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

2014 and 2017 Regional Partnership Grants to Increase the Well-Being of and to Improve the Permanency Outcomes for Children Affected by Substance Abuse:

Sixth 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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December 2021

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EXECUTIVE SUMMARY

A. Regional Partnership Grants

Responding to parental substance use issues as a key factor underlying the abuse or neglect experienced by many children in the child welfare system, in 2006 Congress passed and the president signed the Child and Family Services Improvement Act of 2006 (Pub. L. 109-288). The legislation amended Section 437 of the Social Security Act (42 U.S.C. 629g[f]) to include a new competitive grants program: "Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Abuse" (Box ES.1).

> **Box ES.1 Terminology used in this report**
>
> There has been movement in recent years to discontinue use of non-clinical or stigmatizing language such as "addiction" and "substance abuse" in favor of less stigmatizing language such as "substance use disorder" and "substance use." Whenever possible, this report uses clinical, nonstigmatizing language as set forth in a Surgeon General's report (HHS, 2016), and/or as recommended by the Office of National Drug Control Policy (Botticelli, 2017), except when older terminology appears in proper names such as the title of legislation, a program, or a reference.

Called Regional Partnership Grants (RPGs), the funds were intended to provide, through interagency collaboration and integration of programs and services, services and activities designed to increase the well-being of, improve permanency outcomes for, and enhance the safety of children in or at risk of out-of-home placement as a result of a parent's or caretaker's methamphetamine or other substance misuse.[1] The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) reauthorized the RPG program and extended funding. Beginning in 2007, HHS has funded five cohorts of RPGs.

Round 1. The first cohort of 53 partnerships, funded in September 2007, has ended.

Round 2. The second cohort of 17 partnerships, funded in September 2012, has also ended.

Rounds 3 and 4. In September 2014, HHS funded a cohort of four 5-year RPGs, and in September 2017, HHS funded a fourth cohort of seventeen 5-year RPGs. This report discusses these 21 RPG partnerships, 4 whose grants ended in September 2019 and 17 whose grants end in September 2022. This report refers to these two cohorts as RPG3 and RPG4, respectively, and they are the subject of this report.

Rounds 5 and 6. A fifth cohort of 10 partnerships began in September 2018. Initially funded as three-year grants, midway through the initial grant period, HHS offered 2-year extensions, with additional funds. HHS then funded eight 5-year partnerships in 2019. Information on these two cohorts will be included in future reports.

[1] Misuse of a substance is defined by the Surgeon General as, "the use of any substance in a manner, situation, amount or frequency that can cause harm to users or to those around them. For some substances or individuals, any use (e.g., under-age drinking, injection drug use) would constitute as misuse" (HHS 2016).

RPG is the only federal program specifically and solely intended to address the intersection of child welfare and substance use issues. As required in the legislation, HHS has collected performance and evaluation data from all funded RPGs. To comply with the RPG authorizing legislation and to share progress and findings with policymakers, practitioners, researchers, and the public, HHS has used these data to issue regular reports about the program to Congress. RPG3 grantees are part of a continuing national cross-site evaluation that was initiated with the 2012 RPG funding cycle. This report summarizes the findings on (1) a partnership study conducted on the RPG3 projects and (2) the alignment of their evidence-based practice (EBP) operations with implementation best practices. This report also introduces the RPG4 partnerships and summarizes elements of the emerging redesign for the national cross-site evaluation developed during the first year of these grants.

B. RPG3 key findings

Using data from web-based surveys, combined with data collected during site visits, the cross-site evaluation examined progress in building effective partnerships and implementing EBPs. There was notable progress in both areas.

1. Partnerships

The funding opportunity announcement for RPG3 required grantees to collaborate with a wide range of family-serving agencies, including, but not limited to, child welfare agencies, substance use treatment providers, and other organizations (Administration for Children and Families, 2014). Partnerships among agencies in these sectors can promote positive outcomes for children and families (Green, Rockhill, & Burrus, 2008; McAlpine, Marshall, & Doran, 2001; Semidei, Radel, & Nolan, 2001; Smith & Mogro-Wilson, 2008). Integrating the services provided between child welfare and other systems has been shown to significantly improve child permanency outcomes (Wells, 2012).

The extent of collaboration across organizations in a partnership can be thought of as a continuum, or levels as defined for the cross-site evaluation, described next. Integrated service provision is far along that continuum and requires trust among partner organizations, shared resources and support, and codified procedures for coordinating work across organizations.

All four of the partnerships appear to have established elements of a first level of collaboration. They had (1) a shared interest in solving a common problem and a plan to address that problem, (2) ground rules for working together, and (3) formal communication opportunities both in and outside of RPG meetings as avenues for collaboration to occur. Partnerships expanded their collaboration beyond these foundational activities, demonstrating successes in aligning some operational processes, such as screening and assessment, and staff training, which were all elements of the second level of collaboration. Progress toward providing integrated services was more limited, perhaps because some partnerships did not set it as an explicit goal. However three of the four partnerships did achieve aspects of integrated service provision (the third level), such as sharing information, aligning principles and timeframes and coordinating services with a quarter to a third of their partner organizations.

2. Implementing evidence-based programs and practices

After the reauthorization of RPG in 2011, HHS requested that projects applying for grants include specific, well-defined program services and activities that were based on or informed by evidence. An important component of the inclusion of evidence-based or evidence-informed programs and practices (EBPs) is proper or high-quality implementation. Close adherence to an EBP's prescribed approach is necessary for the approach to bring about the desired outcomes for participants consistently (Metz, Blase, & Bowie, 2007).

