in this report. Those in black text were addressed in earlier reports. Items in shaded boxes will be addressed in future reports.

C. Reports to Congress

The RPG cross-site evaluation collects data on each of the elements (boxes) in the conceptual framework, for RPG reports. Each year, HHS develops a report to Congress to describe the progress of the overall RPG program and the funded projects, using data from the cross-site evaluation. (For more detail, see Appendix A).

The first report to Congress (HHS, 2014b) described how HHS made the grants to the 17 partnerships, identified the grantees, and discussed their planned projects and first-year milestones achieved. It showed that:

- **Partnerships included required members.** Each partnership consisted of at least four and as many as 29 partner agencies, including child welfare agencies responsible for the administration of the state's plan under Title IV-B or IV-E of the Social Security Act.
- **RPG projects incorporated evidence-based and evidence-informed program and practice models (referred to in this report as EBPs).** Of 51 distinct program and practice models proposed by all RPGs combined, 37 had been reviewed by at least one of five evidence sources; seven others had been evaluated at least once, and of the seven remaining models, four were described by their developers as based on research or evidence. These evaluations included randomized, controlled trials, quasi-experimental designs, and/or descriptive methods only. Thus the level of evidence varied across the models, and some had not been evaluated among child welfare populations.
- **HHS successfully established a TA system.** HHS established an infrastructure to provide ongoing program- and evaluation-related TA to grantees through the National Center for Substance Abuse and Child Welfare (NCSACW) and Mathematica Policy Research, Inc., respectively.[8] Together, in the first year they received and responded to over 100 requests for TA.
- **Most grantees' initial evaluation designs met HHS goals for levels of evidence.** HHS reviewed the rigor of the designs grantees proposed to evaluate their projects. The review concluded that, if well-implemented, 12 local evaluations could offer strongest, promising, or limited evidence on program effectiveness. The other seven could not provide evidence of effectiveness, but did offer descriptive information, such as change over time.

The second report to Congress (HHS, 2015b) described the progress in the early implementation of the RPG2 projects. This report found:

- **By April 2014, 16 of the 17 grantees had begun enrollment.** The number enrolled at each site by then ranged from 35 to 700, for a total of 3,365 participants, 65 percent of them children. Nearly all grantees had obtained Institutional Review Board approval for their local evaluations, and 13 had begun enrolling families into the cross-site evaluation.
- **Not only their own efforts but also external factors affected grantees' progress implementing their RPG projects.** Fourteen grantees in 12 states described contextual

[8] The Center for Children and Family Futures, Inc. managed NCSACW, which is funded by ACYF and the Substance Abuse and Mental Health Services Administration.

factors that inhibited or spurred RPG implementation. The main external factors were related to child welfare, such as changes in child welfare practices that reduced referrals to RPG (11 grantees); (2) substance use, or policies affecting substance use disorder (SUD) treatment or individuals with SUDs (7 grantees); and (3) federal or state economic and fiscal conditions (7 grantees).

- **Grantees actively requested TA, including help to obtain needed administrative data.** Grantees submitted 77 requests for programmatic TA to NCSACW, and made another 69 inquiries for TA on evaluation-related topics through an RPG help desk operated by Mathematica. Numerous grantees asked for assistance obtaining administrative data (child welfare data on reports of maltreatment, episodes of removal, as well as adult enrollment in state-funded SUD treatment) they needed for their own evaluations and to submit to the cross-site evaluation.[9] While in most instances their requests for data were well-received, as of March 2014 five grantees still did not have agreements to obtain child welfare data, and nine did not have agreements for substance abuse treatment data.
- **HHS launched the cross-site evaluation.** HHS approved the final design of the cross-site evaluation, received OMB clearance for data collection, and completed two web-based systems for grantees to submit enrollment, services, baseline, and outcome data.

The third report to Congress (HHS, 2016b) updated the status of implementation, and provided an early description of the families being served by the RPG2 projects and the services they were receiving. It also introduced a new cohort of RPG grantees. Findings included:

Implementation was progressing despite challenges. During their third year of implementation, some projects faced challenges related to state level policy or fiscal changes, staff turnover in child welfare organizations, and difficulty meeting enrollment targets. However, projects also demonstrated creativity, innovation, and the use of best practices to meet such challenges.

As intended, RPG2 projects were serving at-risk children and adults—and had engaged them in a subset of planned EBPs. By April 2015, the 17 RPG2 grantees had enrolled a total of 5,517 participants, 59 percent of them children. As intended, RPG2 projects enrolled some children with documented maltreatment or other previous experience with the child welfare system. Of the 567 children in the sample for whom records were received, 31 percent had one or more substantiated episodes of maltreatment in the year prior to enrollment in RPG. At enrollment, 37 percent of the RPG2 adults in the cross-site evaluation sample exhibited high severity of substance use (either drug or alcohol or use of both) in the past 30 days. At least 20 percent of adult RPG2 participants had been in one or more publicly funded substance use disorder treatment programs during the year prior to their enrollment in RPG. In total, RPG2 grantees had enrolled participants in 19 different EBPs.

The current, fourth report to Congress has two goals. First, it completes the description of inputs to implementation (boxes C and D) for the RPG2 grantees and discusses their context (box I). This is the main focus of the report and is addressed in Chapters II, III, IV, and V. Second, the

[9] State agencies that provide public funds for SUD treatment, and collect SUD data for the national Treatment Episode Data Set.

report describes characteristics of RPG3 participants (box B), using data on those enrolled at an early stage of RPG3, in Chapter VI. The third report to Congress (HHS, 2016c) described these characteristics for RPG2 participants at a similar stage in their grants.

HHS will produce one final report on the RPG2 grantees. The five-year period for the 2012 RPG grants comes to a close in September, 2017. At that point, the cross-site evaluation team will develop a report using data collected throughout the evaluation to examine outcomes of the RPG program. The fifth report to Congress will address questions of performance and effectiveness set forth in the legislation. This final report will focus on answering the questions required by legislation. Broadly, it will address the following:

- Whether grantees served their intended target populations
- Whether the services that grantees provided aligned with the services they intended to provide
- Whether participants outcomes improved over time

These findings will address the required research questions in the legislation about whether grantees' met their goals and successfully addressed families' needs. Thus, this report will present a targeted set of findings about RPG, intended to communicate key takeaways about grantee performance and whether and how outcomes were achieved.

The remainder of this chapter describes how and why the cross-site evaluation used concepts from the field of implementation science to study the inputs to implementation (Section D). Section E identifies data sources used in the report and shows how the remainder of the report is organized.

D. Implementation science in the cross-site evaluation

According to the National Implementation Research Network (NIRN), implementation science is "the study of factors that influence the full and effective use of innovations in practice" (NIRN, n.d.).[10] After Congress reauthorized RPG in 2011, HHS required partnerships applying for grants to propose specific, well-defined program services 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 (HHS, n.d.). Evidence-informed practices use the best available research and practice knowledge to guide program design and implementation (HHS, 2011). The cross-site evaluation incorporated implementation science approaches to study this new emphasis on evidence in RPG. In particular, to study the inputs to implementation from boxes C and D of Figure I.1, which are discussed in this report, the evaluation examined (1) the quality of implementation of the EBPs grantees selected and (2) their contexts.

[10] NIRN studies implementation science, organizational change, and system change, to improve human services outcomes.

1. Quality implementation

Social programs, even ones that research shows to be effective, will fail their clients if they are never implemented as intended (Mead, 2016). Increasing the quality of implementation increases the chances that an EBP will achieve its intended outcomes. Many factors can affect the quality of implementation, including (1) the fit of the program within the provider organization; (2) buy-in from key stakeholders, including staff; (3) effective staff training; (4) use of an implementation plan; and (5) provision of TA, coaching, and supervision to staff (Durlak, 2013). To assess the quality of implementation inputs, the cross-site evaluation surveyed frontline staff at selected RPG EBPs and conducted site visits to interview RPG grantees, partners, and EBP frontline staff and program managers. *Frontline staff* are those who work directly with program participants, such as case workers, therapists, or group facilitators, and their supervisors. The survey and the site visit protocols incorporated measurement items and concepts developed through implementation science to assess the quality of implementation. Chapter III introduces these measures and implementation concepts.

2. Context

Wandersman et al. (2016) note that it is important to look not only at the quality of implementation, but also at interventions in the settings (context) in which they are implemented. In the conceptual framework shown in Figure I.1, the partnership, local, state, and national factors provide the context. A definition of *context* relevant to implementation science is the normal conditions into which interventions must be integrated if they are to be workable in practice (paraphrased from May, Johnson, and Finch, 2016). Implementation research examines contextual factors, such as changes in policy direction or organizational turbulence, that play out as both barriers and facilitators to interventions. To understand the context of the RPG projects—and especially to identify barriers the partnerships encountered—the cross-site evaluation analyzed data collected during site visits, and from progress reports submitted to HHS every six months by the grantees.

3. Limitations

One contribution of implementation research is to explain high and low performance in a program. That is, studying implementation helps explain how the program produces the effects it does or why it may fail to produce desired effects. Findings about implementation quality and the contexts in which the partnerships operated, described in this report, will be essential in understanding and interpreting outcome findings. Outcomes will be described in the next report to Congress. However, two limitations of the cross-site evaluation implementation study are important to keep in mind: the study's focus on a subset of RPG-offered EBPs, and the descriptive nature of the study.

The focus on a subset of EBPs. Grantees planned to offer clients an array of EBPs to address substance use disorders, child or adult trauma, parenting skills, and/or child-caregiver relationships. In all, grantees proposed over 50 distinct program and practice models they planned to include in their projects (for a list, see Strong et al., 2013). This was a larger number than the cross-site evaluation could study in depth without financial costs in excess of HHS's budget for the evaluation, and without imposing substantial data collection burdens on RPG

grantees, half of which offered four or more EBPs.[11] Therefore, the evaluation was designed to collect some data on participant enrollment in all EBPs but collect detailed data on a subset of 10 "focal" EBPs (Table I.3; every RPG grantee implemented at least 1 of the focal EBPs). Findings about the quality of EBP implementation presented in Chapters III and IV are based on this limited number of EBPs and may not represent progress made in all EBPs.

The descriptive nature of the implementation study. Although the cross-site evaluation implementation study measures elements of the implementation system—and might, in future reports, be able to link these measures to child, adult, and family outcomes—associations found between implementation system elements and outcomes cannot be interpreted as causal relationships. The next report to Congress, which will address outcomes, will discuss this limitation in more depth.

Table I.3. Focal EBPs

EBP	Description
Celebrating Families!	A parenting-skills curriculum and support group for families in which one or both parents have a serious problem with alcohol or other drugs and in which there is a high risk for domestic violence, child abuse, or neglect.
Nurturing Parenting Programs	Family-centered programs for the prevention and treatment of child abuse and neglect.
Strengthening Families Program	A parenting and family strengthening curriculum for high-risk and other families.
Seeking Safety	A manualized treatment for adolescents and adults with a history of trauma and substance abuse.
Trauma-Focused Cognitive Behavior Therapy	A clinic-based model of psychotherapy designed to treat post-traumatic stress and related emotional and behavioral problems in children and adolescents (ages 3–18).
Hazelden Living in Balance Programs	A manual-based comprehensive addiction treatment program designed for adults that emphasizes relapse prevention.
Matrix Model	An intensive outpatient treatment approach for stimulant abuse and dependence. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing.
Cognitive Behavior Therapy	A form of psychotherapy that emphasizes the important role of thinking in how we feel and what we do. It is not a distinct therapeutic technique, but rather a general term for a class of similar therapies that teach rational self-counseling skills.
Child-Parent Psychotherapy	Child and family therapy designed to help young children regain their sense of safety and attachment—and improve their cognitive, behavioral, and social functioning—after experiencing trauma, by strengthening the parent-child relationship.
Parent and Child Interactive Therapy	Targets families with children ages 3–6 with behavior and parent-child relationship problems. Therapists coach parents during interaction with their children to teach parenting skills.

Source: Strong et al., 2013.

[11] As of fall 2015, five partnerships were offering 10 or more EBPs. More information on the number of EBPs the partnerships selected is provided in Chapter II.

E. Data sources and organization of the report

The data sources referenced throughout the remainder of the report include the following:

- **Grantees' semiannual progress reports.** Federal discretionary grantees are required to report semiannually on their spending and progress during the project period of their grants. Their reports provide information on grantees' changes or planned adaptations of their projects, leadership engagement, successes, and challenges. This report uses semiannual progress reports RPG2 grantees submitted in October 2015 and April 2016, covering activities during the previous six months of the grant period.
- **Site visits.** To understand the design and implementation of the RPG projects, the cross-site evaluation team visited each of the 17 RPG2 grantees in fall 2015.[12] These site visits focused on the RPG planning process; how and why particular EBPs were selected; the ability of the child welfare, substance use disorder treatment, and other service systems to collaborate and support quality implementation of the focal EBPs; challenges experienced; and the potential for sustaining the collaborations and services after RPG funding ends. The site visits included interviews with 17 project directors and, in some sites, project coordinators or other key informants, for a total of 56 respondents. At each site, group interviews were conducted with partners involved in design and implementation of the RPG2 projects; 143 total respondents participated in the group interviews. The site visits also included interviews with supervisors, managers, and frontline staff of focal EBPs. In total, 50 supervisors and managers and 64 frontline staff from the 10 focal EBPs participated in interviews.
- **Survey data.** To examine their support for evidence-based programming, direct service staff who delivered the 10 focal EBPs to RPG2 participants were surveyed in spring 2015.[13] Between April and June 2015, staff who provided direct services to children, adults, and families—such as caseworkers, therapists, and session facilitators and their supervisors—participated in the survey. Ninety-nine staff members across focal EBPs in the 17 RPG2 projects responded to the survey, representing an 87 percent response rate.
- **Enrollment and services data.** To document participant characteristics and their enrollment in EBPs, all grantees provided data on enrollment of and services provided to RPG cases. These data include demographic information on case members, dates of entry into and exit from the RPG program and each EBP, and information on each service delivery contact for of the focal EBPs. This report only used enrollment and services data on participants enrolled in RPG3, from the program's inception through February 2016—a period of time the report characterizes as early enrollment. (Prior reports presented similar information on early enrollment in RPG2.)

[12] Site visits to RPG3 grantees will occur in fall 2018.

[13] The RPG3 staff survey is scheduled for spring 2017.

- **Outcome data.** To measure participant outcomes, all grantees use self-administered instruments collected from RPG adults. Standardized instruments are measures that are always administered, scored and interpreted the same way. These instruments undergo a robust development process and are tested extensively in the field. The standardized instruments used in RPG collected information on child well-being, adult and family functioning, and adult substance use. Grantees also obtained administrative data on a common set of child welfare and substance use disorder treatment data elements. This report only used data from standardized instruments administered at baseline, or program entry, to participants enrolled in RPG3 through March 2016. (Prior reports provided similar data on early enrollment in RPG2.)

The remainder of this report is organized as follows:

- As background context for the detailed discussion of implementation quality of the 10 focal EBPs, Chapter II discusses how the RPG2 projects were designed. It describes the grantees and their roles, and the structure of RPG projects, such as what EBPs partnerships proposed and how they were chosen, delivered, and in some cases modified as implementation progressed. It describes the reasons grantees and their partners gave for these choices.
- Building on the background information from Chapter II, the next two chapters focus on the quality of implementation by the RPG2 grantees of the 10 focal EBPs. After describing how the cross-site evaluation measured implementation quality using meaures and concepts from implementation science, Chapters III and IV describe the RPG2 grantees' progress implementing factors associated with quality implementation. Chapter III addresses staff competence as assessed by the cross-site evaluation. Chapter IV then examines two additional factors that influence implementation quality: (1) organizational supports available to staff and (2) program leadership.
- Chapter V returns to the topic of context. It describes challenges and barriers to implementation that affected (1) the RPG2 projects as a whole and (2) the quality of implementation of the focal EBPs. It also describes the TA grantees received to help them address barriers and plan for sustaining their partnerships and services after RPG2 funding ends in September 2017.
- Because HHS funded the RPG3 grantees two years after RPG2, implementation and evaluation of their projects are at an earlier stage than for RPG2. Chapter VI describes the characteristics of participants in RPG3 projects. It also provides baseline measures of child maltreatment, out-of-home placement, and well-being for RPG3 children at an early point in enrollment. It similarly describes RPG3 adult functioning. Future reports will provide additional evaluation findings about the RPG3 grantees.

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II. DESIGNING RPG ROUND TWO (RPG2) PROJECTS

RPG FOAs did not specify any particular program setting, EBPs, or package of services applicants had to include. Though HHS sought to expand the use of interventions whose effectiveness had been supported by research, grantees were not restricted to a particular approach or set of program or practice models. As a result, the proposed projects varied in many ways. Partnerships offered one or multiple EBPs. Some grantees provided psychosocial EBPs common in behavioral health, whereas others chose family support services; some partnerships combined both. Some provided substance use disorder treatment as part of their RPG project, and others worked with families after an adult completed treatment. Still others targeted adults not yet diagnosed with a substance use disorder and/or their children. This variety reflected the different decisions the grantees made when designing their RPG projects. Accordingly, the cross-site evaluation sought to describe how these choices were made. A key research question for the cross-site evaluation was, "How were the RPG projects structured, and what factors influenced these designs?"