The cross-site evaluation assessed the potential ability of frontline staff (those who work directly with families) to deliver these EBPs with fidelity by examining factors referred to as "implementation drivers," which are best practices that research has shown to be associated with successfully implementing EBPs (Fixsen, Blase, Metz, & Van Dyke, 2013). The best practices examined fall under three categories: staff competency, organizational climate and supports provided to staff, and leadership (Fixsen, Blase, Naoom, & Wallace, 2009; Metz et al., 2007).

The evaluation found that, to build the capacity of staff to implement their selected EBPs, each of the four RPG3 projects had many best practices for implementation in place, as measured by the cross-site evaluation, with some opportunities for improvement, such as better use of data. The practices used varied by projects' unique combinations of staff sizes, target populations, and implementation plans. Two of the projects worked directly with the EBP developers, who were involved in implementation planning, training, and coaching staff, and two did not. Despite these and other differences, staff from the RPG3 projects were nearly uniform in their descriptions of organizational supports, leadership, and organizational climates that supported their work.

C. RPG4 projects and evaluations

In September 2017, HHS awarded a fourth round of seventeen 5-year RPGs authorized by the Child and Family Services Improvement and Innovation Act (Pub. L. 112-34). The projects span the continental United States and Alaska, including both urban and rural areas.

The RPG4 lead agencies (grantees) include multiple types of organizations, though most are service providers. Across the 17 projects, 13 grantees are nonprofit organizations serving children, adults, or families; 3 are large public research universities; and 1 grantee is a state substance use services agency that funds and oversees substance use treatment in the state. Of all 17 RPG4 grantees, 7 participated in previous RPG rounds, including 2 grantees that participated in two previous rounds.

1. Planned services

Although all RPG projects share a common goal of improving the well-being of children affected by a caregiver's substance use issues, they can seek to achieve this goal by providing services to the child, the adult in recovery, the family unit, or a combination of these. Across the 17 RPG4 projects, 10 plan to serve both the child and adult separately or together, 6 plan to offer services only to adults, and 1 plans to offer only child-based services. Despite the variation in approaches to services across the RPG4 projects, they show some commonalities in the types of services they plan to offer. Services generally fall into one of six categories: (1) family strengthening, such as parenting courses and family problem-solving activities; (2) substance use treatment;

(3) trauma, behavioral, or mental health therapy or counseling; (4) case management; (5) peer coaching from a mentor with lived experience in recovering from substance use issues; and (6) medical care for a child's prenatal exposure to substances.

Combined, grantees named 71 programs, curricula, and practices that they plan to implement. The most commonly reported program, the Nurturing Parenting Program (a parenting course with curricula tailored to families with a parent in recovery from a substance use disorder or SUD), will be offered by eight projects. In addition, a few projects will use the same substance use treatment programs, including Seeking Safety (four projects), Helping Women Recover/Helping Men Recover (three), and Living in Balance (three). Some grantees will also use the same approaches to psychotherapy, such as motivational interviewing (five) and cognitive behavioral therapy (three).

2. Local evaluations

As with previous cohorts, HHS requires each RPG4 project team to conduct a local evaluation. As specified in the funding opportunity announcement, each project team must plan and conduct a rigorous evaluation of program effects.

To assess the details of the proposed approaches, HHS worked with the cross-site evaluation contractor to assess each local impact evaluation. In assessing the strength of these designs, HHS considered the level of evidence on project effectiveness that the evaluations could provide if well implemented. HHS assigned a rating to each of the 19 local impact evaluations across the 17 projects (two projects planned to conduct two evaluations each). Six received a strong rating, with most of the remainder receiving a promising rating.

3. The cross-site evaluation

The RPG4 cross-site evaluation will build on the previous cross-site evaluation design implemented for RPG2 and RPG3 but will be tailored to the RPG4 projects and reflect HHS's current priorities. Through the RPG4 cross-site evaluation, HHS seeks to better understand (1) the partnerships that form the basis of each project, (2) who was served, (3) how they were served, (4) their outcomes, and (5) the impacts of the projects. The evaluation will examine (1) services provided, (2) program improvement and sustainability, (3) child and family outcomes, and (4) program impacts (outcomes attributable to the projects).

D. Future Reports to Congress and RPG cohorts

The RPG4 national cross-site evaluation will produce three Reports to Congress, of which this report constitutes the first. HHS will submit an interim report on implementation and early cross-site evaluation findings after the third year of RPG4, in 2021. HHS will submit a final report, with all remaining cross-site evaluation findings, at the end of the 5-year grant period, during fiscal year 2023. HHS funded a fifth cohort of RPGs in September 2018. These ten partnerships will also be included in the cross-site evaluation. Future reports to Congress will describe these grantees and their evaluations and provide findings from the cross-site evaluation.

I. INTRODUCTION

In 1999, six federal agencies came together to publish a first-of-its-kind report on the intersection of substance use and child protection (U.S. Department of Human Services [HHS], 1999). The comprehensive report, *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*, established adult substance use as a critical issue for child welfare because it was a major factor contributing to child neglect and abuse and one of the key barriers to family reunification. The report estimated that 11 percent of U.S. children, 8.3 million individuals, lived with at least one parent who either had an alcohol or other substance use disorder (SUD). It described differences in perspectives, infrastructure, and policies between the child welfare and substance use treatment systems that impeded cooperation, engendered mistrust, and hampered efforts to address co-occurring adult substance use and child maltreatment (Box I.1).

Box I.1 Terminology used in this report

There has been movement in recent years to discontinue use of non-clinical or stigmatizing language such as "addiction" and "substance abuse" in favor of less stigmatizing language such as "substance use disorder" and "substance use." Whenever possible, this report uses clinical, nonstigmatizing language as set forth in a Surgeon General's report (HHS, 2016), and/or as recommended by the Office of National Drug Control Policy (Botticelli, 2017), except when older terminology appears in proper names such as the title of legislation, a program, or a reference.

Research briefs produced by the office of the Assistant Secretary for Planning and Evaluation (ASPE) within HHS, nearly two decades later, echoed the 1999 findings. Exploring potential reasons for a 10 percent increase in the number of children entering foster care after a decade of sustained declines in the foster care caseload, the study described in the briefs found an association between (a) drug overdose deaths and drug-related hospitalizations and (b) child welfare caseload measures (Ghertner, Baldwin, Crouse, Radel, & Waters, 2018; Radel, Baldwin, Crouse, Ghertner, & Waters, 2018). This more recent study of parental substance use and child welfare identified similar barriers to families in the child welfare system accessing substance use treatment as well as barriers to collaboration between the child welfare and substance use treatment systems that prevented meeting the needs of these families.

For example, the 1999 report, *Blending Perspectives and Building Common Ground*, cited barriers, such as:

- Complex child and family needs in addition to adult substance use and child maltreatment, since both rarely occur in isolation.
- Differing perspectives between substance use treatment providers and child welfare agencies on whether the adult or child constitutes the primary client and hence when to prioritize their needs.
- Differences in expected outcomes and definitions of successful outcomes; for instance, treatment might be successful while child safety issues remain or unsuccessful even after child welfare goals have been met.

- Contextual factors such as shortages of substance use treatment services (especially for mothers with young children) and confidentiality requirements that limit shared data or case information across systems.

ASPE's 2018 research on substance use and child welfare caseloads cited similar factors, such as:

- Multiple issues faced by parents using substances, such as domestic or intimate partner violence, mental illness, and exposure to trauma.
- Haphazard assessment for substance use in child welfare cases and a general lack of timely substance use assessments and access to treatment.
- Harmful attitudes, such as misunderstanding and mistrust of using medication for a SUD within the child welfare field, or even within the substance use treatment field, and pessimism among welfare staff about the likelihood of successful resolution of serious substance misuse or disorders.
- Shortages of treatment, especially treatment that addresses family issues and parenting and residential treatment that allows children to reside with their parent in treatment.
- Systemic barriers, such as barriers to data sharing, hindering collaboration between child welfare agencies and substance use treatment programs.

Both studies also described the difficulty that families face navigating competing timelines for substance use treatment and child welfare services. Access to treatment depends on timely assessment for possible SUD, the availability of slots in appropriate programs or facilities, and coverage by Medicaid or private insurance. One or more courses of treatment is often necessary, and relapse is often part of the process of recovery. Many aspects of child development, on the other hand, progress rapidly. The natural sense of urgency in resolving child placement that child welfare caseworkers might feel is reinforced by requirements set forth in the Adoption and Safe Families Act (ASFA) of 1997 (Pub. L. 105-89). To help ensure children do not languish in foster care or experience multiple placements, ASFA requires states to file for termination of parental rights once children have been in foster care for 15 of the most recent 22 months, except in certain allowable circumstances. Family court judges ultimately interpret those allowable circumstances, making the courts a third system, along with substance use treatment and child welfare, that influences whether and how communities and states address the needs of these families.

A. The changing landscape of substance use

According to the HHS 1999 report, many children live with a parent with a substance use issue. Among U.S. children, 3.8 million lived with a parent with an alcohol use disorder. Another 2.1 million lived with a parent who used illicit drugs, and 2.8 million lived with a parent who misused both alcohol and drugs.

Drug use patterns have shifted over time. In the early 2000s, the use of methamphetamines, including by women of child-bearing age, increased (Hohman, Oliver, & Wright, 2004). Production of methamphetamines made from pseudoephedrine in domestic laboratories operated

in or near private homes, primarily in rural or remote areas, also increased (Robles, 2018). Thus, in addition to concerns about the welfare of children due to drug misuse by a parent, children were also endangered by living the scene of laboratories where methamphetamine was manufactured. In these situations, child protective services workers often needed to collaborate with police, district attorneys, and physicians.

Passage of the Combat Methamphetamine Epidemic Act of 2005 (Pub. L. 109-177) and actions by individual states reduced access to pseudoephedrine, and use and domestic production of methamphetamines declined. Meanwhile, however, concerns about undertreatment of severe pain and the spread of misunderstood or misleading information about the likelihood of addiction to opiate analgesics led physicians to increase prescriptions for opioids and opioid-based medications (Jones, Viswanath, Peck, Kaye, Gill, & Simonopoulos, 2018). As a result, opioid misuse and diversion (the illegal transfer of prescription drugs from the person for whom they were prescribed to others), and deaths involving opioids, increased. Some communities and states were especially hard-hit.