This chapter explores the structure of the RPG2 projects and describes the information and processes the grantees used to design their projects. It discusses the characteristics and roles of the grantees. It also describes the number of EBPs offered and how they were delivered, the other services grantees provided, and the settings in which the EBPs and services were offered. Finally, the chapter examines how grantees selected their projects' target populations and EBPs, and the changes grantees made to the EBPs originally proposed. This contextual information is crucial to help readers understand the detailed analyses of EBP implementation quality and project challenges presented in Chapters III, IV, and V. The primary data for this chapter were obtained during site visits that collected information from interviews with grantees and their partners involved in the design and implementation of the RPG2 projects.[14]

A. Grantee characteristics and roles

Systems. The 17 RPG2 grantees represented organizations across both the substance use disorder treatment and child welfare systems at the state and local levels. HHS required each RPG grantee to include in its partnership the state child welfare agency responsible for the administration of the state's plan under Title IV-B or IV-E of the Social Security Act and at least one partner. In four of the partnerships, the grantee itself was a state or county child welfare agency. Six grantees were part of the substance use disorder treatment system, including three state substance use services agencies and three substance use disorder treatment providers.[15]

[14] Not all questions were answered by all interview respondents. In some cases the questions did not apply, and sometimes questions were not asked or answered due to time constraints. In this chapter, the findings are reported at the grantee level, where the number of total possible grantees reporting any finding is 17. Information about enrollment in EBPs was gathered from enrollment and services data grantees provided. Analysis of the site visit data was a multistep process, including writing interview notes, coding notes according to key research questions, and analyzing coded data to identify themes. Descriptive statistics were calculated from the enrollment and services data.

[15] One grant was awarded jointly to a state child welfare agency and a state substance use services agency. This partnership was included in both the state child welfare agency and state substance use services agency counts.

Levels. Seven grantees were state-level agencies and 10 were local service agencies. The local grantees were a county child welfare agency, three substance use disorder treatment providers, three health or mental health service providers, and three child welfare or family services providers. The state-level agencies were three child welfare agencies, three substance use services agencies, a judicial branch, and a state university.

Roles. The state-level and local grantees tended to play different roles in their projects: in general, the state agency grantees provided administrative oversight, contracting delivery of EBPs to other local organizations, whereas the local grantees implemented the EBPs themselves. However, one state child welfare agency administered the grant and provided one of the EBPs offered by the project, and one local grantee—a county child welfare agency—contracted delivery of EBPs to other organizations. Of the 10 grantees that provided EBPs, 6 provided all of the EBPs offered by their RPG projects, and the other 4 grantees delivered one or more EBPs themselves but had at least one partner who also delivered EBPs. In addition to providing oversight of its project, the state university grantee also led the local evaluation of the project. Table II.1 summarizes the grantees by agency level (state or local), type of grantee, and project role.

Table II.1. Number of grantees by agency level, type, and role

	State			Local		
	Child welfare agency	Substance use services agency	Other[a]	Child welfare or family services provider	Substance use disorder treatment provider	Health or mental health services provider
Oversight only	2	3	2	1[b]	0	0
Delivered EBPs	1	0	0	3	3	3
All EBPs	0	0	0	3	2	1
Some EBPs	1	0	0	0	1	2

Source: RPG site visits fall 2015.

Note: One grant was awarded jointly to a state child welfare agency and a state substance use services agency. This grantee was included in both the state child welfare agency and state substance use services agency counts.

[a]Includes a judicial branch and a state university. In addition to administrative oversight, the state university also conducted the local evaluation of the project.

[b]Represents a county child welfare agency.

B. Number of EBPs offered

A notable feature of the RPG program was its lack of a defined RPG program model. Through the RPG program, HHS sought to expand the use of interventions whose effectiveness had been supported by research, but grantees were not restricted to a particular approach or set of EBPs. Partnerships could propose any number and any type of EBP grantees demonstrated as appropriate for the RPG target population and having the potential to achieve RPG's target outcomes (HHS, 2012b). Thus, as required by the FOA, all grantees proposed at least one program or practice model it characterized as evidence-based (these grantee-selected programs or practices are herein referred to as EBPs). However, both the number and the types of EBPs offered varied across the partnerships. EBPs included those that address substance use disorders, trauma, parenting skills, and child-caregiver relationships.

Table II.2 displays the number of EBPs offered by RPG2 grantees as of fall 2015. Across the RPG2 grantees, the number of EBPs offered ranged from 1 to 13. Some grantees concentrated on providing one or two EBPs, whereas others offered an array of EBPs to meet multiple needs. Two grantees' projects offered a single EBP. The other 15 grantees offered more than 1 EBP, and 11 offered 3 or more EBPs.

Table II.2. Number of EBPs offered by RPG2 grantees, as of fall 2015

Grantee	Number of EBPs grantee offered
Preferred Family Healthcare, Missouri	13
Helen Ross McNabb Center, Tennessee	11
Center Point, Inc., California	10
Children's Research Triangle, Illinois	10
The Center for Children and Families, Montana	10[a]
Kentucky Department for Community Based Services	6
Northwest Iowa Mental Health/Seasons Center	5
Commonwealth of Massachusetts	5
Nevada Division of Child and Family Services	4
Sentara RMH Community Health, Virginia	4
Georgia State University Research Foundation, Inc.	3
Judicial Branch, State of Iowa	2
Summit County Children Services, Ohio	2
Oklahoma Department of Mental Health and Substance Abuse Services	2
Tennessee Department of Mental Health and Substance Abuse Services	2
Families and Children Together, Maine	1
Health Federation of Philadelphia, Inc., Pennsylvania	1

Source: RPG site visits fall 2015.

[a]The Center for Children and Families mentioned 10 additional auxiliary EBPs that may be offered to participants, for a total of 20.

By the end of March 2016, RPG2 grantees had enrolled participants in 35 distinct EBPs, and 1,225 of 1,476 RPG2 cases (77 percent) were enrolled in at least one of the following EBPs.[16,17] Across grantees, 1,011 cases (68 percent of all cases) had been enrolled in a focal EBP by March 31, 2016.

- 12-Step Facilitation Therapy
- Attachment, Self-Regulation, and Competence (ARC)
- Beyond Trauma
- Celebrating Families!
- Child and Adolescent Services System Program (CASSP)
- Child-Parent Psychotherapy (CPP)
- Cognitive Behavior Therapy (CBT)
- Dialetical Behavior Therapy
- Family Behavior Therapy
- Family Treatment Drug Court (FTDC)
- Hazelden Co-Occurring Disorders Program
- Hazelden Living Balance Programs
- Head Start
- Healthy Families
- Helping Men Recover
- Homebuilders Intensive Family Preservation Services
- Incredible Years Parenting Class
- Keys for Interactive Parenting (KIPS)
- Matrix Model program
- Modified Therapeutic Community (MTC)
- Motivational Interviewing
- Nurturing Parenting Programs (NPP)
- Parent and Child Interactive Therapy (PCIT)
- Parent Child Assistance Program (PCAP)
- Parents and Children Together (PACT)
- Parents as Teachers curriculum
- Partners in Parenting
- Peer Recovery Support Services
- SafeCare
- Seeking Safety
- Solution Focused Brief Therapy (SFBT)
- Strengthening Families
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Supportive Education for Children of Addicted Parents
- Trauma Focused Cognitive Behavior Therapy (TF-CBT)

[16] A case was considered to be enrolled in an EBP if at least one person in the case was enrolled in the EBP.

[17] Cases not enrolled in an EBP may have been receiving other RPG services or waiting for an open EBP slot or cycle to begin.

C. EBP delivery structure, other services, and setting

The grantees took various approaches to program delivery based on the number and type of EBPs offered. Some grantees concentrated on a single EBP provided to all participants. Other grantees provided access to multiple EBPs—either offering several EBPs in combination, with most or all cases receiving the same suite of EBPs, or offering a range of EBPs and providing a subset to each case based on case members' needs and progress. The grantees also differed in the type and quantity of other services offered and the settings in which the EBPs and services were delivered.

1. EBP delivery structure

Two of the 17 RPG2 grantees focused on a single EBP. For example, one grantee concentrated on filling a specific unmet need in the community. The grantee's target population was families with children in out-of-home placement. These families were already receiving a variety of reunification-focused services related to employment, life skills, and parenting through another agency. The grantee noted that the parent-child relationship was not a focus of any of the services provided. They proposed to fill this gap by offering RPG participants an EBP designed to strengthen and restore the parent-child relationship.

The 15 grantees offering multiple EBPs used one of three program delivery structures: (1) offering several EBPs in combination, with most or all cases receiving the same suite of EBPs; (2) offering a range of EBPs and providing a subset to each case based on participants' needs and progress; or (3) a mixed strategy offering the same set of EBPs to all participants and providing various other EBPs to select participants as needed.

- **Package of EBPs offered.** Seven grantees, including three residential substance use disorder treatment programs and three of the four intensive outpatient substance use disorder treatment programs,[18] identified a set of EBPs that all clients received. The RPG program was the same for all clients. One grantee offered each participant one of three packages based on whether they were receiving residential, intensive outpatient, or in-home substance use disorder treatment services.
- **Menu of EBPs offered.** Six grantees offered different combinations of EBPs to each client. One grantee noted that the families they served had varied and complex needs, making determinations about the appropriate EBPs for each family and the sequence of those EBPs a complicated decision-making process. The six grantees developed individualized treatment plans for clients based on their needs and selected appropriate EBPs from a menu of available EBPs. For example, one grantee used standardized instruments used to collect data for the cross-site evaluation to assess families' needs. A treatment team composed of the frontline staff member and management staff reviewed the results and developed a treatment plan that outlined the indicated EBPs and any additional services needed.

[18] Intensive outpatient substance use disorder treatment programs are characterized by an intensive schedule of treatment sessions, often multiple times a week (http://www.samhsa.gov/treatment/substance-use-disorders).

- **Mixed strategy.** Two grantees offered a combination of EBPs that all clients received, as well as EBPs based on a client's need. In one project, all clients participated in a parenting skills EBP and were offered additional EBPs based on their need and interest. Another grantee offered an intensive outpatient substance use disorder program in which all participants received the same core set of EBPs. Staff reviewed clients' needs regularly and recommended additional auxiliary EBPs and services, such as mental health counseling, as indicated by the client's treatment plan and progress.

2. Services offered

In addition to EBPs, grantees offered RPG clients other activities and services. All 17 of the grantees' projects offered case management services,[19] such as service coordination, help accessing benefits, and referrals for additional services. For example, one project provided case managers that helped clients without Medicaid to access substance use disorder treatment, educated clients on the child welfare system and helped them navigate it, and helped clients address barriers to accessing and engaging community resources.

Peer support, typically offered in addition to traditional case management, was the next most common service, included in five grantees' projects. For example, one grantee assigned mentors to each family. These mentors were individuals in long-term recovery from their substance use disorders who had personal experience with the child welfare system. The mentors served as role models, and also helped keep families engaged by advocating for their needs, driving them to treatment, and providing other services. The mentors worked closely with the family's social worker. Less frequently, grantees' projects offered employment services and short-term housing to clients. One of the three grantees offering employment services provided clients with job readiness training, such as instruction on how to complete applications, appropriate attire for interviews, and interviews tips. The project then supported clients through the job-search process. Two grantees offered short-term housing to clients.

3. Program setting

The EBPs and services were delivered in multiple settings both across and within grantee projects. The majority of grantees (10) reported that EBPs were delivered in community-based settings, such as the grantee's or implementing agency's office or a local community-based organization. Six grantees served clients in families' homes. Three provided residential substance use disorder treatment. In five projects, RPG EBPs and services were delivered in multiple settings. In one case, the setting varied by the type of activity, with case management services being offered through home visiting while a family-strengthening EBP was offered in a group community-based setting. In another, the service area dictated the setting. This grantee offered EBPs in community-based settings in the more urban area, and in families' homes in the rural areas.

[19] Some grantees offered evidence-based structured case management services.

D. Selecting the target population and EBPs

The RPG program was designed to focus on child well-being, and grantees were required to implement evidence-based or evidence-informed programs or practices, but grantees could choose a specific population to target and particular EBPs to offer. Grantees considered multiple factors when selecting the projects' focus and EBPs. Early implementation experiences resulted in changes to some grantees' EBP offerings.

1. Program focus and service area

The target population for the RPG program was children in or at risk of out-of-home placement due to a parent or caregiver's substance use disorder, but grantees had discretion to define their project focus and the geographic service areas. For example, grantees needed to decide whether to focus on (1) families with children at risk of out-of-home placement, children already in out-of-home placement, or both, and (2) within those families, to concentrate on individuals (either parents or children) or the entire family.

Grantees' decisions about their RPG project focus were influenced by a number of overlapping considerations, including the desire to provide more-comprehensive care by serving the family rather than just the parent or child, the results of a needs assessment, and partner suggestions. More than one-third of the grantees reported that when deciding upon the focus for the project, they determined that to best to meet the RPG program's goals related to child well-being, safety, and permanency outcomes, they would need to address the needs of the entire family rather than focus exclusively on the child or the parent. Seven RPG2 grantees had also received RPG1 grants; three of them shifted from serving individuals to serving families based on lessons learned through their experiences on the first grant. For example, one grantee worked exclusively with children during RPG1, and the frontline staff felt that the lack of services for the biological parents represented a gap in the program, so the grantee broadened the target population for RPG2 to encompass biological parents. Less commonly, grantees selected their focus based on an assessment of the needs of the populations their organizations were serving or based on requests from the state or local child welfare agency to serve a specific subgroup within the larger child welfare population.

In tandem with choosing a project focus, grantees also had to determine the geographic area they wanted to serve. Six of the seven grantees who also received RPG1 grants reported identifying new service areas to target for their RPG2 grant. Three of these grantees chose their service area based on an assessment of the number of families at risk of becoming or being already involved in the child welfare system. For two grantees, the location of new partners dictated where the RPG services were provided. The sixth grantee provided services to rural counties during RPG1. After receiving an RPG2 grant, the partnership expanded the service area to urban areas to be inclusive of the variety of settings in the state.

In addition to selecting a new service area based on an assessment of the number of potential participants there, one grantee's experiences with RPG1 guided the service area selection for RPG2. The grantee leadership reported that they never achieved full implementation of their RPG1 project because they had to invest significant resources to build the infrastructure to support service delivery—such as developing referral sources, building support for RPG, and finding program locations. Thus, for RPG2, the grantee first thoroughly assessed an area's local

resources, including the presence of local service providers, to ensure that the area had an existing infrastructure on which to build the RPG project. The grantee also gauged the commitment of the community, partners, and service providers to work on behalf of the RPG target population.

2. Selecting EBPs

Multiple factors went into each grantee's decision-making process when choosing its project's EBPs. Most grantees selected EBPs based on their and their partners' experience delivering EBPs, whereas others engaged in a thorough research and vetting process. For some grantees, the selection process differed by EBP. For example, some may have chosen a trauma-focused EBP because a partner was providing it, but when selecting a family-strengthening EBP, they researched various options. Table II.3 summarizes the factors grantees considered when selecting EBPs. Grantees based their decisions on factors such as lessons learned from RPG1 or their assessment of the evidence base for the model, with the most common deciding factor being the model's prior use by the grantee or a partner.

- **Already in place.** Almost two-thirds of grantees reported that they selected EBPs that they or a key partner was already implementing. One grantee noted that it proposed using an existing EBP because the frontline staff liked the model, and the grantee wanted to use a model that seemed to be working well. Another grantee that was not involved in direct service delivery reported feeling that it was important to use EBPs for which there were already experienced providers in the area.
- **RPG1 experiences.** Nine grantees reported that they chose EBPs based on their own or others' RPG1 experiences. In the process of assessing RPG1 project outcomes, one grantee noted that clients' substance use disorder outcomes improved with treatment, and child welfare outcomes improved through child welfare–related services, but the grantee did not have an EBP that specifically addressed the intersection of substance use disorders and child abuse and neglect. Thus, the grantee selected a family-strengthening EBP with a focus on addressing issues related to substance use disorders. Another grantee reported that its local evaluation of RPG1 revealed that the project was achieving better outcomes for mothers than fathers. Therefore, the team decided to also offer an EBP designed specifically for fathers.
- **Evidence of effectiveness.** Eight grantees reported examining the evaluation evidence base of a model, the model's use with the grantee's target population, and the targeted outcomes. Five of these grantees specifically noted that they used systemic evidence reviews, to assess the EBPs being considered. Two of these grantees also reported contacting the developers of EBPs they were considering, to gather additional information.
- **Partner recommendation.** Seven grantees cited recommendations from partners as the basis for the selection of some EBPs. In four projects, the grantee's local evaluator recommended an EBP. State child welfare and state substance use services agencies requested that two grantees include specific EBPs in their RPG projects. In another project, a partner had stressed the importance of providing comprehensive services by offering mental health counseling services through an EBP in addition to substance use disorder treatment.

Table II.3. Factors grantees considered when selecting EBPs

Selection factors	Number of grantees
Prior use by the grantee or a partner	11
RPG1 experiences	9
Evidence of effectiveness	8
Partner recommendation	7
Needs assessment	6
Familiarity	6
Other	2

Source: RPG site visits, fall 2015.

Note: Grantees reported multiple factors when asked why and how they chose their set of EBPs.

3. Changes to EBPs

Despite the careful process RPG2 grantees used to design their projects and select their EBPs, more than two-thirds of grantees made changes (with HHS permission) to the EBPs they originally proposed offering. Changes included dropping, adding, or replacing EBPs.

- **Dropping EBPs.** Grantees typically cited multiple reasons for dropping an EBP they had planned to provide or had begun providing. One of the most common reasons reported for eliminating an EBP, mentioned by four grantees, was that the EBP required too many sessions to complete. For example, one grantee originally offered two EBPs sequentially but decided to eliminate one because the time commitment to complete both EBPs was a burden for families. Four grantees also reported eliminating an EBP because it required a substantial investment of grantee resources. For example, they eliminated some EBPs because they were too costly to purchase,[20] were burdensome for staff because the sessions were offered in the evenings, or involved an intensive training process that was not sustainable due to staff turnover. Other reasons stated for dropping EBPs were that some were inappropriate for the population enrolling in RPG and some duplicated existing services.
- **Adding EBPs.** Of the EBPs added to grantees' RPG projects, most were added to replace an EBP that was not working well within the context of the RPG projects. The new EBPs were similar to the dropped EBPs, but grantees believed they were better suited to address the particular needs of their clients. In selecting replacement EBPs, grantees chose EBPs that addressed the challenge presented by the original EBP they implemented. For example, grantees replaced more-intensive EBPs with ones that involved fewer sessions or were less burdensome for families. Grantees who increased the number of EBPs they offered explained that they did so to address an identified gap in services needed by their clients.