In response, federal, state, and industry efforts to reduce the proliferation of opioids have been instituted, and prescriptions for opioids have decreased somewhat. However, as one unintended consequence, in 2013, deaths from heroin overdose increased as people substituted heroin, which had become cheap and easily obtained in some regions of the country, for opioids that were less available or more costly (Ciccarone, 2017).[2] In a new phase of the opioid crises in the United States, deaths from synthetic opioids, such as fentanyl, rose from 2013 to 2016.

Along with treatment providers and medical and law enforcement agencies, local and state child welfare systems have been on the front lines of the national response to changing drug availability and drug use patterns (Kohumban, Rodriguez, & Haskins, 2018). Most recently, anecdotal and other evidence indicate that the opioid epidemic has burdened or, in some areas, overwhelmed the capacity of the foster care system. Nationally, rates of drug overdose deaths and drug-related hospitalizations have been correlated with child welfare caseload rates (Ghertner et al., 2018). Increases in rates of overdose deaths and drug-related hospitalizations are correlated with a higher proportion of children entering foster care after reports of child maltreatment.

The alarming rise of opioid use led to a large federal effort centered on the Comprehensive Addiction and Recovery Act (Pub. L. 114-198), which includes increased funding for evidence-based opioid and heroin treatment and intervention programs. Although opioid misuse has rightfully gained national attention, the number of parents using tobacco and misusing alcohol is substantially higher than the number misusing opioids. And importantly, despite the focus in the media and public policy debates on illicit drugs, alcohol-related hospitalizations have a slightly higher, statistically significant relationship with foster care entry rates (Ghertner et al., 2018).

[2] Deaths due to heroin-related overdose increased by 286 percent from 2002 to 2013, and approximately 80 percent of heroin users admitted to misusing prescription opioids before turning to heroin (National Capital Poison Control Center, 2018).

Trends in substance use have changed over time; however, child welfare agencies continue to confront three basic challenges (HHS, 2017):

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

B. Regional Partnership Grants program, evaluation, and technical assistance

Responding to parental substance use issues as a key factor underlying the abuse or neglect experienced by many children in the child welfare system, in 2006 Congress passed and the president signed the Child and Family Services Improvement Act of 2006 (Pub. L. 109-288). The legislation amended Section 437 of the Social Security Act (42 U.S.C. 629g[f]) to include a new competitive grants program: "Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine or Other Substance Abuse." Called "Regional Partnership Grants" (RPG), the funds were intended to provide, through interagency collaboration and integration of programs and services, services and activities designed to increase the well-being of, improve permanency outcomes for, and enhance the safety of children in or at risk of out-of-home placement as a result of a parent's or caretaker's methamphetamine or other substance misuse.[3] The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) reauthorized the RPG program and extended funding. The legislation removed most references to methamphetamine, including the requirement that gave weight to grant applications focused on methamphetamine use.

Based on the authorizing and reauthorizing legislation, beginning in 2007, HHS has funded five cohorts of RPGs:

- Round 1. The first cohort of 53 partnerships, funded in September 2007, has ended.
- Round 2. The second cohort of 17 partnerships, funded in September 2012, has also ended.
- Rounds 3 and 4. In September 2014, HHS funded a cohort of four 5-year RPGs, and in September 2017, HHS funded a fourth cohort of seventeen 5-year RPGs. This report discusses these 21 RPG partnerships, 4 whose grants ended in September 2019 and 17 whose grants end in September 2022. This report refers to these two cohorts as RPG3 and RPG4, respectively. They are the subjects of this report.
- Rounds 5 and 6. A fifth cohort of 10 partnerships began in September 2018. Initially funded as three-year grants, midway through the initial grant period, HHS offered 2-year

[3] Misuse of a substance is defined by the Surgeon General as, "the use of any substance in a manner, situation, amount or frequency that can cause harm to users or to those around them. For some substances or individuals, any use (e.g., under-age drinking, injection drug use) would constitute as misuse" (HHS 2016).

extensions, with additional funds. HHS funded eight 5-year partnerships in 2019. These cohorts will be discussed in future reports.

1. The RPG program

As the program's name indicates, the central strategy of RPG is the formation of collaborative partnerships to bring together state and local systems to more effectively address the needs of families with substance use issues and child maltreatment risk or involvement. The RPG authorizing legislation defined "regional partnerships" as two or more partners, one of which must be the state child welfare agency responsible for administration of the state plan under Title IV-B or IV-E of the Social Security Act. Tribes have been exempt from this requirement, but had to include at least one nontribal partner. Partnerships could be of any size, but were to include at least one of the following parties:

- A state substance use agency
- An Indian tribe or tribal consortium
- Nonprofit or private child welfare service providers
- Community health service providers
- Community mental health providers
- Local law enforcement agencies
- Judges and court personnel
- Juvenile justice officials
- School personnel
- Tribal child welfare agencies, or consortia of such agencies
- Other child and family service agencies or entities

The legislation specified that grant funds could be used for six general purposes:

1. Family-based, comprehensive, long-term, substance use treatment services
2. Early intervention and preventive services
3. Child and family counseling
4. Mental health services
5. Parenting skills training
6. Replication of successful models for providing family-based, comprehensive, long-term, substance use treatment services

One main difference between the first and second round of RPG was the emphasis on the use of evidence-based or evidence-informed programs and practices (EBPs) by HHS for the second round (and later rounds) of the grants. *Evidence-based* programs or practices use a defined curriculum or set of services that, when implemented with fidelity as a whole, have been

validated by some form of scientific evidence. *Evidence-informed* programs or practices use the best available research and practice knowledge to guide program design and implementation; they allow for innovation while incorporating the lessons learned from existing research (Child Welfare Information Gateway, n.d.).

2. Evaluation

The authorizing legislation also set forth requirements that HHS select and then obtain from grantees performance indicators to assess the grantees' outcomes. For the first round of grants, awarded in 2007, HHS initiated consultation with the field as to appropriate performance indicators. Ultimately, and with support from the Center for Children and Family Futures, Inc. (CCFF), the RPG grantees and HHS developed a set of performance indicators used for required reports to Congress. All 53 grantees submitted to CCFF subsets of the indicators appropriate to their projects, goals, and target populations. When the second round of RPG projects was funded in 2012, HHS contracted with Mathematica to design and conduct a national cross-site evaluation of the RPG program using common data elements collected from all 17 of the partnerships awarded grants in 2012.

Data elements approved by HHS for the cross-site evaluation, which began with the second cohort of grantees, were similar to the performance indicators used for the earlier round of RPG. For example, both CCFF and Mathematica collected data to assess the RPG partnerships by describing members, partner roles, and the quality and level of collaboration that occurred. Both obtained data on the characteristics of adults and children who enrolled in RPG in order to describe the target populations selected and served by each project and by the overall program. The performance indicator study and the cross-site evaluation both gathered data to track implementation, including enrollment in RPG and the delivery of the unique programs and services developed by the projects, as well as data on the implementation successes and challenges experienced by the projects. And both measured changes in family outcomes between enrollment and a follow-up point such as program completion (HHS, 2016; HHS, forthcoming).

The cross-site evaluation also examined the evidence base of some 50 EBPs proposed by the 2012 RPG grantees (Strong, Avellar, Francis, Angus, & Mraz Esposito, 2013) and collected data to examine whether they were implemented using implementation drivers. These are defined as "processes that can be leveraged to improve competence and to create a more hospitable organizational and systems environment for an evidence-based program or practice" (Fixsen, Blase, Naoom, & Duda, 2013–2015).

3. Technical assistance

Partnerships selected for RPG grant awards received the significant benefit of federal funding to help address their stated goals, but they also shouldered important responsibilities. To support their efforts, HHS provided technical assistance (TA) to the grantees through two federal contractors. As part of its contract to manage the National Center for Substance Abuse and Child Welfare (NCSACW, which is funded by the Administration for Children, Youth and Families [ACYF] and the Substance Abuse and Mental Health Services Administration [SAMHSA]), CCFF provided TA and other activities to support the RPG projects funded in 2007 and 2012. This included assisting the 2007 grantees to collect and submit performance

measures and to conduct their own, project-specific evaluations. Similarly, as part of its contract to design and conduct the RPG national cross-site evaluation beginning in 2012, Mathematica provided TA to support that cohort's project-specific evaluations, referred to in this report as "local evaluations," and grantees' participation in the national cross-site evaluation. Both contractors also provided group TA, using such methods as webinars and presentations at grantee /conferences organized each year by HHS.

C. Reports to Congress

To comply with the RPG authorizing legislation and to share progress and findings with policymakers, practitioners, researchers, and the public, HHS has regularly issued reports about the program to Congress. RPG is the only federal program specifically and solely intended to address the intersection of child welfare and substance use issues. As such, it generates qualitative and quantitative data of importance to these audiences. Prior reports provide a library of information on relevant topics in this field. Planned or anticipated reports on ongoing and future cohorts of grantees will continue to build knowledge.

1. Prior RPG reports to Congress

HHS submitted four reports on the first cohort of partnerships funded in 2007 (Table I.1). These reports used performance measures submitted by the lead agencies for each partnership to track performance and family outcomes. The final report on this first cohort of RPG partnerships, referred to in this report as "RPG1," provided a comprehensive and detailed summary of RPG project implementation and outcomes. It described families who participated in RPG, improvements in child safety and permanency, adult recovery, participant well-being, and collaboration across systems. It identified numerous lessons learned in project implementation, cross-system collaboration, sustainability, and project evaluation.

Table I.1. RPG reports to Congress

RPG cohort (and year funded)	Report title	Year released
RPG1 (2007)	*Targeted grants to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse: First Annual Report to Congress.*	2012
RPG1 (2007)	*Targeted grants to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse: Second Annual Report to Congress.*	2013
RPG1 (2007)	*Targeted grants to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse: Third Annual Report to Congress.*	2014
RPG1 (2007)	*Targeted grants to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse: Fourth Annual Report to Congress.*	2017
RPG2 (2012)	*2012 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: First Annual Report to Congress*	2014
RPG2 (2012)	*2012 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: Second Annual Report to Congress*	2015

Table I.1 (continued)

RPG cohort (and year funded)	Report title	Year released
RPG2, 3 (2012, 2014)	*2012 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: Third Annual Report to Congress*	2016
RPG2 (2012, 2014)	*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*	2018
RPG2 (2012)	*2012 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: Fifth Annual Report to Congress*	2020
RPG3, 4 (2014 and 2017)	*2014 and 2017 Regional Partnership Grants to Increase the Well-Being of and to Improve the Permanency Outcomes for Children Affected by Substance Abuse: Sixth Report to Congress* (the current report)	TBD
RPG4, 5, and 6 (2017, 2018, and 2019)	*2017, 2018, and 2019 Regional Partnership Grants to Increase the Well-Being of and to Improve the Permanency Outcomes for Children Affected by Substance Abuse: Seventh Report to Congress*	TBD
RPG4, 5, and 6 (2017, 2018, and 2019)	*2017, 2018, and 2019 Regional Partnership Grants to Increase the Well-Being of and to Improve the Permanency Outcomes for Children Affected by Substance Abuse: Eighth Report to Congress*	TBD

Note: RPG = Regional Partnership Grants; TBD = to be determined.