[20] EBP developers often license their EBPs or require payments for certification of staff, training, manuals, or other materials.

Table II.4 summarizes the changes grantees made to the list of EBPs they originally proposed. Ten grantees reported dropping an EBP at some point during the first 3 years of the grant, and 10 reported adding an EBP. Eight of the 10 grantees who dropped an EBP, replaced it with another EBP. In addition to the grantees who added EBPs to replace dropped EBPs, three grantees increased the total number of EBPs offered.

Table II.4. Changes grantees made to originally proposed list of EBPs

Change	Number of grantees
Dropped an EBP	10
Added an EBP	10
Replaced dropped EBP with another EBP	8

Source: RPG site visits fall 2015.

Note: Some grantees reported multiple changes to their list of proposed EBPs. For example, a grantee may have dropped two EBPs but only replaced one of the dropped EBPs. The count of grantees that replaced a dropped EBP with another EBP is a subset of the previous counts.

E. Participant referral sources

Only three grantees—all child welfare agencies—served their own clients through their RPG projects. The other 14 grantees, including the other child welfare agency, relied on partners to refer clients to RPG. Across all grantees, eight partnered with a single source for RPG referrals and nine grantees reported multiple referral sources. Table II.5 displays the number of grantees relying on various sources of referrals for the RPG projects. All but one grantee received referrals from child welfare agencies; that grantee received all its referrals from a drug court. Most grantees who indicated multiple sources of referrals reported receiving the bulk of their referrals from child welfare agencies, but grantees also reported receiving referrals from probation offices and the courts; health care clinics and public health agencies; self or family referrals; and less frequently from schools, home visiting programs, and social service agencies.

Table II.5. Referrals sources for the RPG2 projects

Referral source	Number of grantees
Child welfare agency	16
Probation offices and courts	8
Health care clinics and public health agencies	4
Self or family	3
Other[a]	3

Source: RPG2 site visits fall 2015.

Note: The count of grantees reporting each referral source does not equal 17 because 9 grantees reported relying on more than one source for referrals.

[a]Includes schools, social service organizations, and home visiting programs.

III. BUILDING CAPACITY TO IMPLEMENT EBPS

After Congress reauthorized RPG in 2011, HHS requested partnerships applying for grants to propose specific, well-defined program services and activities that were *evidence based* or *evidence informed*. This request was consistent with many social science fields that are focusing on identifying and delivering practices that are supported by strong scientific research and active integration of research evidence into day-to-day service provision (Crayton, Wilson, & Walsh, 2012)—although HHS did not set specific evidence standards for partnerships to use in selecting EBPs or for grant reviewers to use in assessing RPG applications. In addition to RPG, HHS funds numerous efforts to identify and help grantees and providers find and select EBPs in child welfare and behavioral health interventions.[21] Two important goals of the RPG cross-site evaluation were (1) adding to the evidence base on what works for RPG target populations by examining outcomes and (2) building understanding of how to effectively implement evidence-based approaches through RPG or similar efforts.

Implementation is the set of activities required to put an EBP into practice in a way that consistently brings about the intended outcomes the EBP was designed to produce (Metz, Blase, & Bowie, 2007). High-quality implementation prepares staff to deliver a program through the following:

- Teaching staff the curriculum, and skills needed to connect with participants
- Monitoring staff performance and providing staff with feedback and ongoing training
- Establishing organizational structures and resources that staff need to deliver the EBP
- Aligning the mission and values of the organization with the EBP
- Having leadership to guide the organization as it puts the EBP into practice (Metz, Blase, & Bowie, 2007)

High-quality implementation reduces differences between how an EBP was intended to be delivered and how staff ultimately deliver it. High-quality implementation is important because it helps ensure fidelity.[22] Conversely, poorly implemented EBPs might not produce the desired outcomes of the policy or program because the positive outcomes that EBPs are supposed to produce require adherence to the EBP's model. Therefore, looking at how providers implemented a model is important for understanding their capacity to deliver EBPs in ways that achieve the intended outcomes consistently.

[21] For example, the Children's Bureau funds the National Child Welfare Workforce Institute to identify and disseminate information regarding EBPs relevant to child welfare work force development and leadership. SAHMSA funds the National Registry of Evidence-Based Programs and Practices, an evidence-based repository and review system designed to provide the public with reliable information on mental health and substance abuse interventions (see http://nrepp.samhsa.gov).

[22] To implement an EBP with fidelity means to implement all components of the program or practice in a manner that adheres to its intended content or approach or principles. The cross-site evaluation will assess fidelity of implementation of the focal EBPs in future reports.

Two data sources were used in Chapter III: site visits and a staff survey.[23] This chapter begins by outlining how the cross-site evaluation used a particular framework from the implementation science literature (the NIRN Implementation Drivers Framework) to assess the implementation of focal EBPs by the RPG partnerships. It provides results of an overall assessment of implementation quality. The remainder of the chapter then takes a detailed look at individual factors that affect the *competency of staff* to deliver EBPs—one of three aspects of the Implementation Drivers Framework. The next chapter (Chapter IV) uses data from the same sources to discuss the remaining two aspects of the framework by describing the providers' *organizational structures* to support EBP delivery, and how *leadership* (people who supervised and managed frontline staff providing the focal EBPs, and organization managers or RPG project directors), guided staff as they put the focal EBPs into practice.

A. Implementation framework

The cross-site evaluation aimed to document what EBPs grantees selected (Strong et al., 2013) and grantees' capacity to deliver these models. To do so, the cross-site evaluation collected in-depth data on the ten 10 focal EBPs during the site visits and in a survey of staff members providing those EBPs on factors shown in the research literature to be associated with quality implementation of evidence-based models (Fixsen et al., 2005; Meyers, Durlak, & Wandersman, 2012). Specifically, the cross-site evaluation examined the capacity of providers to deliver their focal EBPs with fidelity through practices thought to ensure or "drive" effective evidence-based interventions, as identified by NIRN (Fixsen et al., 2013). A description of the methods used to conduct these analyses is in Appendix B.

1. The implementation drivers

NIRN's implementation drivers are best practices that are thought to be required to successfully implement EBPs in ways that follow the developer's model to consistently achieve the intended outcomes the EBP was designed to produce. The drivers are interrelated processes that complement one another to bring about high-quality implementation of EBPs (Fixsen et al. 2010). The best practices fall under three categories: staff competency, organizational supports, and leadership (Fixsen et al., 2009; Metz, Blase, & Bowie, 2007):

- **Staff competency** comprises appropriate staff selection and hiring, training, and coaching processes that build the capacity of staff to deliver the intervention with fidelity.
- **Organizational supports** are structures and systems that create an environment conducive to the successful delivery of EBPs. These include having a data system (for example, a management information system) to support decision making through tracking delivery and outcomes, and providing an administrative infrastructure (such as using written plans to guide work) to ensure that frontline staff have adequate time, skills, funding, and other resources needed to deliver an EBP.

[23] Site visits made to each of the 17 RPG2 grantees in fall 2015 included interviews with EBP managers and supervisors (50 respondents) and with therapists, facilitators, group leaders, and other staff who provide services directly to participants—referred to in this report as *frontline staff* (64 respondents). The staff survey collected data from 99 EBP staff from the provider agencies for the RPG2 grantees. The staff survey asked for detailed descriptive information on staff characteristics and information about staff training and supervision.

- **Leadership** involves guiding staff and identifying and solving barriers to service delivery.

2. RPG progress in establishing the implementation drivers

As measured by the NIRN implementation drivers, by fall 2015 the providers of focal EBPs for RPG2 grantees had in place the overall capacity to deliver the focal EBPs—with some variation.[24] As displayed in Table III.1, focal EBP providers from all 17 RPG2 grantees had the 3 types of drivers—staff competency, organizational supports, and leadership—either in place (meaning the majority of the staff during the site visits reported that their agency exhibited the individual elements described as best practices) or partially in place (meaning staff were about evenly split in their assessment of having some but not all best practices in place). Focal EBP providers from most grantees had staff competency and organizational supports in place for the focal EBPs (13 and 14 grantees, respectively). Focal EBP providers from fewer grantees (11)—but still a majority—had leadership in place. These ratings for the three categories (bolded in Table III.1) are the averages of each grantee's ratings for the drivers that make up each category. See Appendix B for a description of the scoring process.

Table III.1. Capacity of EBP providers to deliver the focal EBPs as indicated by the implementation drivers, at the grantee-level

	Number of RPG2 grantees at each stage			
	In place	Partially in place	Not In place	Not enough information
Staff competency	**13**	**4**	**0**	**0**
Staff selection and hiring	9	8	0	0
Training	11	6	0	0
Coaching	9	8	0	0
Organizational supports	**14**	**3**	**0**	**0**
Data systems to support decision making	13	4	0	0
Administrative infrastructure	14	3	0	0
Leadership	**11**	**5**	**0**	**1**

Source: RPG site visits, fall 2015.

Note: The overall staff competency and organizational supports scores are averages of the average scores for each individual driver in the category.

For staff competency, one driver—training—was most often rated as in place. Among all of the implementation drivers, staff selection and hiring, and coaching, were least often rated as in place. Focal EBP providers from nine grantees had staff selection in place, whereas eight had this driver partially in place. Likewise, focal EBP providers from nine grantees had coaching in place, whereas eight had coaching partially in place.

Focal EBP providers from most RPG grantees had organizational supports in place (14 grantees), and a few had them partially in place (3 grantees). Focal EBP providers for 11 grantees had the

[24] All measures and discussions of the implementation drivers presented in this report are summarized at the grantee level. Data was aggregated across all focal EBP providers for each grantee that was interviewed during the site visits. In some cases, the grantee organization itself provided the focal EBP (or one or more of the focal EBPs, if the partnership offered more than one). If more than one organization provided one or more of the focal EBPs, site visitors sought to conduct interviews at up to two focal EBP organizations or locations per partnership.

leadership best practices in place. The five that had leadership rated partially in place, however, varied in which elements were missing (and one grantee could not be rated). Nonetheless, one commonality among the focal EBP providers from the five grantees with leadership rated as partially in place was that respondents often said leaders rarely provided technical guidance on EBP delivery. Chapter IV describes in more detail the progress focal EBP providers made in setting up the organizational supports and leadership needed to facilitate the delivery the focal EBPs. The rest of this chapter describes the supports in place to give staff the capacity to deliver the focal EBPs—through selection and hiring, training, and coaching and supervision.

B. Staff selection and hiring for EBPs

The goal of staff selection and hiring is to identify staff who are equipped to implement an EBP in the way intended by its developers and who possess the skills to build rapport with participants—both of which help bring about the intended outcomes of an EBP consistently (Metz, Bandy, & Burkhauser, 2009). Because of the importance of understanding the hiring process used to select frontline staff, cross-site evaluation site visitors interviewed EBP managers and supervisors about the hiring processes for these staff. Across grantees, these EBP managers and supervisors reported that they led the interviewing and selecting of frontline staff. To assess the skills of candidates, EBP managers and supervisors primarily evaluated candidates' responses to interview questions. Fourteen percent of managers and supervisors said that interview questions typically involved the candidate's relevant training and experience delivering EBPs, and 8 percent said the interview questions asked about the applicants' interests in the position, delivering EBPs, and working with the grantee's target population. In addition, 16 percent of managers and supervisors reported that their agency created case scenarios and assessed applicants' therapeutic skills in a mock therapy session or their ability to produce mock progress notes or a treatment plan.

To describe selected characteristics of frontline staff, the staff survey collected information about staff education and experience, their job titles, and whether they had supervisory responsibilities. The survey also measured the openness of staff to implementing EBPs, an important measure in selecting staff for an intervention because staff who are open to using evidence-based models are more likely to deliver them consistently and in the way intended by developers. In addition, site visitors asked EBP managers, supervisors, and frontline staff to provide their accounts of the skills needed for effectively serving and connecting with the target population.

1. EBP staff education and experience

Data from the staff survey show the characteristics of people employed by the providers who implemented the 10 focal EBPs. As displayed in Table III.2, more than 90 percent of staff survey respondents had at least a four-year college degree, and at least 60 percent had graduate or professional degrees.[25] Eighty-one percent of supervisors had a graduate or professional degree.

[25] All statistics from the RPG EBP staff survey are reported at the partnership level so that they represent an average across all 17 RPG sites. To compute percentages, the percentage within each site (which sometimes included respondents from multiple providers) was first calculated and then the percentages were averaged across the 17 partnerships. Thus all sites are weighted equally regardless of the number of survey respondents at each site.

Table III.2. Education level of surveyed staff

Highest education level	Percentage of all surveyed staff	Percentage of supervisors	Percentage of nonsupervisors
Less than a four-year degree	9	7	11
Four-year undergraduate degree	20	12	26
Graduate or professional degree	71	81	63

Source: RPG EBP staff survey.

Note: The full sample size across grantees was 99. There were 27 respondents across 15 grantees included in the supervisors' results and 70 respondents across 17 grantees included in the nonsupervisors' results. Two respondents did not identify as either supervisors or nonsupervisors.

Table III.3 displays the years of staff experience. It shows that the majority of respondents had at least two years of relevant work experience. Nearly half of respondents had been working at their current organization for two to four years, and more than 30 percent had been working at their current organization for five or more years. Approximately half of respondents had five or more years of experience providing services to the targeted RPG populations: children and families involved in the child welfare system (55 percent) and adults with substance use disorders (45 percent). Generally, staff had more experience working with the child welfare system than with substance use disorder treatment.[26] Forty-one percent of staff had 10 or more years' experience providing services to children and families involved in the child welfare system, compared to 22 percent who had the same amount of experience with substance use disorder assessment and treatment services.

Table III.3. Percentage of staff with related experience

Years of experience	Working at current organization	Providing services to children and families involved in the child welfare system	Providing substance use disorder treatment
Less than 1 year	13	5	18
1 year	10	13	13
2–4 years	45	28	25
5–9 years	17	14	23
10 or more years	15	41	22

Source: RPG staff survey.

Note: Responses were weighted such that all 17 grantees contributed equally to the analyses, regardless of the number of respondents. The full sample size across grantees was 99.

These questions asked about staff experiences in general, rather than those related to the specific EBP they were implementing.

[26] The survey question was phrased as "substance abuse assessment or treatment services."

2. Staff job titles

Table III.4 displays the breakdown of EBP staff by job title, showing that most staff had a job title that aligned with their roles in implementing the EBPs. At least 40 percent of both supervisors and nonsupervisors (frontline staff without supervisory duties) self-identified as licensed therapists, with titles including mental health counselor, therapist, psychologist, early intervention or child development therapist, and social worker. Supervisors mostly had administrative job titles, such as administrator, facilitator, supervisor, and program coordinator; nonsupervisors had job titles involving direct services (other than a licensed therapist), such as recovery coach or case manager. The mix of job titles is a reflection of the types of programs and practices selected as focal EBPs and the types of staff required for those programs (such as therapists or case managers or both).

Table III.4. Percentage of staff with each job title

Job title	All staff	Supervisors	Nonsupervisors
Licensed therapists[a]	43	42	40
Recovery coaches and substance abuse counselors	20	13	22
Case managers, family advocates, child development specialists, and navigators	18	1	28
Administrators, facilitators, supervisors, and program coordinators	15	42	3
Other professions	7	0	7

Source: RPG EBP staff survey.

Note: The full sample size across grantees was 99. The supervisors' results included 27 respondents across 15 grantees, and the nonsupervisors' results included 70 respondents across 17 grantees.

Respondents could only select one job title.

[a]Licensed therapists included mental health counselors, therapists, psychologists, child development therapists, and social workers.

3. Staff openness to EBPs

Staff who are open to implementing evidence-based models are much more likely to deliver the content of an EBP in the manner intended by developers. Because adherence to the program model is so critical for achieving intended outcomes, the staff survey measured staff attitudes using a scale developed for that purpose: the Evidence-Based Practice Attitude Scale (Aarons, 2004). Table III.5 displays the results of this scale. Frontline staff and supervisors reported being open to using EBPs in their work, with a mean rating of 3.7 on a 4-point scale. Frontline staff and supervisors said that they would be likely "to a great extent" (a rating of 4) to adopt a hypothetical EBP based on the appeal of the intervention. "Appeal" meant the intervention was intuitively appealing and made sense to them, and that staff felt they had enough training to deliver it and knew that colleagues were happy delivering the same intervention. They similarly rated items on their likelihood of adopting an EBP based on requirements set by supervisors, implementing agencies, or their state.

Table III.5. Mean ratings on attitudes toward implementing EBPs from 1 (not at all) to 5 (to a very great extent)

Evidence-Based Practice Attitude Scale constructs	Number of items in scale	Internal consistency reliability (Cronbach's alpha[a])	Mean (standard deviation)
Openness to using EBPs	4	.91	3.7 (.49)
Adopt EBPs based on appeal	4	.78	4.1 (.34)
Adopt EBPs based on requirements	3	.90	4.2 (.31)

Source: RPG EBP staff survey.

Note: The means in the table were calculcated by finding the mean frequency of responses at each grantee and then combining them to calculate the mean across all 17 grantees. In this way, all 17 grantees contributed equally to the analyses, regardless of their number of respondents. There were 99 survey respondents across 17 RPG grantees.