For the RPG projects funded in 2012, HHS has submitted five reports to Congress to date (Table I.1). HHS integrated the four partnerships that received grants in 2014 into the ongoing cross-site evaluation. Therefore, two of the reports included information on these grantees, describing their selected projects and early implementation. The fifth and final report on the 2012-funded projects presented findings from the cross-site evaluation on (1) the composition of partnerships, their quality of collaboration, and integration of services; (2) the population(s) served by projects and the extent to which they matched RPG and project-specific targets; (3) participation in EBPs by enrollees; and (4) child and adult outcomes. It showed that most of the 2012 RPG projects primarily offered programs and services for adults, with the expectation that improvements in adult (parent) circumstances would lead to desired child outcomes. It showed whether and how this approach influenced both adult and child outcomes and, based on these findings, discussed the conceptual linkage between program strategies and both proximal outcomes (directly influenced by the program, in the short term) and distal outcomes (addressed indirectly, perhaps changing in the medium or short term).

2. The current report

As noted in Table I.1, this report presents selected evaluation findings for and descriptions of activities of the third and fourth rounds of grants, RPG3 and RPG4.

The RPG3 cross-site evaluation has three component studies.

- A partnership study uses data from a survey of each grantee and their partner agencies, information collected during site visits to each partnership, and data from semi-annual progress reports filed by grantees. It examines the extent and quality of collaboration among the partners.

- An implementation study examines characteristics of those enrolled in RPG, as well as the implementation of EBPs to understand (1) whether the partnerships reached their intended target populations; (2) whether EBPs were implemented in accordance with best practices (referred to as implementation drivers developed in implementation science (Fixsen et al., 2013—2015); (3) families' enrollment and participation in planned EBPs; and (4) content received by families participating in selected EBPs.
- An outcomes study compares certain characteristics of adults and children at RPG enrollment and program exit, to measure whether changes have occurred in one or more of five outcome domains: child safety, permanency, and well-being; adult recovery; and family functioning.

This report summarizes the findings from the partnership study and discusses the alignment of EBP implementation with implementation drivers, in Chapters II and III, respectively. The cross-site evaluation also conducted an impact study using pooled comparison group and program group data from 3 of the 4 RPG3 projects, published separately (Cole, Burnett, & Strong, 2021).

Under the existing authorizing legislation, HHS funded 17 new RPG projects in September 2017 (RPG4). The first six months of the 2018 fiscal year (FY) for RPG4 were set aside as a planning period. During this time, the lead agencies for the RPG projects worked closely with their partner organizations, their project officers and others at HHS, and with the two federal TA contractors, to finalize the program and evaluation designs proposed in their grant applications. Mathematica worked with HHS to update and refine the RPG cross-site evaluation to reflect lessons learned from the RPG2/RPG3 cross-site evaluation, and to align with the target populations, goals, and planned projects proposed for RPG4. Chapter IV introduces the RPG4 partnerships, and Chapter V describes the emerging design for the national cross-site evaluation developed during that time period.

3. Future reports to Congress and RPG cohorts

The RPG4 national cross-site evaluation will produce three reports to Congress (Table I.1), of which this report constitutes the first. HHS will submit an interim report on implementation and early cross-site evaluation findings after the third year of RPG4, in 2021. A final report, with all remaining cross-site evaluation findings, will be submitted at the end of the 5-year grant period, during FY 2023.

There is an ongoing need for resources to ensure cross-system collaboration to address the needs of families affected by substance use and child maltreatment and to ensure use of evidence-based treatment, parenting, family support, and other services to meet their needs. Funding and requirements for additional rounds of RPGs are on the horizon. The Bipartisan Budget Act of 2018 (H.R. 1892, Pub. L. 115-123), passed on February 9, 2018, was signed by the president and included the Family First Prevention Services Act (FFPSA) (Children's Defense Fund, 2018). The act included numerous reforms to child welfare policy and reauthorized RPG.

The Consolidated Appropriations Act of 2018, signed into law in March, added funds to the Promoting Safe and Stable Families Title IV-B program to continue RPG while waiting for FFPSA to take effect and to help address the increasing needs created by opioids (Administration for Children and Families [ACF], 2018a; Child Welfare League of America, 2018). It added

$20 million for FY 2018. With these funds, HHS solicited applications for a 3-year RPG program. Applications were due by mid-August 2018, and HHS funded ten RPG partnerships. Midway through the initial grant period, HHS offered 2-year extensions, with additional funds. HHS integrated these RPG5 projects into the revised RPG cross-site evaluation developed for the RPG4 cohort.

The FFPSA amended Titles IV-B, IV-E, and Section 1108 of the Social Security Act. Among many other notable changes in child welfare and foster care, it revised the Regional Partnership Grant program to focus on heroin, opioids, and other substance misuse and made other changes to the program (ACF, 2018b), effective October 1, 2018:

- FFPSA requires that not only the state child welfare agency be a partner in the grant application, but also the state agency that administers the substance use prevention and treatment block grant. It also slightly revises the list of optional partners.
- It requires that the grants be disbursed in two separate phases: a planning phase and an implementation phase; expands the current RPG application requirements to include descriptions of additional substance use and treatment goals and outcomes for children, parents, and families; and requires semiannual reports from grantees to the Secretary (the previous requirement was an annual report).
- The act reauthorizes the grant program through FY 2021, and reduces the authorized possible grant amounts from between $500,000 to $1,000,000 to between $250,000 and $1,000,000 (sections 436(b)(5) and 437(f) of the act).

HHS will integrate these changes in future RPG funding opportunity announcements, and potentially will establish additional department goals and criteria. In future RPG reports identified in Table I.1, HHS will update Congress on its RPG plans and projects as they evolve in response to the new legislation as well as the changing landscape of substance use and the needs of America’s families.

II. RPG3 PARTNERSHIPS

Collaboration across the child welfare, SUD treatment, and court systems can efficiently and effectively meet the needs of families served by the RPG program. The funding opportunity announcement for RPG3 specifically required grantees to collaborate with a wide range of family-serving agencies, including, but not limited to, child welfare agencies, substance use treatment providers, mental health agencies, courts, and other service organizations (ACF, 2014). When individuals from these separate systems collaborate and work together to help families whose needs span multiple systems, they have greater opportunity to provide comprehensive services to strengthen all aspects of the family than when intervening independently on only a single dimension of needs.

Collaboration can enable organizations from multiple social service systems to undertake joint work to achieve common goals, potentially to a greater degree than the organizations could do working independently (Blakey, 2014). With respect to the goals of RPG, partnerships among child welfare, substance use treatment providers, and the courts can promote positive outcomes for children and families (Green, Rockhill, & Burrus, 2008; McAlpine, Marshall, & Doran, 2001; Semidei, Radel, & Nolan, 2001; Smith & Mogro-Wilson, 2008). One particular aspect of collaboration, the integration of service provision between child welfare and other systems, has been shown to significantly improve child permanency outcomes (Wells, 2012).

The extent of collaboration across organizations in a partnership can be thought of as a continuum. Integrated service provision is far along that continuum and requires trust among partner organizations, shared resources and support, and codified procedures for how to coordinate work across organizations. On the other end of the continuum are collaborative activities including developing shared goals and building rules for effective communication. These foundational activities are often the initial work that organizations engage in when first forming a collaborative relationship.

In developing their collaborations, partnerships move from introductory communication (such as kickoff meetings where shared goals are developed) toward more complex and coordinated activities (including, potentially, full integration of service provision). They are likely to move through these stages at differing paces because achieving seamless, integrated service collaborations is difficult (Blakey, 2014; Byles, 1985; Coates, 2017; Green et al., 2008). However, the continuum of collaboration activities does not represent a set of steps that must be followed in sequence before service integration is achieved. For example, partnerships do not always establish ground rules for communication before they begin plans for service integration. In fact, among RPG partnerships, it is common for organizations to be engaged in a variety of collaboration activities across several phases of the continuum (HHS, forthcoming).

With this background, this chapter answers two cross-site evaluation research questions about partnership members and their activities (Strong et al., 2014):

1. Who was involved in each of the four RPG3 grants?
2. How did the RPG3 partner organizations work together?

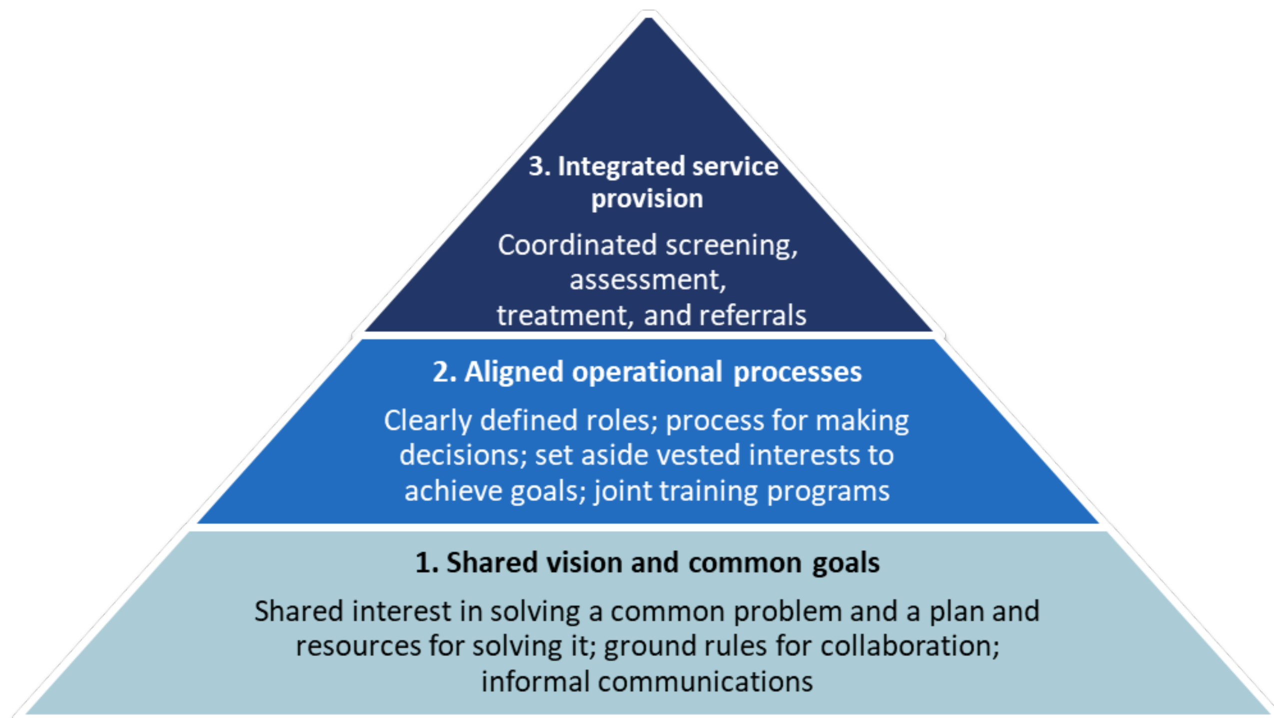
The cross-site evaluation surveyed RPG3 grantees and the organizations in their partnerships to measure the characteristics of the participating organizations, their views about the collaboration, and their various communication and coordination activities on the RPG3 project. Qualitative data obtained from site visits with the RPG3 grantees provided both additional context and illustrations of grantee successes and challenges in collaborating. More detailed descriptions of these data sources are provided in subsequent sections.