[a]The Cronbach's alpha values were calculated based on the RPG survey sample. Cronbach's alpha measures the extent to which all the items on a scale measure the same construct or idea. Values closer to 1 indicate higher concurrence among items.

4. Staff skills

Staff need to be knowledgeable about an EBP's content, but they also need to be able to build rapport with participants. Being able to connect with the provider's target population is an important skill for consistently bringing about the intended outcomes of an EBP because participants are more likely to be engaged with an EBP when participants feel empathy, rapport, and in other ways connected with providers. During site visits, managers, supervisors, and frontline staff described skills that they felt were needed for serving and connecting with the target population and for cultural competency.

Table III.6 shows that the most frequently reported skills for connecting with the target population were showing empathy, warmth, and compassion; building rapport with participants; and having a deep understanding of substance abuse, addiction, child welfare systems, and trauma. Frontline staff also named bringing their own life experiences, having a nonjudgmental attitude, and building rapport as important skills. By contrast, managers and supervisors felt it was more important for staff to have appropriate knowledge and training. For example, they said that counseling skills or knowledge related to substance abuse, addiction, child welfare, and trauma were important for connecting with the target population. Managers and supervisors also felt that another critical skill for staff working directly with participants was being able to balance their desire to connect with participants with a need to set personal boundaries and practice self-care, to avoid burnout. However, frontline staff members themselves did not mention this skill.

When providers serve participants of diverse backgrounds, staff need cultural competency skills that allow them to build rapport with participants. Cultural competency involves "the ability to work with and respond to participants in a way that acknowledges and respects participants' culturally based beliefs, attitudes, behaviors, and customs" (Metz, Bandy, & Burkhauser 2009). When asked about skills needed to demonstrate cultural competency during the site visits, 20 percent of respondents said that it was important or that their agency provided training in cultural competency, but did not identify specific skills. As shown in Table III.6, among staff who did identify specific cultural competency skills, the most common were skills to understand the circumstances and unique challenges of the community and differences between themselves and

their participants in culture, language/communication styles, religious beliefs, parenting beliefs, and education levels. Respondents also mentioned some of the same skills needed for connecting with the target population. For example, five percent of frontline staff stressed the importance of being nonjudgmental.

Table III.6. Skills respondents named for connecting with the target population and demonstrating cultural competency

Skills	Percentage of all staff	Percentage of managers and supervisors	Percentage of frontline staff
For connecting with the target population			
Showing empathy, warmth, and compassion	32	40	25
Building rapport and relationships	22	16	27
Understanding substance abuse, addiction, child welfare systems, and trauma	18	30	9
Demonstrating counseling, group facilitation, and teaching skills	17	24	11
Maintaining a nonjudgmental attitude	16	12	19
Encouraging engagement	11	8	13
Demonstrating listening and communication skills	10	14	6
Being authentic	9	8	9
Having relevant life experience	7	2	11
Setting boundaries and engaging in self-care	4	10	0
For demonstrating cultural competency			
Understanding the unique circumstances and challenges of a community	20	30	13
Being aware of cultural differences between the therapist and client	9	10	8
Maintaining a nonjudgmental attitude	4	4	5

Source: RPG site visits fall 2015.

Note: *N* = 114 (50 managers and supervisors and 64 frontline staff). Some respondents are counted more than once because they mentioned more than one skill. Only themes represented by 5 or more respondents among all staff are included.

For the site visit interview data, interview responses to open-ended questions were coded at the respondent level because this also allowed for variation within grantees. Therefore, all statistics reported from the site visits are at the respondent level.

[a]This skill was mentioned for both connecting with the target population and for demonstrating cultural competency.

C. Training on EBPs

Training builds staff capacity by preparing staff to work with participants, introducing the EBP's content, and teaching how to deliver the EBP in the way intended by developers of the program model or practice. Regardless of EBP content, training should incorporate background information such as the development and evaluation history of the model, theory of action, and philosophy of an EBP to describe and explain the underlying assumptions of the EBP. Effective training also introduces and demonstrates the key components and practices of EBPs and allows staff to practice their new skills while receiving constructive feedback (Bertram, Blase, & Fixsen, 2014). As described next, most frontline staff reported receiving initial training on the focal EBPs, but fewer than half received ongoing training, despite feeling the need for it.

1. Initial EBP training

Seventy-five percent of staff who responded to the staff survey agreed that training and TA were readily available to staff members at their organizations involved in implementing the EBPs. Participants in the site visits corroborated this finding and said that training typically incorporated background and underlying assumptions about the models. Among the frontline staff interviewed, 84 percent said they received some sort of EBP training, and more than 75 percent reported completing training before delivery of the EBP began.

Training for new hires. Most site visit participants reported integrating training into their hiring process for new EBP staff. Thirty-six percent of managers and supervisors reported their agencies had new staff complete an orientation or training for new hires and 24 percent reported their agencies had staff complete job shadowing. Three supervisors reported that they provided intensive supervision and feedback while the new hire was transitioning into his or her role.

Types of initial EBP training. There was some variation in the type of EBP training staff received.[27] Most frontline staff (75 percent) said that they received formal EBP training from a program developer or certified trainer. Frontline staff frequently said they received formal EBP training from the developer of, or a certified trainer for, the EBP that they delivered. These trainings typically were conducted in person. Other modes of formal training (mentioned much less frequently by frontline staff) included participating in a developer's online EBP training programs or viewing an EBPs's training DVDs—sometimes as a refresher or as a temporary method until a formal, in-person training could be scheduled. Eight percent of frontline staff received structured EBP training from their supervisors instead of from a developer or certified trainer for the EBP (either a professional trainer or part of a train-the-trainer model).

Other staff (9 percent) said that they received informal training about the EBPs rather than formal training from a program developer or certified trainer. Their training consisted of on-the-job training, informal conversations with their supervisors about the EBP, and using the EBP manual to teach themselves about the EBP. These staff said that their on-the-job training included job shadowing, in which they sat in on EBP sessions facilitated by their supervisors.

2. Ongoing training

Ongoing training is part of the back-and-forth process of effective training and bridges the activities of initial training before delivering an EBP and coaching (Collins & Metz, 2009). The goal of ongoing training is to address areas of weakness frontline staff exhibit after implementing a new practice in real-world settings to ensure fidelity of an intervention model. Ongoing training is important when learning a new skill such as an EBP because evidence indicates that new skills are learned most effectively when individuals have time to practice the new skills and

[27] Although there were few distinct trends in how training was organized among the EBPs, cognitive behavioral therapy (CBT) stood out among the focal EBPs because frontline staff reported having had this training in graduate school instead of having it provided by their agency. Staff described CBT training as a standard component of psychological and psychiatric graduate programs. Consequently, frontline staff reported that they came to their position at the RPG implementing agencies having already completed CBT training. Supervisors also reported this characteristic of CBT.

receive feedback and booster training on them (Metz, Burkhauser, & Bowie, 2009). Therefore, ongoing training is an integral part of learning how to maintain fidelity to an intervention model.

Despite the importance of ongoing training, fewer than 40 percent of frontline staff interviewed during site visits reported receiving ongoing training related to their EBPs. Those that did receive ongoing training reported having received (1) in-person refresher or booster trainings with the EBP developer or certified EBP trainer, (2) refresher training provided by their supervisor, (3) consultation calls with an EBP trainer, and (4) refresher training via online or DVD training tools.

Although ongoing training on EBPs was not commonly provided, staff desired it. In site visit interviews, supervisors and frontline staff identified training in several specific areas they felt would have benefited them:

- Tailoring the EBP content to participants
- Implementing substance use disorder components of EBPs, as applicable
- Addressing issues related to cultural diversity
- Handling safety issues when working with participants, especially with in-home delivery
- Dealing with crisis situations
- Completing required paperwork on EBPs
- Leading group sessions on EBPs
- Working with children and tailoring EBP content for young children
- Covering EBP content in the allotted time for sessions

3. Supervisor training

Effective training is not only for frontline staff who will deliver the EBPs, but also for staff of all levels at implementing agencies. For example, evidence from implementation science indicates that supervisors who have attended the same training as frontline staff are more effective at supporting frontline staff in the implementation of programs (Metz, Burkhauser, & Bowie, 2009). Additionally, supervisor-specific trainings can also build upon the typical EBP training to instruct supervisors on how to provide coaching and how to adhere to fidelity.

During the site visits, almost 60 percent of supervisors and managers with supervisory responsibilities reported receiving EBP training. However, EBP-specific training on supervision skills was uncommon. Supervisors described their EBP training as the same training that frontline staff received. Only two supervisors reported receiving supervisor-specific training on an EBP. In part, this may reflect the lack of availability of such training from many EBPs, rather than failure of providing agencies to enroll supervisors in such training.

D. Coaching and supervision for EBPs

Although staff must learn the core components of an EBP through training, staff also require ongoing support when delivering an EBP to enhance their skill development and provide them with feedback on their performance (Bertram, Blase, & Fixsen, 2014; Metz, Blase, & Bowie, 2007). Without these coaching and supervision activities, staff may deviate from the way developers intended an EBP to be delivered. Coaching and supervision, thus, are essential for providing an EBP in ways that will most likely bring about its intended outcomes.

Supervision and coaching are related and can be difficult to distinguish. In fact, coaching is sometimes simply defined as ongoing support *and* supervision (Burkhauser & Metz, 2009). For purposes of RPG, coaching specifically refers to activities that provide individual staff members or groups of staff members with on-the-job observations, instruction, modeling, feedback, debriefings, and emotional support, all of which are often adapted to fit the individual needs of staff members. Supervision, on the other hand, specifically entails the process of monitoring staff performance. Nonetheless, because coaching and supervision are intertwined, they were assessed together.

Supervisors and frontline staff were asked about their experiences with coaching and supervision in the staff survey and during the site visits. In the survey, staff were asked whether they had a supervisor and the types of supervision they received. During the site visits, frontline staff and supervisors were asked to describe the coaching and supervision the frontline staff received, including who provided the coaching and supervision and the types of coaching and supervision activities.

1. Supervisors and coaches

To provide coaching and supervision, providers must have staff who fill these roles. Nearly all staff who responded to the survey (98 percent) reported having a supervisor. Similarly, during the site visits, the vast majority of frontline staff (73 percent) reported that they received coaching on their EBP. Only 11 percent of frontline staff did not receive any coaching on their EBP. (Other frontline staff did not complete this survey item).

Table III.7 reports the types of staff who served as coaches for frontline staff. More than 60 percent of these frontline staff said that their supervisor or manager provided coaching, and 33 percent said that other frontline staff provided peer-to-peer coaching. Far fewer frontline staff said RPG project directors, learning collaborative members, clinical supervisors, and partner agency staff provided coaching.

Supervisors' reports that they provided coaching aligned with what the frontline staff said, but their description of coaching did not align with what frontline staff said about peer-to-peer coaching. About 60 percent of supervisors said that supervisors or managers served as coaches for frontline staff, whereas only about 15 percent said that frontline staff received coaching from peers and 6 percent said frontline staff received coaching from EBP trainers.

Table III.7. Percentage of frontline staff and supervisors who reported frontline staff received coaching from each source

Types of staff who served as coaches	Percentage of frontline staff	Percentage of supervisors
Supervisors and managers	63	60
Peers	33	15
EBP trainer	9	6
RPG project director	5	0
Learning collaborative	5	0
Clinical supervisor	5	0
Partner agency	2	0

Source: RPG site visits, fall 2015.

Note: *N* = 64 frontline staff and 34 supervisors. Some respondents are counted more than once because they received coaching from more than one source.

2. Types of supervision and coaching

As displayed in Table III.8, findings from the staff survey showed that a majority of respondents, who were either frontline staff or supservisors trained in an EBP, met with their supervisor at least once a month in both one-on-one (79 percent) and group meetings (87 percent). More than 40 percent of staff met with their supervisors one-on-one once a week or more, and about 55 percent reported attending group supervision meetings once a week or more often. Site visit respondents described the meetings as involving consultations with EBP supervisors, trainers, or developers; addressing client issues and concerns; discussing safety; and reviewing research evaluation results. Some site visit participants said team meetings also included representatives from the different agencies involved in the RPG project, such as child welfare and drug courts.

Table III.8. Percentage of staff reporting participating in each type of meeting

	Percentage of staff	
Frequency of meeting	One-on-one meeting with supervisor	Group supervision meetings
Once per week or more	43	55
Twice per month	20	15
Once per month	16	17
Less than once per month	21	14

Source: RPG staff survey.

Note: Responses were weighted such that all 17 grantees contributed equally to the analyses, regardless of the number of respondents. The responses in the table were calculcated by finding the mean frequency of responses at each grantee and then combining them to calculate the mean across all 17 grantees. In this way, all 17 grantees contributed equally to the analyses, regardless of their number of respondents. The full sample size across grantees was 99.

During site visits, supervisors reported that they provided specific types of coaching for their frontline staff in addition to team meetings. Of the 34 supervisors interviewed, 44 percent said they provided feedback to staff, 41 percent said they provided on-the-job observations of staff, and 38 percent said they provided instruction on EBPs and emotional support. In addition, 35 percent reported conducting debriefings with staff, and 27 percent provided modeling.

3. Types of supervisor support

Respondents to the staff survey reported receiving high levels of supervisor support with an average close to 5 on a 1-to-6 scale measuring supervisor support (Table III.9).[28] The staff survey measured three elements of supervisor support: team support, emotional support, and technical support. Team support refers to the extent that the supervisor encourages staff to mentor one another and work together. Emotional support refers to the extent that the supervisor cares for, empathizes with, and supports staff. Technical support refers to the extent that the supervisor is knowledgeable and provides expert help to staff. Respondents to the staff survey were primarily in agreement that their supervisors provided each element. Mean ratings were similar for team support (mean = 5.1), emotional support (mean = 5.1), and technical support (mean = 5.2).

Table III.9. Mean ratings of supervisor support on a scale of 1 (strongly disagree) to 6 (strongly agree)

Supervisor support scale	Number of items in scale	Internal consistency reliability (Cronbach's alpha[a])	Mean and standard deviation
Supervisor provides team support	2	.82	5.1 (.46)
Supervisor provides emotional support	5	.93	5.1 (.51)
Supervisor provides technical support	10	.96	5.2 (.44)

Source: RPG staff survey.

Note: The responses in the table were calculcated by finding the mean frequency of responses at each grantee and then combining them to calculate the mean across all 17 grantees. In this way, all 17 grantees contributed equally to the analyses, regardless of their number of respondents. The full sample size across grantees was 99.

[a]The Cronbach's alpha values were calculated based on the RPG survey sample. Cronbach's alpha measures the extent to which all the items on a scale measure the same construct or idea. Values closer to 1 indicate higher concurrence among items.

[28] The Dickinson and Painter scale is a 19-item scale that assesses five dimensions of organizational climate: (1) agency vision and mission is clear, (2) compensation is satisfactory, (3) agency is committed to a safe and satisfactory work environment, (4) agency has a positive public image, and (5) agency gives workers decision-making autonomy (Dickinson & Painter, 2009). Among these dimensions, mean ratings were within or close to the "agree" to "strongly agree" range (4.0 and 5.0 on the scale).

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IV. DEVELOPING ORGANIZATIONAL SUPPORTS AND LEADERSHIP TO FACILITATE THE DELIVERY OF EBPS

In addition to building capacity to deliver the EBPs by focusing on staff competency, RPG projects must provide organizational support and leadership to set the stage for high-quality implementation of the EBPs. Organizational support includes the structures and systems in place for staff to use that create an environment conducive to implementing EBPs. These structures and systems include implementation teams and written plans to guide the overall work of staff; data systems, such as a management information system, to track participant data and services provided to participants; professional development opportunities for staff; and adequate funding and facilities (such as office space, session space, or supplies). Leadership refers to a core group of individuals who guide the staff providing services and identify and solve everyday and more-complex problems that arise when delivering EBPs. Organizational support and leadership are critical parts of the delivery of EBPs because they allow staff to focus on service provision rather than on facilities and problem solving.

This chapter uses data from the staff survey and site visits to describe the progress the RPG projects made in setting up the organizational supports and leadership needed to facilitate the delivery of the focal EBPs. The chapter opens with the findings from the staff survey of frontline staff's feelings, attitudes, and perceptions about the organizational climate of the providers implementing the EBPs (Section A). These findings about organizational climate address the overall working environment for the staff delivering services and create the basis for discussions of organizational support and leadership. Then the sections that follow discuss the extent to which the organizational supports (Section B) and leadership (Section C) were in place at the provider agencies.

A. Organizational climate

Organizational climate is defined as the "shared perceptions of and the meaning attached to the policies, practices, and procedures employees experience" (Schneider, Ehrhart, & Macey 2013). Organizational climate is typically measured through surveys of employees, by aggregating individual responses to questions about the characteristics of an organization into constructs that represent peoples' work settings and experiences. Measuring organizational climate is important because research shows a link between the strength of the organization's climate and the outcomes of the organization (González-Romá, Peiró, & Tordera 2002; Schneider, Salvaggio, & Subirats, 2002). Thus, for RPG, the more positive staff feel the organizational climate to be, the more likely the staff can carry out their jobs of providing high-quality services to their participants, helping to ensure fidelity to the EBP program and practice models established by their developers.

As rated across five different dimensions, frontline staff and supervisors that responded to the staff survey agreed that the providers they worked for had a positive organizational climate—though there was less satisfaction with compensation than the other four dimensions of organizational climate. Table IV.1 shows five dimensions of organizational climate and mean ratings on each dimension, as measured by the organizational climate scales (Dickinson & Painter, 2009) that were used in the staff survey.

Table IV.1. Mean ratings of organizational climate on a scale of 1 (strongly disagree) to 6 (strongly agree)

Dickinson and Painter organizational climate scales	Number of items in scale	Internal consistency reliability (Cronbach's alpha[a])	Mean and standard deviation
Agency vision and mission is clear.	4	.78	5.3 (.49)
Compensation is satisfactory.	3	.97	3.9 (.76)
Agency is committed to a safe and satisfactory work environment.	4	.92	5.0 (.68)
Agency has a positive public image.	4	.90	4.8 (.67)
Agency gives workers decision-making autonomy.	4	.90	4.9 (.62)

Source: RPG EBP staff survey.

Note: The responses in the table were calculcated by finding the mean frequency of responses at each grantee and then combining them to calculate the mean across all 17 grantees. In this way, all 17 grantees contributed equally to the analyses, regardless of their number of respondents. The full sample size across grantees was 99.

[a]The Cronbach's alpha values were calculated based on the RPG survey sample. Cronbach's alpha measures the extent to which all the items on a scale measure the same construct or idea. Values closer to 1 indicate higher concurrence among items.

Frontline staff and supervisors scored their agencies as high (5.0 or above on a scale of 1–6) on two dimensions: having a clear vision and mission, and providing a safe and satisfactory working environment. The vision and mission scale included statements such as, "The mission of this organization is clear to me," and "I feel good about what this organization does for RPG program participants." Having a safe and satisfactory work environment was assessed through survey items such as, "I am satisfied with the physical work environment at this organization," and "This organization is committed to my personal safety in the office."

Frontline staff and supervisors also positively rated their agencies on maintaining a positive public image and providing their workers with decision-making autonomy, with average scores between 4.8 and 4.9 on a scale of 1–6. The public image scale included items such as, "I am proud to tell others that I am part of this organization," and "Employees of this organization are respected by other community professionals." In considering decision-making autonomy, staff and supervisors were asked their level of agreement with statements such as, "I have sufficient input in formulating policies that govern my work," and "I have the support to make work-related decisions when appropriate."

Staff and supervisors only somewhat agreed that their compensation was satisfactory, with a mean rating of 3.9. This scale was composed of three items: "I am satisfied with the salary I receive from this organization," "I am paid fairly considering my education and training," and "I am paid fairly considering the responsibilities I have."

As discussed above, the strength of the staff's rating of organizational climate is linked to accomplishing the intended outcomes of an organization—in this case, high-quality implementation of EBPs. Overall, most staff felt the providers where they worked maintained a positive organizational climate. The next sections discuss how agencies contributed toward the development of a positive organizational climate for their staff by establishing and maintaining organizational supports and effective leadership.

B. Organizational supports

The implementation science literature suggests that certain structures and processes should be in place to ensure that frontline staff have adequate time, skills, funding, and other resources for high-quality implementation of an EBP (Collins & Metz, 2009; Metz, Blase, & Bowie, 2007). Having the necessary organizational supports in place strengthens implementation quality of a program by helping ensure that staff can focus on delivery of the EBP.

Focal EBP providers for most RPG grantees had the organizational supports their staff needed in place to deliver services (see Table III.1). However, focal EBP providers for three grantees had these supports only partially in place. In such a situation, staff may need to devote time and energy to solve problems on their own, such as finding a way to share session space to deliver services if space is limited, or stretching funding available to purchase supplies. This section reports findings from the site visit interviews, which describe the extent to which four organizational supports were in place: (1) implementation teams and written plans for guiding implementation of the EBPs, (2) data systems for maintaining records of participants and services, (3) facilities and staff capabilities, and (4) professional development.

1. Implementation teams and written plans

Implementing EBPs involves multiple decisions, actions, and corrections to change the structures and conditions through which organizations and systems support and promote new program models, innovations, and initiatives (Metz et al., 2015). Facilitating this process requires ongoing engagement of, and coordination among, project leadership, partners, and staff. Given these complexities, the research literature points to the importance of organizations forming teams to guide implementation, maintain institutional knowledge about the project and EBPs, and sustain relationships.

About half of managers and supervisors interviewed during site visits said there was an initial planning team for the EBP. Although the composition of the team differed across providers, all teams included the EBP manager and/or supervisor. Other team members included the project director, select frontline staff members, the executive director or CEO of the agency, members of the RPG local evaluation team, and staff from partnering agencies. Implementation teams played various roles, including the following:

- Researching, selecting, and planning for the EBPs
- Managing the day-to-day operations and challenges that arose with service delivery
- Informing partners about the EBPs and working through collaboration issues with partners
- Reviewing program data to identify issues and solutions

Although planning was an important function for almost all implementation teams, this was not their only function for most projects. Nearly all respondents who indicated that they had an implementation team reported that the team continued beyond the planning period to provide ongoing support. The implementation teams facilitated collaboration with other RPG partners and served as advisors for identifying solutions to overcome implementation challenges, such as staff turnover or problems delivering an EBP.

To deliver services with consistency, staff need written guidance that they can reference to understand their roles and what is expected of them as part of the larger organization. Written plans are a shared resource for staff, supervisors, managers and agency leadership to document plans and procedures for carrying out work within the organization. Grantees established written implementation plans for the RPG projects, but fewer respondents described developing similar plans specifically for EBP implementation.

RPG project plans. Site visitors also asked RPG project directors and implementation team members about written plans to guide RPG. Seventy-one percent of project directors said that they had written plans available to guide the implementation of the RPG project as a whole (aside from the plans outlined in their grant applications). These plans included the following:

- Program treatment manuals, implementation checklists, and other documents on policies and procedures to ensure consistency of service delivery
- Flowcharts or blueprints to show staff and partners how participants get referred and enter treatment
- Participant handbooks and brochures

EBP implementation plans. Written materials outlining the proper delivery and procedures are also important to guide EBP implementation. Few respondents described having written plans specifically for implementation of their focal EBP. Only 12 percent of EBP managers and supervisors (representing 3 out of 12 providers), reported having any written plans available for implementing the EBPs. Plans that were available to guide EBP implementation included program treatment manuals, implementation checklists (lists of best practices, activities, and tasks required for implementation), and other documents on policies and procedures designed to ensure consistent service delivery.

2. Data systems

To manage, treat, and monitor cases, staff need a system they can use to accurately track and easily access information on their participants such as background characteristics, needs, services received, and outcomes. A data system can be electronic, such as a management information system, which is a computer-based information-processing system designed to support the activities of an organization. A management information system can often be used to produce reports to look at data on the individual person or case level, or in the aggregate, such as each staff member's caseload or the overall EBP. Paper-based data systems are typically organized at the individual level and serve as more of a case management tool through which management or staff can only look at one case at a time.

Regardless of format, an electronic or paper-based system provides a way to track participant activity and helps managers and supervisors monitor the delivery of EBPs, such as by ensuring that certain topics and activities are covered. Data systems can also inform adjustments to processes that help staff adhere to a standard delivery of an EBP, such as training and coaching. Such monitoring and adjustments by managers and supervisors can improve implementation of the EBP (Bertram, Blase, & Fixsen, 2014; Mildon, 2011; Metz, Bandy, & Burkhauser, 2009; Collins & Metz, 2009).

Data system in place. All focal EBP frontline staff, managers, and supervisors who were asked whether their agency had a data system reported that they had either an electronic or paper-based system. Frontline staff used an electronic system less often than supervisors and managers. For frontline staff, 36 percent reported using an electronic system, whereas 40 percent of managers and supervisors reported using an electronic system. However, two frontline staff described a two-step process for managing data collected on individual cases, in which paper-based data recorded by frontline staff was entered into an electronic records system that managers and supervisors could access.

Use of data for participant planning. One way the organization can use a data system is to produce frequent reports on individual participants to monitor their outcomes (Bandy, Burkhauser, & Metz, 2009). This can help staff better understand whether the participant is on the "right path" with the treatment being delivered. Whether they used a paper-based or electronic system, frontline staff said they recorded session details: the content of the session, which participants attended, the engagement of those participants, the severity of their symptoms and challenges, and future plans for working with the participant. About two-thirds of frontline staff reported using the data they collected on individual participants, most often for planning or for monitoring the individual progress of each participant. Although one-third of frontline staff reported that they had opportunities to review aggregated data, most staff did not use these data because they were focused only on planning and monitoring at the case level and not on program improvement. Frontline staff primarily used individual-level data, whether paper based or electronic, to plan for the next session (40 percent) or for progress monitoring toward treatment goals (8 percent). For example, frontline staff from one agency reported that their participants completed an assessment during each session; the staff graphed the results and monitored their progress over time.

Use of data for program improvement. Over a third of managers and supervisors participating in site visit interviews said they used data for program improvement. Those who used data in this way provided several examples of how data were used to improve implementation: to identify sessions that were most successful and those that needed additional materials or adjustments; to review participant satisfaction surveys and feedback to get ideas for improvements; and to identify barriers to treatment, such as transportation and space, and work through ways to overcome them.[29] Ideally, all supervisors and managers should be using data to look at participation patterns across participants or at the consistency of services delivered, such as number or length of sessions, in order to assess and improve implementation (Fixsen et al., 2009).

3. Facilities and staff capabilities

In working directly with program participants, staff implementing EBPs need appropriate facilities, adequate funding, and support from staff with specific skills to do their jobs well. Site visitors asked EBP managers, supervisors, and frontline staff to rate the adequacy of these supports.

[29] Due to time constraints during the interviews, only half of managers and supervisors were asked about their use of data for improving implementation.

As shown in Table IV.2, at least 75 percent of frontline staff, managers, and supervisors described their facilities, including supplies, session space, and office space as adequate. However, nearly one-third of staff described limited office space and the subsequent lack of privacy to deliver services to participants as a concern. Most of the staff expressing this concern worked for two EBP providers that did not provide dedicated offices for individual staff members.

Table IV.2. Adequacy of facilities, funding, and staff capabilities, as perceived by staff

Support	Percentage of respondents rating supports as adequate
Facilities	
Supplies	81
Session space	75
Office space	71
Funding	64
Staff capabilities	
Education levels of staff	83
Credentials of staff	80
Commitment to mission of staff	81
Cultural competency of staff	78
Coaching of staff	78
Training of staff	75
Administrative support staff	75

Source: RPG site visits, fall 2015.

Note: *n* = 114 EBP managers, supervisors, and frontline staff.

In terms of funding, nearly 40 percent of staff felt that the funding for their EBP or agency was inadequate to train and hire staff to deliver services. Staff felt they needed more funding to pay for additional training or supplies, to hire more staff at all levels, and to sustain their program past the grant period.

Staff were also asked how they perceived the overall capabilities of the staff (as a group) currently working at the provider. At least 75 percent of staff interviewed during the site visits described staff education and credentials, commitment to the mission of the organization, and cultural competency of their fellow staff members as adequate. The same percentage also felt that staff were given adequate coaching and training by their organizations (despite the lack of ongoing EBP training frontline staff reported, as described in Chapter III). Although almost 80 percent of staff felt the staff delivering EBPs had adequate cultural competency, many of the same staff added that more training in this area is always needed because it is a central skill needed for connecting with the target population (see Chapter III). Finally, 75 percent of staff reported their access to administrative support, such as administrative assistants who can order supplies and troubleshoot facilities issues for them, was adequate.

4. Skill development for frontline staff

Managers and supervisors prioritized skill development for frontline staff as a means to support the implementation of the EBPs. About half of EBP managers and supervisors felt frontline staff received adequate time for skill development. Managers and supervisors described several strategies to ensure frontline staff had sufficient time for skill development:

- Giving staff the opportunity to practice and develop their skills on a day-to-day basis through leading sessions of EBPs
- Encouraging participation in training that was valued by the grantee organization, balancing clinical responsibilities with training opportunities and using regular staff meetings as a chance to supervise frontline staff and provide training
- Providing support as a supervisor
- Encouraging peer support
- Allocating frontline staff a set amount of planning time that can be used to seek support or pursue professional development opportunities

The 20 percent of managers and supervisors who felt frontline staff did not have adequate time for skill development attributed this gap to a need to maximize billable services or to not having enough staff to implement the EBP. (The remaining 30 percent of managers and supervisors did not provide information on this subject.)

Practical goals for staff development. Implementing agencies supported skill development by setting attainable and practical goals designed to help staff grow professionally and improve their ability to successfully implement the EBP. Frontline staff and their managers and supervisors set training goals focused on getting certified in a particular therapy or completing refresher courses on the EBPs or therapies they were currently implementing.

Peer support for professional development. About two-thirds of frontline staff felt they had time to interact with other staff around the implementation of the EBPs—through informal and formal channels. Proximity seemed to be a key driver of informal staff interaction; several frontline staff stated that because they were all in the same office, they interacted with one another constantly. About half of frontline staff named formal channels such as scheduled meetings or team and group supervision meetings as the main opportunities to interact with one another.

C. Leadership

It may not be enough to have competent, well-trained staff with access to organizational resources if there is no responsive leadership in place to guide staff and, especially, to correct course when problems or barriers arise. Effective leaders can clearly identify and understand problems, gather relevant information and resources to address problems, assign tasks to alleviate problems, and monitor task completion (Bertram, Blase, & Fixsen, 2014; Fronk, Gurko, & Austin, 2013; Mildon, 2011; Daly & Chrispeel, 2008; Fixsen et al., 2005). To resolve barriers to implementation of EBPs, effective leaders bring together groups of staff to identify

and understand problems and to work toward a consensus for a solution (Bertram, Blase, & Fixsen, 2014).

Based on measures used in the cross-site evaluation, EBP providers for 11 RPG grantees had the leadership best practices in place which was still a majority of grantees, but fewer than had the other two drivers, staff competency and organizational supports, in place (see Table III.1). In assessing leadership, site visit interviews asked frontline staff how well-supported they felt by two layers of leadership relevant for RPG: (1) EBP managers and supervisors, and (2) provider organization directors and/or RPG project directors.

1. Open communication with leadership

Most frontline staff reported that they experienced consistent communication with their managers and supervisors. This communication made it easy for staff to report any issues they were experiencing in implementing the EBPs. About 75 percent of staff used formal, informal, or both channels to give EBP managers and supervisors feedback about the implementation of the EBPs. Frontline staff reported connecting with their managers and supervisors formally through supervisory or staff meetings, or informally through email, passing each other in the hall at the office, dropping in to discuss an issue, and frequent texting or phone calls.

Frontline staff did not have the same open communication with the leadership of their organizations or the overall RPG project. Very few frontline staff (less than 10 percent) said their agencies had an open-door policy where they could address concerns with organization and project leadership directly. Rather, frontline staff reported that communication to RPG project directors or provider agency executive directors most often occurred through their own managers and supervisors. More than 40 percent of frontline staff explained that when issues arose with the implementation of the EBP, they expressed concerns to midlevel management, who would then elevate the issue as needed up the chain of command. About 20 percent of frontline staff raised issues with their upper management via informal channels—such as email, phone, or text—and about 15 percent described staff meetings as venues where they could bring up concerns to leadership.

2. Responsiveness of leadership to frontline staff

Frontline staff not only felt EBP managers and supervisors were accessible, they also felt that they were responsive to their concerns. More than 80 percent of frontline staff interviewed reported that their managers and supervisors were responsive to staff concerns about barriers to implementing the EBPs with fidelity. For example, addressing concerns about missing logistical needs for delivering the EBP, such as the lack of office or group meeting space; support for troubleshooting participant issues; or difficulty getting referrals of potential participants from other agencies. From the point of view of staff, their EBP managers and supervisors displayed strong leadership by listening to these concerns and bringing them to organization or RPG leadership, when needed, to address those barriers.

Similarly, once an issue (such as increasing referrals, increasing participant incentives, and creating a more flexible and safe work environment for staff) was brought to organization directors and RPG project directors, staff reported that they made every effort to respond to the problems. Consistent with the approach to soliciting feedback, frontline staff mainly heard about

policy changes from their own managers and supervisors rather than directly from leaders who made such decisions. About half of frontline staff noted, however, that changes in the organization's or agency's policies were only communicated to them on a need-to-know basis, and usually communicated to staff after a policy was changed rather than discussing possible changes in advance.

3. Guidance on EBPs

Although coaching and supervision (such as emotional support, feedback on performance, or debriefings on problems or work activities) provide broad support for implementing EBPs, frontline staff were also asked if they received technical guidance on how to deliver their EBPs. Technical guidance, in contrast to coaching or supervision, focuses on guidance about the delivery structure, dosage, and timing of services—and providing such guidance is an important role for leadership. Almost 70 percent of frontline staff, managers, and supervisors reported that organization and RPG project directors understood the core components of the EBPs but were not typically involved in providing technical guidance.

When asked about such technical guidance, only about 40 percent of frontline staff interviewed said they were provided with it, generally from their supervisors. For the minority of staff provided with technical guidance, they described the guidance their supervisors provided as:

- Being available as a resource for problem solving, guidance, and answering questions;
- Becoming involved with providing technical guidance on how to deliver the EBPs early during implementation; and
- Guiding staff through the technical aspects of delivering the EBPs during meetings and supervision.

This aspect of technical leadership was the most commonly missing piece among provider leadership. Though some frontline staff who reported that managers and supervisors did not provide technical guidance on EBPs felt they did not need such guidance, according to implementation science leadership with technical knowledge of EBPs may reduce the variability of service delivery and increase adherence to the program model.

4. Recognition for staff work

More than 70 percent of frontline staff reported that managers and supervisors recognized their hard work providing services to participants and families, further contributing to a positive work climate. About 60 percent of supervisors and managers said they used the following ways to recognize staff for exemplary staff work:

- Providing verbal praise to staff during meetings or one on one
- Formally recognizing a staff member as employee of the month or quarter
- Providing monetary bonuses tied to employee performance

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V. RPG2 IMPLEMENTATION BARRIERS

It is important to look at not only the quality of implementation, but also interventions in the settings (context) in which they are implemented (Wandersman et al., 2016). C*ontext* is the normal conditions into which interventions must be integrated if they are to be workable in practice (paraphrased from May, Johnson, and Finch, 2016). These conditions often create barriers to the implementation of programs and practices. As with any complex initiative, the RPG grantees faced numerous barriers to implementation at every stage of the project, from obtaining referrals of potential clients to maintaining the ongoing engagement of clients in services. To help grantees implement their programs, develop strategies to address these barriers, and plan for sustaining their programs and partnerships after RPG funding ended, HHS provided TA. As part of its contract to manage NCSACW, which is funded by the Administration on Children, Youth & Families and SAMHSA, the Center for Children and Family Futures provided TA and other activities to support the RPG projects.

To understand the context of the RPG projects—and especially to identify barriers the partnerships encountered—the cross-site evaluation analyzed data collected during site visits and from progress reports submitted to HHS every six months by the grantees. This chapter discusses the range of barriers faced by the grantees (Section A). Section B describes the program TA NCSACW provided to help grantees overcome barriers and sustain their RPG programs. Findings are presented at the grantee-level and include challenges described by staff from grantees and focal EBP providers.

A. Implementation barriers

RPG projects are complex undertakings involving coordination across several partners to serve children and families with multiple needs—so it is perhaps not surprising they encountered challenges. The grantees reported challenges related to (1) obtaining referrals, (2) enrolling participants, (3) retaining participants in EBPs and program services, and (4) recruiting and retaining project staff.

1. Fewer referrals than expected

As of April 2016, the RPG2 grantees had been enrolling participants for at least two years. However, nearly all grantees struggled with the preliminary step to enrollment—obtaining referrals of potential clients. Fourteen of the 17 RPG2 grantees reported recruitment problems.

Limited referrals from child welfare. The most common challenge, cited by nine RPG grantees, was limited referrals from child welfare. Grantees were not receiving the expected number of referrals. Even child welfare agency grantees were not immune to this challenge: three of the four state or county child welfare agency grantees encountered difficulties securing referrals. Grantees attributed the limited referrals from child welfare to a number of issues, including the following:

- **Staff turnover in child welfare agencies.** Grantees reported that, because of high rates of staff turnover in child welfare agencies, they had to regularly introduce the new staff to the RPG project.

- **Staff capacity in child welfare agencies.** Grantees also reported that child welfare workers were too overwhelmed with high caseloads and adjusting to internal policy and procedural changes to make referrals to RPG.

- **Lack of support for the program being offered.** Several grantees received feedback that child welfare caseworkers felt clients should be focused on substance use disorder treatment, which in some cases was not offered by the RPG partnership, rather than the child-caregiver relationship, which was the focus of their RPG projects.

- **Concerns about evaluation designs.** Grantees also reported that child welfare caseworkers were reluctant to refer people to RPG projects that were using rigorous designs for their local evaluation because some referrals would be assigned to a control group not receiving RPG services (even though they would receive other services as usual).

- **Concerns about capacity and sustainability.** One grantee speculated that the limited enrollment capacity of their RPG project deterred some referral sources from investing in RPG. The referral sources had other service options, so they preferred to make referrals to programs that could accommodate more of their clients. Another grantee noted that some child welfare caseworkers were hesitant to refer to RPG because it is a grant-funded project; the caseworkers were concerned about introducing a new process and service that might not be available once the grant ended.

Policy changes. Five RPG2 grantees reported that policy changes within the child welfare system affected anticipated referrals. For two grantees, child welfare policies limited the pool of potential participants for the project. For example, in one state, the grantee—a family drug court—could not enroll families unless the welfare agency opened a formal court case, which child welfare policy did not require under all circumstances. Thus, the grantee could only serve a subset of the child welfare population. In another state, child welfare policy began to focus on improving the timeliness of permanency determinations. The grantee explained that this shift resulted in a reluctance by child welfare caseworkers to refer clients to a lengthy residential substance use disorder treatment program.

Ineligible referrals. Five RPG2 grantees also reported problems with ineligible referrals. Some sources referred people who were not part of the RPG target population. Staff turnover within the child welfare or other referring agencies exacerbated the problem of inappropriate referrals because new staff were not familiar with the grantee's stated eligibility criteria. Some referrals did not meet the eligibility criteria set by the grantee for the RPG project because the universal screening tool being used by community partners was not identifying clients with eligible risk factors, such as low education levels, being a single-parent household, or adult depression.

Less commonly, grantees reported that local norms hindered RPG referrals and outreach. For example, one grantee battled the perception that substance use disorders were personal problems only. The community did not value supporting the families affected by a parent's or caretaker's substance use. Another grantee felt that the stigma related to substance use prevented many families from seeking RPG services.

2. Engaging and enrolling clients

Once referrals were received, converting those referrals into enrolled participants proved another challenge for grantees. Eleven RPG2 grantees reported difficulty getting potential clients to enroll in RPG. Factors included clients' competing demands or lack of readiness for services, limited family engagement, and concerns about the potential implications of participation in RPG on open legal and child welfare cases. Grantees often had difficulties locating potential clients referred to them.

Competing demands on clients and clients' readiness for services. Seven grantees reported that clients had competing needs and obligations that imposed a barrier to enrollment in the project or EBPs. Grantees discovered that many clients had pressing needs that had to be met before the clients could engage in services. For example, some clients needed substance use disorder treatment before they could begin other RPG services, such as family-strengthening programs. Other clients were homeless or lacked adequate housing. Thus, the grantees first focused on getting these clients into stable housing to facilitate their engagement in the RPG projects. One grantee's initial goal was to engage clients in substance use disorder treatment within 24 to 48 hours of RPG enrollment, but enrollees needed basic items such as food for their families before they could begin treatment. Therefore, the grantee changed its goal to initiating treatment within five days of RPG enrollment.

Grantees also reported that potential clients often had competing obligations they had to meet before they were willing to or could engage in RPG. One grantee noted that drug court clients often had a number of therapeutic interventions, such as cognitive behavioral therapy, that they had to complete before they could participate in the voluntary trauma services offered by RPG. By the time the clients finished their mandated activities, they were no longer interested in the trauma intervention because they felt they had already participated in sufficient therapy, even if it was not trauma specific.

Locating potential clients. Locating potential clients hindered enrollment for six grantees. Contacting clients was difficult in some cases because the client did not have a phone or a permanent address. In contrast to the grantees that had trouble getting referrals, some grantees had more referrals than they could accommodate, so they had to initiate waitlists. Often, by the time a slot was open, grantees were unable to locate clients on the waitlist or the clients refused services.

Enrolling family members. Several grantees designed their projects to serve families rather than focusing on just the biological parent or child. However, engaging other family members proved challenging for four grantees, particularly with families with children in out-of-home placements. One grantee that worked only with noncustodial parents reported that enrolling children in RPG was difficult because the custodial parent, primarily the biological mother, would not give consent for the children to enroll in services. The grantee reported that the mothers did not consider the noncustodial parent's substance use disorder a problem that needed to be addressed as a family. Rather, the mothers felt it was a problem the father needed to address on his own. Similarly, garnering the cooperation of foster parents was a challenge for one grantee. The grantee noted that foster parents were apprehensive about allowing the child to engage in services with the biological parent.

Concerns about involvement in external systems. Three grantees reported that enrollment was hindered by clients' concerns about enrolling in RPG due to their involvement with the child welfare and judicial systems. Some attorneys representing parents with open child welfare cases advised their clients against participating in RPG. The grantee that struggled to enroll the children of noncustodial parents explained that the custodial parents would not grant permission because they were wary of involvement with the court-administered RPG project. The custodial parents were reluctant to invite the scrutiny of the child welfare system, which they felt would occur by being part of the RPG project.

3. Retaining clients in EBPs

Successfully enrolling clients in RPG was not the final hurdle for grantees. More than two-thirds of RPG2 grantees reported struggling to maintain clients' ongoing participation. Clients dropped out for various reasons, including relapse, termination of parental rights, and lack of stable housing. Additional examples of barriers to retention mentioned by grantees included transportation issues and differing perspectives on clients' progress.

In some cases, clients' participation was hindered because they did not have access to a vehicle and public transportation was limited. Getting children who were in out-of-home placements to treatment was also a challenge. One grantee that provided child-caregiver therapy reported that coordinating the schedules and transportation of the parent and the child was difficult. They had to rely on the child welfare providers to coordinate transportation for the children, but some of those providers did not have funds for transportation.

Another barrier to retention was that grantees and partners sometimes had different perspectives on when a participant had successfully completed the RPG project. In some cases, child welfare caseworkers or probation officers decided that the clients had met their treatment obligation before the client's enrollment in RPG was scheduled to end. In most cases, clients withdrew from RPG once they no longer had an obligation to participate.

4. Retaining staff and preparing them to deliver EBPs

Some RPG2 grantees had trouble finding and retaining qualified staff to deliver EBPs. Grantees mostly attributed these challenges to low compensation, the demanding workload of the job, or the shortage of candidates who met the education or licensing credentials. Staffing challenges often exacerbated enrollment and retention challenges. For example, grantees operated below enrollment capacity when positions were unfilled, needed time to rebuild rapport with clients when the staff delivering the EBPs changed, and used scarce resources to train new staff. One grantee noted that frontline staff received three months of training before they began serving clients. Thus, when frontline staff left the agency, enrollment capacity declined while new staff were recruited and trained.

B. Programmatic TA offered to RPG grantees

In response to these and other challenges, the NCSACW staff provided TA to the RPG grantees through a team of program management liaisons (PMLs) assigned to work with each grantee. PMLs responded to 50 formal requests from grantees for programmatic TA during the year. In addition to working one-on-one with grantees through telephone and email conversations, NCSACW facilitated 12 other in-person or web-based events, including hosting three peer-to-

peer discussions and various sessions at the 2015 Children's Bureau Annual Combined Discretionary Grantees Meeting, where the RPG annual grantee meeting was held. The PMLs also provided on-site assistance to two RPG2 grantees that experienced implementation challenges resulting in changes to their RPG programs.

Across their work with grantees, NCSACW staff identified common challenges faced by grantees, consistent with the challenges the grantees described in site visits and semiannual progress reports. In addition, NCSACW staff worked with grantees to strengthen partnerships and address local factors that influenced RPG implementation—and the implementation of EBPs in particular. Encouraging grantees to plan for sustaining partnerships and programs after RPG grant funding ends was also a priority for NCSACW.

Outreach, recruitment, engagement, and retention. The PMLs worked with grantees to examine the problems with referrals, program enrollment, and attrition mentioned above. These included challenges in identifying eligible participants, receiving anticipated numbers of referrals (including referrals from child welfare agencies), and hiring and retaining RPG staff. PMLs worked with grantees to increase communication with existing referral partners, as well as to find new referral sources. They also worked with grantees on how to retain clients in services. Strategies included engaging recovery support specialists to work with clients, planning for contingency management (a strategy used in substance use disorder treatment that involves giving clients tangible rewards to reinforce positive behaviors such as abstinence), and working with staff on motivational interviewing in their work with clients.

Partnerships, key stakeholders, and contextual issues. Grantees continued to focus on strengthening relationships with their partners, with several grantees reporting increased interest and momentum in collaborative activities. Despite this progress, the majority of grantees also experienced contextual events or community factors that impacted their RPG projects. These included budget cuts and fiscal issues, changes in state policy, and changes in agency personnel.

Implementation of EBPs. Several grantees worked to maintain fidelity of their current EBPs, whereas others modified or replaced their originally selected EBPs to improve service delivery and better meet the needs of their target populations. The NCSACW team assisted grantees as they focused on ensuring that services fit target populations, implementing strategies to become more trauma-informed in their approach to services, and monitored fidelity. Several grantees also sought TA on implementing medication-assisted treatment. One grantee began implementing the treatment, whereas others received training on it and formed work groups to develop policies and procedures to guide field staff on the use of this type of treatment.

Sustainability of RPG services after RPG funding. Grantees were at various stages of sustainability planning. Some grantees integrated sustainability planning into every aspect of grant planning and implementation, whereas others had made little progress identifying funding for services and collaboration after the grant period ended. The majority of grantees experienced some type of sustainability barrier, including implementation challenges, not having enough data to show potential funders that their programs were effective, or losing potential other (non-RPG) funding due to federal or state budget cuts. NCSACW reported that despite these challenges, 12 of the 17 RPG2 grantees reported progress toward being able to sustain at least some components of their program when grant funding ends in 2017. To assist grantees with sustainability planning, PMLs worked with grantees to assess their progress toward sustaining services, planning for sustainability, and identifying potential funding sources.

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VI. RPG ROUND THREE (RPG3) CASES, CHILDREN, AND ADULTS AT EARLY ENROLLMENT

In September 2014, HHS funded four additional RPG projects in a third round of grants, referred to in this report as RPG3. The new partnerships participate in all components of the national cross-site evaluation that began two years earlier with the 2012 RPG2 grants, including the implementation, partnership, and outcomes studies, as well as an impact study, if appropriate given the design of their local evaluations.

The previous report to Congress (HHS, 2016c) described the RPG3 grantees in detail, including their programs, partnerships, and local evaluation designs. The target populations of the four RPG3 grantees varied:

- **Our Kids of Miami-Dade/Monroe Inc.** (Florida) served families with children aged 0 to 11 who were at risk for maltreatment and had a relative with either a suspected or verified substance use disorder.
- **The University of Kansas Center for Research** (Kansas) served families that included a parent with a substance use disorder and a child aged 0 to 3—with a focus on children in foster care or identified as at risk of removal.
- **Montefiore Medical Center** (New York) served families that included a parent with a substance use disorder and children at risk for removal due to abuse and/or neglect.
- **Volunteers of America** (Oregon) served parents in recovery from substance use disorders who were either engaged with or at risk of engagement with child welfare. They emphasized working with African American parents and families.

By April 2016 (about 18 months after their grants began), these grantees had enrolled 369 adults and children.[30] This included 11 participants at Montefiore Medical Center, 48 enrolled by Our Kids of Miami-Dade/Monroe Inc., 117 at Volunteers of America, and 179 at the University of Kansas Center for Research. Because the University of Kansas had the greatest enrollment (46 percent of the total RPG3 caseload), their participants, including very young children in foster care, heavily influenced the aggregate case member characteristics and baseline measures reported throughout this chapter.

Participant characteristics are one important component of the inputs to implementation being studied in the cross-site evaluation (box B in Figure I.1). The characteristics, needs, and strengths of participants influence how the implementation system operates, the outputs of that system, and RPG project outcomes. Therefore, the cross-site evaluation asked grantees to provide detailed background and demographic data to describe participants at the time of their enrollment into the RPG3 projects. Additionally, grantees collected and submitted baseline data

[30] The number of people enrolled as reported by grantees in the semi-annual progress reports (369) is higher than the number of people recorded in the RPG enrollment and services data (177). This difference is largely driven by Volunteers of America, which enrolled a subset of their program participants into their evaluation. Volunteers of America began serving cases before the cross-site evaluation began, and in addition some people enrolled since then have not consented to be in the cross-site evaluation.

on participant characteristics in five outcome domains studied by the cross-site evaluation (see Figure I.1): child well-being, permanency, and safety; adult recovery; and family functioning. Grantees collected the data from participants when they enrolled in RPG services. Grantees will collect follow-up measures when participants exit the program (due to completion or other reasons), in order to measure change over time.

This chapter describes case composition and demographic characteristics of adults and children enrolled in RPG3 during the first 18 months of RPG3 projects (Section A). Sections B, C, D, and E describe baseline child and adult measures in four of the five domains of interest for the cross-site evaluation: (1) child permanency, (2) child safety, (3) adult recovery, and (4) family functioning/stability. At this time the sample is too small to enable analysis of child well-being.[31]

A. RPG Round Three (RPG3) case composition

RPG3 grantees enrolled into the cross-site evaluation 177 people in 65 cases between July 2015 and February 2016. Table VI.1 describes the composition of cases. Because RPG addresses the needs of children at risk due to a potential or actual substance use disorder by an adult close to them, each RPG case included at least two members: one adult and one child.[32] In other respects, the composition of cases varied. There was no cap on the number of people who could be in a single case, and cases could include members who were biologically or nonbiologically related. In addition, some RPG cases did not include all members of a family or household, because some household members did not receive RPG services.

Table VI.1. RPG3 case composition

	RPG3 grantees
Total number of cases	**65**
Total number of individuals	**177**
Total number of adults	84
Total number of children	93
Number of members per case	
Percentage of cases with two members	51
Percentage of cases with three members	34
Percentage of cases with four members	12
Percentage of cases with more than four members	3
Percentage of cases with more than one child	28
Percentage of cases with more than one adult	26
Percentage of two-person cases composed of only biological parents and their children	97

Source: RPG enrollment and services data from July 24, 2015, to February 29, 2016.

Note: Because of rounding, category percentages may add to slightly more or less than 100 percent. The sample size for each statistic was the number of focal children with a nonmissing response to the question.

[31] Most of the child well-being standardized instruments are administered to children of specific age bands, so the sample size of any given measure may be much smaller than the 65 RPG3 focal children in the full sample. For this reason, the sample sizes were too small to draw any conclusions about the well-being of RPG3 focal children at baseline.

[32] An RPG "case" consists of the group of individuals that present themselves to enroll in an RPG program. This may include members of the family, household, or other individuals who may or may not be biologically related.

Most of the 65 cases enrolled in RPG3 projects comprised two or three members. About half of cases (51 percent) included two members—one adult and one child—and 34 percent included three members. The remaining RPG3 cases had four members (12 percent) or more (3 percent). About one-quarter of cases (28 percent) included more than one child, and a similar proportion (26 percent) included more than one adult member.

In most RPG3 cases, all members were biologically related to one another. Ninety-eight percent of cases included a parent or parents and their biological children, and most—94 percent of cases—included no other members. In the six percent of cases that also included other members, those members were foster parents,[33] grandparents, stepparents or parents' partners, or other relatives. Of the 33 cases with only two members, 97 percent were composed of a child and his or her biological parent, usually the mother. Similarly, 88 percent of cases with three or more members were composed of only biologically related siblings and their biological parent or parents.

B. Characteristics of children and adults in RPG Round Three (RPG3) cases at enrollment

For the cross-site evaluation, grantees provided information on the characteristics of both adults and children in each case. This section describes two groups of children: focal children, on whom grantees submitted detailed outcome information, and other children in RPG cases. Biological parents of focal children make up the bulk of the adult case members, and are described next.

1. Children

By February 2016, RPG3 grantees had enrolled 93 children into the cross-site evaluation. Although cases could include multiple children, grantees collected more-detailed data on only one focal child in each case, to reduce the burden of data collection for the cross-site evaluation. Each grantee defined its own rule for selecting the focal child when there was more than one child in a case. Three RPG3 grantees used the age of the children in the case to identify a focal child, though the particular rule differed for each. One grantee chose the youngest child, another chose the oldest child, and the third chose the child closest to age nine. The fourth grantee selected the child that had been cared for the longest by the adult receiving RPG services. Table VI.2 presents this information for the 65 cases enrolled in RPG3 projects by February 2016.

On average, focal children in RPG3 cases were three years old. Seventy-four percent were under age 5, including 29 percent who were younger than 1 year. The average age of other children in RPG3 cases was eight years.

Some children were in foster care when they were enrolled in RPG. At least 43 percent of focal children lived in a foster parent's home, kinship care provider's home, or group home at the time

[33] Some cases included foster parents because some children enrolled in RPG were in foster care. In such cases, the foster parents were part of the case only because of their relationship with one or more children in the case, not because they had, or were suspected of having, substance use problems.

of enrollment, as did at least 21 percent of other children.[34] Forty-five percent of RPG3 focal children, and 61 percent of other children in RPG cases, lived in the primary residence of an adult case member.

Table VI.2. Demographic characteristics of focal and other children in RPG3 cases

	Percentage unless otherwise noted	
	Focal child	**Other children**
Total number of children	**65 children**	**28 children**
Average age at enrollment into RPG	3 years	8 years
Age at enrollment, by category		
Younger than 1	29	7
1 to 4	45	36
5 to 8	9	18
9 or older	17	39
Gender		
Female	54	46
Male	46	54
Race (*n* = 63; 26)[a]		
White only	52	42
Black only	25	50
American Indian or Alaska Native, Asian, or Native Hawaiian or Pacific Islander only	2	0
More than one race	21	8
Ethnicity (*n* = 61; 28)[b]		
Hispanic	31	25
Non-Hispanic	69	75
Primary language spoken at home (*n* = 64; 28)		
English	97	100
Spanish	3	0
Other	0	0
Residence		
Primary residence of adult case member	45	61
Foster parent's residence or group home	43	21
Treatment facility, shelter, or correctional facility[c]	5	11
Other residence[d]	8	7

Source: RPG enrollment and services data from July 24, 2015, to February 29, 2016.

Note: Because of rounding, category percentages may add to slightly more or less than 100 percent. The sample size for each statistic was the number of focal children with a nonmissing response to the question.

[a]Respondents could choose one or more race categories from the following list: White, Black or African American, American Indian or Native American, Asian, and Native Hawaiian or Other Pacific Islander. People who endorsed more than one racial category were categorized as multiracial.

[b]All respondents (regardless of race) were asked to select their ethnicity, either Hispanic or non-Hispanic.

[34] This number may undercount the number who were in foster or kinship care because some children who were in informal, voluntary, or formal kinship foster care were not described as living in a foster parent's home. Some children reported as living in an "other" residence may live with a kinship care provider, but the records did not include enough information to determine the nature of their living situation. *Informal kinship care* refers to arrangements made by the parents and other family members without any involvement from either the child welfare system or the juvenile court system. *Voluntary kinship care* refers to situations in which the children live with relatives and the child welfare system is involved, but the state does not take legal custody. *Formal kinship care* refers to cases in which the children are placed in the legal custody of the state by a judge, and the child welfare system then places the children with grandparents or other kin (HHS, 2009).

Table VI.2. (*continued*)

[c]Children who lived in treatment facilities may have lived in those facilities with their biological parents.

[d]Children whose residences were in this category most often lived with a relative, such as a parent or grandparent who was not included in the RPG case. It is possible that some of these relatives were kinship foster care providers.

Fifty-two percent of focal children and 42 percent of other children were White, 25 percent of focal children and 50 percent of other children were Black, and 21 percent of focal children and 8 percent of other children were multiracial. Thirty-one percent of focal children and 25 percent of other children were Hispanic. Nearly all children (focal and other children) spoke English as their primary language. The most prevalent combinations of race, ethnicity, and language categories among focal children were: White, non-Hispanic, and English speaking (29 percent) and Black, non-Hispanic, and English speaking (22 percent).

2. Biological parents

Virtually every RPG3 case (64 of 65) included at least one biological parent. Table VI.3 presents the demographic and other characteristics of those biological parents at the time they enrolled into RPG3. In cases with two biological parents, we examined the parent who was defined as the focal child's caregiver.[35] Most biological parents were female (86 percent), with an average age of 31. Less than half (48 percent) of RPG3 biological parents were caring for the focal child at the time of enrollment into an RPG project.[36]

Not surprisingly, biological parents shared many of the demographic and background characteristics with the focal children, though fewer parents identified as multiracial. The majority were either White (62 percent) or Black (26 percent) and identified as non-Hispanic (74 percent). Ninety-five percent spoke English as their primary language. The most prevalent combinations of race, ethnicity, and language categories among parents were: White, non-Hispanic, and English speaking (42 percent) and Black, non-Hispanic, and English speaking (22 percent).

Many biological parents enrolled in RPG3 faced financial hardship. Sixty-five percent had earned less than $10,000 in the year preceding enrollment, and about the same percentage were unemployed at the time of enrollment. Almost a quarter (24 percent) reported having no source of income in the previous year.

Parental education status was more mixed. Although 38 percent of RPG3 parents had less than a high school education, 30 percent had a high school diploma or GED, and another 32 percent had at least some postsecondary education. A majority (63 percent) were single, divorced, separated, or widowed at the time they enrolled in RPG. The rest reported being married or living with a partner, most of whom were the focal child's other biological parent. Nine percent of parents lived in an institutional setting at enrollment, usually a substance use disorder treatment center, but in some instances a homeless shelter or correctional facility.

[35] Grantees requested data related to family functioning and child well-being for the cross-site evaluation from the person who was the focal child's caregiver from the child's family of origin—defined as the family in which the focal child grew up or usually resided.

[36] This finding reflects enrollment of foster cases by the University of Kansas, which contributed 46 percent of the sample.

Table VI.3. Demographic characteristics of biological parents in RPG3 cases

Characteristic	Percentage, unless otherwise specified RPG3 Grantees
Number of biological parents	64 parents
Average age at enrollment into RPG	31 years
Gender	
Female	86
Male	14
Race (n = 61)[a]	
White only	62
Black only	26
American Indian or Alaska Native, Asian, or Native Hawaiian or Pacific Islander only	3
More than one race	8
Ethnicity (n = 62)[b]	
Hispanic	26
Non-Hispanic	74
Primary language spoken at home	
English	95
Spanish	5
Other	0
Lived in an institutional setting at enrollment (n = 55)	9
Highest level of education (n = 63)	
Less than high school	38
High school diploma/GED	30
Some postsecondary education[c]	30
Bachelor's degree or higher	2
Income in past 12 months (n = 62)	
$0–$9,999	65
$10,000–$19,000	18
$19,001–$24,999	10
$25,000 or higher	8
Income source (n = 62)[d]	
Wage or salary	32
Public assistance	31
Retirement or pension	2
Disability	10
Other	11
None	24
Employment status (n = 63)	
Full-time employment	13
Part-time employment	14
Self-employed	2
Unemployed	64
Not in the labor force	8
Relationship status (n = 63)	
Single, divorced, separated, or widowed	63
Married to or cohabiting with focal child's biological parent	27
Married to or cohabiting with other individual	10
Parent has care of the focal child	
Yes	48
No[e]	52

Source: RPG enrollment and services data from July 24, 2015, to February 29, 2016.

Table VI.3. (*continued*)

[a]Respondents could choose one or more race categories from the following list: White, Black or African American, American Indian or Native American, Asian, and Native Hawaiian or Other Pacific Islander. Individuals who endorsed more than one racial category were categorized as multiracial.

[b]All respondents (regardless of race) were asked to select their ethnicity, either Hispanic or non-Hispanic.

[c]Includes vocational/technical education or diploma and associate's degree.

[d]Individuals may select more than one response for this field, so percentages add to over 100 percent.

[e]Includes adults who were the primary caregiver from the family of origin but did not have care of the focal child at enrollment, as well as adults in cases where the biological parent was not the primary caregiver from the family of origin but who were enrolled in the case to report on substance use.

C. Child safety and permanency

RPG3 grantees sought to enroll families that included children who were at risk of removal from their homes due to child maltreatment. The cross-site evaluation measured safety (maltreatment) and permanency (removal from and reunification with families) outcomes using child welfare administrative data, and Table VI.4 displays the findings from these data for the year prior to RPG enrollment.

Table VI.4. Proportion of RPG3 focal children experiencing maltreatment and/or removals and placements at least once in the year prior to entering RPG

	Percentage of focal children experiencing event
Maltreatment	
Substantiated maltreatment	28
Unsubstantiated maltreatment	46
Abuse	
Substantiated abuse	3
Unsubstantiated abuse	20
Neglect	
Substantiated neglect	12
Unsubstantiated neglect	23
Removals and placements	
Removed from the home	58
Placed in a permanent setting[a]	16

Source: Administrative data collected from state or county child welfare agencies

Note: Sample sizes are based on the subset of RPG3 grantees who submitted these data elements. All four RPG3 grantees and 65 focal children are included in the safety results (maltreatment, abuse, and neglect). Three grantees and 53 focal children are included in the results on removals and placements.

[a]Percentage of the subset of focal children removed during the year prior to enrollment who were eventually placed into a permanent setting by April 2016. All were ultimately reunited with their family of origin or primary caretakers.

Child maltreatment. As displayed in Table VI.4, of the 65 focal children in the RPG3 sample, 28 percent (18 children) had one or more substantiated episodes of maltreatment, and 46 percent (30 children) had one or more unsubstantiated episodes of maltreatment, in the year prior to enrollment in RPG.[37] Measuring both substantiated and unsubstantiated maltreatment is useful,

[37] A report of maltreatment is substantiated when an investigation by child protective services concludes that the report was supported or founded as defined by state law or policy (HHS, 2015c).

because children with either type of records are at similar risk for poor child well-being outcomes (Casanueva et al., 2012).

Maltreatment includes two primary categories—*abuse* and *neglect*—and rates of each of these are also reported in Table VI.4.[38] *Abuse* is defined as any recent act that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or that presents an imminent risk of serious harm (HHS, 2015b). Among RPG3 focal children, 3 percent were subjects of one or more instances of substantiated abuse and 20 percent were subjects of one or more instances of unsubstantiated abuse. *Neglect* is defined as any recent failure to act on the part of a parent or caretaker that may result in any of the same types of harm or presents an imminent risk of serious harm to the child. Twelve and 23 percent of focal children were subjects of one or more instances of substantiated or unsubstantiated neglect, respectively.

Out-of-home placements. Table VI.4 shows that 58 percent of RPG3 focal children were removed from their homes at some point during the year prior to RPG enrollment.[39] This result is based on data for three of the four RPG3 grantees. The other RPG3 grantee was unable to obtain data on children's removals from the state child welfare agency in time for inclusion in this report.

Foster care is not intended to be a permanent solution for a child; the goal is to find a permanent, stable, and safe home, such as by reunifying the family or through adoption of the child (Center for Advanced Studies in Child Welfare, n.d.). As shown in Table IV.4, of the RPG3 focal children who were removed during the year prior to RPG enrollment, 16 percent were reunited with their family of origin or primary caretakers by April 2016.

D. Adult substance use and treatment

Adults' situations also influence the current or future safety, permanency, and well-being of their children. RPG grantees targeted families in which an adult had a substance use disorder or was at risk of developing one. Therefore, the cross-site evaluation also collects data on adults—including their recent substance use and participation in treatment. Grantees administered the Addiction Severity Index–Self Report (ASI-SR; McLellan et al., 1992), which measures substance use and related symptoms, and the Trauma Symptoms Checklist (TSC-40; Briere & Runtz, 1989), which measures trauma symptoms, to one adult in each case. For this adult, grantees also obtained administrative data on whether he or she had received and completed substance disorder treatment in the year prior to enrollment in RPG. Table VI.5 displays the

[38] Children may also be subject to maltreatment and reported as "other" if it does not fit within abuse or neglect categories or is unknown. The percentage of children experiencing any maltreatment reported in Table VI.4, includes abuse, neglect, and "other."

[39] This number does not include children who were already living outside the home at the beginning of the one-year period prior to enrollment. Some children were already living outside the home before the year prior to RPG enrollment; these children have placement dates but no removal date during the year, which indicates that they were removed prior to the start of the data collection period. In addition, some children may have been removed prior to the data collection period and not subsequently placed during the period, and thus their removal cannot be identified as living outside the home.

drug and alcohol use, trauma symptoms, and participation in substance use treatment among RPG3 adults prior to the start of RPG services.

Drug and alcohol use. Drug use and severe drug use were more prevalent than alcohol use and severe alcohol use, respectively, among RPG3 adults who completed the ASI-SR. Of RPG3 adults who reported fully on the substance use measures, 30 percent exhibited high severity of drug use and just 2 percent exhibited high severity of alcohol use in the past 30 days (Table VI.5). The level of severity is measured by scores estimated using data from the ASI-SR. On a scale from 0 to 1, with 0 representing the lowest severity rating (no alcohol or drug use or related problems in the last 30 days) and 1 the highest, the mean composite scores for drug use and alcohol use for RPG3 adults were 0.11 and 0.03, respectively.

The drug use composite score was nearly the same as the average score for a nationally representative sample of adults in substance use disorder treatment settings (0.10) described in McClellan et al. (2006). However, the alcohol use composite score was markedly lower than the national sample of adults in treatment for this index (0.22). Overall, these findings suggest that among RPG3 adults, drug use tended to be more prevalent than alcohol use, and average severity of drug use among this population was markedly similar to the average use among adults in substance use disorder treatment settings.

Table VI.5. Substance use, treatment, and trauma symptoms of RPG3 adults at baseline

	Instrument	Number	Mean (SD) or percentage	National mean (SD)
Drug use				
Mean score	ASI-SR	53	0.11 (0.14)	0.10 (0.13)[a]
Percentage in high severity category	ASI-SR	53	30%	n.a.
Alcohol use				
Mean score	ASI-SR	51	0.03 (0.06)	0.22 (0.25)[a]
Percentage in high severity category	ASI-SR	51	2%	n.a.
Percentage enrolled in at least one treatment in year prior to programming	n.a.	23	35%	n.a.
Childhood/adult trauma symptoms	TSC-40	56	26.84 (20.36)	33.39 (22.23)[b]

Source: RPG baseline administration of ASI-SR and TSC-40 instruments and administrative data from state substance abuse agencies on treatment participation.

Note: Sample sizes are based on the subset of RPG3 grantees who submitted these data elements. All four RPG3 grantees are included in the ASI-SR and TSC-40 results, and two grantees are included in the results on participation in treatment. Descriptions of all risk indicators are provided in the third report to Congress, Appendix A (U.S. Department of Health & Human Services, 2016b).

SD = standard deviation; n.a. = not applicable.

[a]As reported in McClellan et al., 2006.

[b]The national mean score was computed across several studies that researched high-risk populations: Elliott & Briere, 1992; Zlotnick, 1996; Heffner, Blom, & Anthenelli, 2011; and Whiffen & Benazon, 1997.

Participation in treatment. In addition to administering the ASI-SR to assess substance use prior to RPG enrollment, two of the RPG grantees obtained administrative records on participation in state-funded substance use programs in time for inclusion in this report. As shown in Table VI.5, approximately 35 percent of adult RPG3 participants had been in one or

more publicly funded substance use disorder treatment programs during the year prior to their enrollment in RPG. Only two grantees provided data on participation in substance use programs, and therefore, this statistic is only representative of two of the four RPG3 grantees.

Trauma symptoms. Adults with a substance use disorder often suffer from symptoms related to past or ongoing trauma exposure (Najavits et al., 1997; HHS, 2013b). Therefore every adult who completed the ASI-SR was also asked to complete the TSC-40 to measure symptoms of significant childhood or adult trauma (for example, anxiety attacks or desire to physically hurt oneself). Scores on the TSC-40 range from 0 to 120, where 0 represents never having experienced any trauma symptoms and 120 represents experiencing a wide variety of trauma symptoms with regularity, across the 40 symptoms presented on the instrument. Table VI.5 shows that among the RPG3 participants who completed the TSC-40, the mean total score was 26.84, which was lower than the average score reported for other high-risk populations—specifically, individuals who experienced sexual abuse (Elliot et al., 1992; Whiffen, 1997), were enrolled in psychiatric settings (Zlotnick et al., 1996), or who indicated that they had alcohol use disorder (Heffner, Blom, and Anthenelli, 2011). This suggests that trauma symptoms were not as prevalent among RPG3 adults as might have been expected, given the literature noted above.

E. Family functioning

To understand other important aspects of adult well-being and gain insight into family functioning, the cross-site evaluation collected additional data from the adult in the case who was the focal child's primary caregiver from the child's family of origin—defined as the family in which the focal child grew up or usually resided. In most cases, the focal child's primary caregiver was the biological parent and the same adult reporting on substance use. To measure family functioning at baseline (and to examine differences after RPG participation later on), grantees administered three standardized instruments: the Parenting Stress Index–Short Form (PSI-SF; Abidin, 1995), which measures stress specifically related to the adult's relationship with the focal child; the Center for Epidemiology Studies Depression Scale (CES-D; Radloff, 1977), a measure of depressive symptoms; and the Adult Adolescent Parenting Inventory (AAPI-2; Bavolek and Keene, 1999), which assesses parenting and child-rearing attitudes. Table VI.6 displays the levels of parenting stress, depressive symptoms, and parenting attitudes among RPG3 adults compared to national samples.

Parenting stress. Parenting stress contributes to dysfunctional parenting and is associated with child maltreatment potential (Testa & Smith, 2009; Berger, 2004). As shown in Table VI.6, the mean score on the PSI-SF for RPG3 adults was 76, indicating that they had higher levels of parenting stress on average compared to the national mean of 69. According to the PSI scoring manual, a score above 90 places a person in the high-risk category, which means that he or she reports what would be considered a clinically significant level of parenting stress. Sixteen percent ($N = 33$) of RPG3 adults had a clinically significant level of parenting stress based on this measure, which is higher than the 10 percent of adults scoring in this range in the general population.

Depressive symptoms. On average, RPG3 adults reported levels of depressive symptoms similar to those observed in the general population, as shown in Table VI.6. The mean score on the CES-D among these adults was 10.98, just above the national mean of 9.25. Among the

adult respondents, 29 percent exhibited symptoms of severe depression as defined in the test manual. The interpretation of this risk category is that these adults might need further evaluation and assessment to diagnose depression and determine possible interventions to address it.

Table VI.6. RPG3 caregiver well-being and parenting at enrollment

	Instrument	Sample size for analysis	Mean (SD) or percentage	National mean (SD)	Percentage of adults in high-severity category
Parenting stress	PSI-SF	33	76.48 (15.87)	69 (15.5)[a]	16
Depressive symptoms	CES-D	48	10.98 (9.14)	9.25 (8.58)[b]	29
Inappropriate expectations for child	AAPI-2	43	6.23 (1.56)	5.5 (2)[c]	19
Lack of empathy for child	AAPI-2	43	6.40 (1.59)	5.5 (2)[c]	26
Values corporal punishment	AAPI-2	43	5.74 (1.87)	5.5 (2)[c]	19
Treats child like an adult peer, not a child	AAPI-2	43	6.09 (1.96)	5.5 (2)[c]	21
Oppresses child's independence	AAPI-2	43	6.72 (1.83)	5.5 (2)[c]	35

Source: RPG baseline administration of the AAPI-2, CES-D, and PSI-SF instruments.

Note: Sample sizes are based on the subset of RPG3 grantees who submitted these data elements. All four RPG3 grantees are included in the PSI results and three grantees are included in the CES-D and AAPI-2 results. The AAPI-2 scales are transformed so that higher scores always indicate negative parenting attitude.

SD = standard deviation; n.a. = not applicable.

[a]National means and SD for the PSI-SF were calculated based on the percentile ranks associated with a given raw score in the scoring manual (Abidin, 1995). For example, a raw score of 69 on the PSI-SF corresponds to the 50th percentile.

[b]National means and SD for the CES-D are based on the original norming study of the CES-D described in Radloff (1977).

[c]National means and SD for the AAPI-2 are presented in the scoring manual for the instrument (Bavolek & Keene, 1999).

Parenting attitudes. The AAPI-2 assesses parenting and child-rearing attitudes. For example, the instrument provides information about parental expectations of their children (whether they are age appropriate or not) and their use of corporal punishment (whether they value this approach or prefer alternatives). Across the five scales of the AAPI-2, scores range from one to ten, with higher scores indicating attitudes more strongly associated with child risk of maltreatment. Table VI.6 shows that RPG3 adults scored above the national mean in all five constructs assessed by this instrument. The average scores ranged from 5.74 for the construct "values corporal punishment" to 6.72 for the construct "oppresses child's independence," compared to the national mean of 5.5. As described in the AAPI manual, high scores on the "oppresses child's independence" construct characterize adults who strongly value strict obedience and compliance with parental authority, devalue compromise, and discourage children from voicing their own opinions. Thirty-five percent of RPG3 adults expressed attitudes in this area that were suggestive of a risk for child maltreatment.

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APPENDIX A

SUMMARY OF FINDINGS FROM REGIONAL PARTNERSHIP GRANT REPORTS TO CONGRESS

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The Regional Partnership Grant (RPG) cross-site evaluation provides legislatively mandated performance measurement and assesses the extent to which the grants have been successful in addressing the needs of families with substance use disorders that come to the attention of the child welfare system. It comprises studies of implementation and partnerships, outcomes, and impacts. Each year, the U.S. Department of Health & Human Services (HHS) develops an annual report to Congress to describe the activities of the partnerships and summarize evaluation findings to date (HHS, 2014b, 2015b, 2016b). Below is a summary of findings from the first three reports to Congress.

A. First report to Congress

The first report to Congress (HHS, 2014b) focused on the award and initial implementation of the RPG2 program following reauthorization. Highlights of the report include:

- **RPG partnerships and programs.** As required by the RPG funding, all partnerships included child welfare agencies responsible for the administration of the state's plan under Title IV-B or IV-E of the Social Security Act. In addition, grantees partnered with a number of other agencies—from 4 to 29, including state and county agencies; courts; and private, nonprofit, and faith-based organizations. Each partnership planned to offer between 1 and 15 evidence-informed or evidence-based programs (EBPs) and practices to RPG participants. Across all grantees combined, more than 50 EBPs were planned or in place. Each partnership planned to offer at least one, and as many as 15 different EBPs to participants as part of its RPG project. Across all grantees combined, a total of 51 different EBPs were planned. Of the 51 models, 37 had been reviewed by at least one of five evidence sources; seven others had been evaluated at least once, and of the seven remaining models, four were described by their developers as based on research or evidence.
- **Technical assistance (TA).** HHS established an infrastructure to provide ongoing program- and evaluation-related TA to grantees through the National Center for Substance Abuse and Child Welfare (NCSACW) and Mathematica Policy Research, Inc., respectively.[47] Together, in the first year they received and responded to over 100 requests for TA. NCSACW responded to numerous requests from grantees on such topics as strategies to cross-train staff on child welfare and substance use disorder treatment and sustainability after the grant program ends. Mathematica Policy Research responded to TA requests on such topics as designing an evaluation, obtaining families' consent, recruiting and enrolling families, and working with institutional review boards. In addition to responding to requests, both TA providers held monthly calls with grantees and met with them in-person at two meetings to provide ongoing support and assistance.
- **Evaluation and accountability.** To contribute to the evidence base on effective programs for families served by RPG, HHS required that each grantee evaluate its project with a comparison group study or other rigorous design. HHS reviewed the rigor of the proposed designs, concluding that six local evaluations could offer the strongest level of evidence on program effects; six could offer promising or limited evidence on program effects; and

[47] The Center for Children and Family Futures, Inc. managed NCSACW, which is funded by ACYF and the Substance Abuse and Mental Health Services Administration.

seven could offer descriptive information, such as change over time. HHS also designed the cross-site evaluation.

B. Second report to Congress

The second report to Congress described the progress in the early implementation of the RPG2 projects (HHS, 2015b). Highlights of the report include:

- **Enrollment.** By April 2014, 16 of the 17 grantees had begun enrollment. The number enrolled at each site by then ranged from 35 to just more than 700, for a total of 3,365 participants, 65 percent of them children. Fifteen grantees had obtained Institutional Review Board approval for their local evaluations, and the others had applied for approval. Thirteen had begun enrolling families into the cross-site evaluation.
- **Context.** Not only their own efforts but also external factors affected grantees' progress implementing their RPG projects. Fourteen grantees in 12 states described contextual factors that affected their RPG projects The main factors were: (1) factors related to child welfare (11 grantees); (2) factors related to substance use, or policies affecting substance use disorder (SUD) treatment or individuals with SUDs (7 grantees); and (3) federal or state economic and fiscal factors (7 grantees).
- **Local evaluations.** HHS approved the final design of the cross-site evaluation; received OMB clearance for cross-site evaluation data collection in March 2014; and completed two web-based systems for grantees to submit enrollment, services, baseline, and outcome data. As of April 2014, 15 grantees had obtained Institutional Review Board (IRB) approval for their local evaluations, and others had applied for approval. By that time, of the 19 local evaluations (2 grantees are conducting 2 evaluations of separate projects), 13 had begun participating in the cross-site study, including obtaining IRB approval, enrolling families into the cross-site evaluation, and collecting data for the cross-site evaluation.
- **TA.** Grantees submitted 77 requests for TA, and made another 69 inquiries through an RPG help desk established to provide quick-turnaround information on cross-site evaluation data. The 17 RPG2 grantees made 63 requests to NCSACW for program assistance between May 1, 2013, and April 30, 2014. Common requests were for help in developing strategies to cross-train staff in child welfare, substance use disorder treatment, and other agencies providing services to RPG clients to expand their understanding of the child welfare, substance use disorder treatment, and court systems; planning to sustain the RPG projects after the grant program ends; and addressing underlying values among partners. In addition to program TA, Mathematica received 14 requests from 8 of the 17 grantees to provide TA on evaluation-related topics during the second year of the RPG2 program. Half of the TA requests related to questions about data-collection plans, which reflected the fact that most grantees were preparing to collect evaluation data. In addition, a "help desk" designed to quickly address questions on individual data-collection instruments and processes received 69 inquiries.
- **Addressing trauma.** RPG projects addressed trauma by encouraging trauma-informed practices by providers and RPG partners and through the programs they offered participants. Trauma-informed practices are based on an understanding of the vulnerabilities of trauma survivors that traditional service-delivery approaches may trigger or exacerbate; these

services and programs can be more supportive and avoid retraumatizing participants. Ten grantees implemented EBPs specifically designed to address symptoms of trauma in children and/or adults.

- **Data sharing.** For the RPG evaluations, grantees were encouraged to obtain administrative data on child welfare and substance use disorder treatment to measure outcomes for their local evaluations and for use in the cross-site evaluation. Grantees had mixed success getting agreements in place to obtain these data. State agencies were reluctant to share information if they did not have established relationships with the requesting organizations. Such agencies also had competing demands and often found it difficult to marshal the resources needed to fulfill requests for data. While HHS strongly encourages state child welfare agencies to share data with discretionary grantees—and only five grantees had failed to establish agreements to receive these data—the grantees had less leverage with state substance use services agencies, and nine still had not received approvals for their requested substance use disorder treatment data. The experience of the RPG2 grantees suggests that challenges can undermine or prevent the use of administrative data for evaluation purposes.

C. Third report to Congress

The third report to Congress updated the status of implementation, and provided an early description of the families being served by the RPG2 projects and the services they were receiving. It also introduced the new cohort of RPG3 grantees. The main sources of data were: (1) grantees' semiannual progress reports submitted in October 2014 and April 2015, (2) data on the enrollment of and services provided to RPG2 cases between February 2014 and April 2015, and (3) outcome data collected from RPG2 adults using standardized instruments as well as administrative data on a common set of child welfare and substance use disorder treatment elements. The report described the characteristics measured at baseline, or program entry, for participants enrolled as of April 2015. Highlights of the report include:

- **Enrollment.** By April 2015, the 17 RPG2 grantees had enrolled a total of 5,517 participants, 59 percent of them children. Due to the fact that the RPG program addresses the needs of children at risk of entering the child welfare system due to substance use disorder experienced by an adult close to them, each RPG case includes at least two members: one adult and one child. Nearly half of the cases (46 percent) enrolled included only these two members; the remaining half of the cases (54 percent) included more than two members.
- **Rates of maltreatment.** Data obtained by grantees from their state or county child welfare agencies showed that, as intended, RPG2 projects enrolled some children with documented maltreatment or other previous experience with the child welfare system. Of the 567 focal children in the sample for whom records were received, 31 percent (176 children) had one or more substantiated episodes of maltreatment in the year prior to enrollment in RPG.
- **Caregiver substance use.** In order to gauge the extent to which caregiver substance misuse existed in the lives of RPG2 adults, grantees provided data on (1) substance use severity for RPG2 adults, (2) contextual/life factors affected by substance use, (3) trauma exposure, and (4) participation in substance use disorder treatment. The results of the data analysis demonstrated that:

  - Just over one-third (37 percent) of the RPG2 adults exhibited high severity of substance use (either drug or alcohol or use of both) in the past 30 days.
  - More than one-fourth (27 percent) of all primary caregivers of RPG2 children experienced elevated levels of parenting stress, and their mean score for parenting stress exceeded the national mean as measured by the Parenting Stress Index-Short Form.
  - On average, RPG2 adults reported levels of depressive symptoms that were higher than observed in the general population. Among the adult respondents, 38 percent exhibited symptoms of severe depression, as defined by the test manual for the instrument used by grantees.
  - A trauma assessment administered at baseline to the adults for whom substance use and treatment data were collected showed that adults had, on average, symptoms of post-traumatic stress disorder at rates similar to people who had previously experienced sexual abuse (Elliott & Briere, 1992; Whiffen & Benazon, 1997), were enrolled in psychiatric settings (Zlotnick, 1996), or indicated alcohol use disorder (Heffner, Blom, & Anthenelli, 2011).
  - At least 20 percent of adult RPG2 participants had been in one or more publicly funded substance use disorder treatment programs during the year prior to their enrollment in RPG.

- **Child well-being.** Child well-being was also assessed; data from instruments revealed that, at enrollment, RPG2 children were at higher risk than national samples of children in some, but not all, areas of well-being. Children were assessed at baseline on five aspects of child well-being: sensory processing, executive functioning, emotional and behavioral problems, socialization, and trauma symptoms.
- **Delivery of evidence-based programs or practices.** In total, 16 RPG2 grantees enrolled participants in 19 different EBPs. The grantees provided five different types of EBPs to meet the needs of their target populations: family strengthening, response to trauma, child-caregiver therapy, therapy or counseling styles, substance use disorder treatment, and family treatment drug court. Only 2 of the grantees offered just one EBP; the remaining offered several EBPs. Among the five types of EBPs:
  - 53 percent of all RPG cases enrolled in family-strengthening EBPs.
  - 19 percent enrolled in response-to-trauma EBPs.
  - 13 percent enrolled in substance use disorder treatment EBPs.
  - 6 percent enrolled in counseling style EBPs.
  - 5 percent enrolled in child-caregiver therapy EBPs.
  - 1 percent enrolled in family treatment drug court EBPs.
- **Implementation status.** RPG2 projects were in their third year of implementation. Some projects faced challenges related to state level changes, staff turnover in child welfare organizations, and challenges related to meeting enrollment targets. However, projects also demonstrated creativity, innovation, and the use of best practices to enroll participants and engage providers.

- **RPG3 grantees.** Four new five-year grants (RPG3 projects) were awarded in September 2014. With their partners, RPG3 grantees planned to provide a variety of services to children and their caregivers in the identified target groups. Planned services included, for example, parenting education or skills trainings programs, referral to substance use disorder treatment or other needed services, counseling, support from a peer specialist, and trauma interventions and/or trauma screening. One project planned to offer a drop-in center as a hub for all services.

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APPENDIX B

OPERATIONALIZING THE NATIONAL IMPLEMENTATION RESEARCH NETWORK IMPLEMENTATION DRIVERS

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As a framework for examining the implementation of the focal evidence-based programs (EBPs), the cross-site evaluation developed measures of the implementation drivers from the implementation sciences literature, collected data from the RPG2 grantees on the measures, and then used a process to rate their progress toward the implementation of the drivers.

The National Implementation Research Network (NIRN) provides an assessment protocol for the implementation drivers (Fixsen et al., 2013), but the assessment tool is intended for group discussion applications, rather than interviews to collect data on the status of the drivers. To adapt it for data collection and analysis for the cross-site evaluation, the evaluation contractor carried out the following steps:

1. Conducted a literature search to define the drivers and other relevant key terms associated with the drivers
2. Identified the key elements found in the literature to be important aspects of each implementation driver, and used the literature to develop definitions of each element[48]
3. Using definitions and key elements from the literature, created questions for each element across the drivers that were included in the EBP provider site visit interview protocols

The data collected about each element for each driver during the site visits were then coded and analyzed. Each element was rated as "in place," "partially in place," or "not in place." If there was not enough information (for example, if there was no time for certain questions to be asked in the interview), the element was coded as "not enough information for a rating."[49]

Multiple staff were asked the questions about the implementation drivers, and there was some variation across staff in their responses. In general, a "majority rules" approach to rating was followed, so that a driver element was rated by what the majority of respondents for each EBP provider reported. An element was rated as "partially in place" for a provider if respondents were about evenly split in their reports or if the element was in place for one of the grantee's EBPs but not for another EBP.

[48] For example, key elements of the training driver include that training is provided in a formal, organized way; that the training covers background, theory, and goals of the policy or program; and that training includes demonstrations of key concepts. The discussion guides developed for the cross-site evaluation site visit interviews thus included questions about each of these topics.

[49] If fewer than half of the site visit participants from a grantee provided information about a driver, it was coded as "not enough information for a rating."

To aggregate the ratings of the elements to a rating for the drivers, a rating of "in place" was assigned for a score of two, a rating of "partially in place" for a score of one, and a rating of "not in place" for a score of zero. The ratings of the elements were then averaged to determine the rating of the driver.[50] Finally, an average of the driver ratings was calculated to determine if the staff competency, organization, and leadership drivers were in place, partially in place, or not in place for each provider.

[50] If the average score was two, the driver was deemed "in place." If the average score was one, the driver was deemed "partially in place." If the average score rounded to zero, the driver was deemed "not in place." For individual elements of the driver lacking enough information for a rating were not included when creating the score for the driver.

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