Box II.1. Partnership survey sample and response rates

The cross-site evaluation received a list of partner organizations and representatives from each of the four RPG3 grantees. All partner organizations completed a 25-minute web-based survey, for a response rate of 100 percent for each RPG project. Appendix A provides detail about the content of this partnership survey administered to grantees.

The information obtained from the survey and from the site visit was organized into a framework (Figure II.1) to sort the activities occurring along the continuum of collaboration into three levels: (1) shared vision and common goals, (2) aligned operational processes, and (3) integrated service provision.

Figure II.1. Levels and types of collaboration



The remainder of this chapter describes the extent to which the current cohort of RPG3 partnerships developed selected elements at each level of collaboration that support positive outcomes for children and parents (Blakey, 2014). Section A addresses the first research question and provides a description of the four RPG3 partnerships and the organizations involved in each. Sections B, C, and D address the second research question and describe the elements of collaboration that grantees had in place along each of the three levels of the framework. The chapter concludes with a brief summary of limitations.

A. Description of partnerships and members

The funding opportunity announcement for RPG3 required that grantees collaborate with a wide range of family-serving agencies, including, but not limited to, child welfare agencies, SUD treatment providers, mental health agencies, and the courts or judicial systems (ACF, 2014). Because the intended target population in the funding opportunity was children who are in an out-of-home placement or are at risk of being placed in out-of-home care as a result of a parent's or caretaker's substance use, several organizations were expected to be part of each RPG3 partnership.

1. Organizations involved in partnerships

As in past RPG cohorts, the four RPG3 partnerships varied substantially in their size and composition (HHS, forthcoming). They also varied in terms of the geographic areas and congressional districts that they served (Table II.1).

Table II.1. RPG3 grantees and the geographic areas and congressional districts they serve

Grantee	Geographic area	Congressional district
Montefiore Medical Center[a]	Located in the Bronx, New York, and serving Bronx Borough	NY-15
Our Kids of Miami-Dade/Monroe, Inc.[a]	Located in Miami, Florida, and serving Miami-Dade County	FL-27
University of Kansas Center for Research, Inc./School of Social Welfare	Located in Lawrence, Kansas, and serving all Kansas counties	KS-1, 2, 3, 4
Volunteers of America, Oregon[a]	Located in Portland, Oregon, and serving Multnomah County	OR-3

[a] Grantee is a participant in the RPG cross-site impact evaluation.

The partnerships associated with each RPG3 grantee are each briefly described below:

- **Partnership A**[4] included 13 partner organizations and served families with children referred through a child protective investigation for diversion or prevention. It included a total of 10 service providers (3 SUD treatment providers, 2 child welfare providers, one child therapy provider, and 4 organizations that provide a combination of mental health and substance use treatment services). Partnership A also included a state department, a court/judicial agency, and a university as key partner organizations.
- **Partnership B** included seven partner organizations and served families with SUDs with young children in foster care or at risk of out-of-home placement. Within this partnership, two organizations were child welfare providers and two were state departments. The remaining partner organizations were a university, a Head Start facility, and an organization involved in research and evaluation.
- **Partnership C,** the smallest, included four partner organizations. This partnership served adults with both an SUD and an open and indicated/substantiated child welfare case where children were at risk for removal. Three partner organizations provided services (one was a

[4] To help maintain anonymity of respondents, the partnerships are not identified.

substance use treatment provider and two were child welfare providers), and the fourth was involved in research and evaluation.

- **Partnership D,** the largest partnership, included 14 partner organizations. This partnership served parents in recovery who completed substance use treatment and were engaged with, or at risk of engagement with, child welfare. Nine of the participating organizations were substance use treatment or prevention providers, two of which also provided mental health services. In addition, this partnership included state and local government organizations, a university, an organization conducting evaluation and research, and a court or judicial agency.

In general, the composition of the four RPG3 partnerships aligned with the funding opportunity announcement. Table II.2 presents additional information on each partnership, showing the most common activities conducted by partner organizations and the extent to which each partnership had at least one organization conducting any particular activity.

The most common activities conducted by partner organizations were case management (34 percent of organizations), child welfare services (33 percent), SUD treatment (30 percent), and mental health services (28 percent). Within each of the four partnerships, at least one organization conducted each of these key activities, with two exceptions. Partnership B did not have a substance use treatment provider as a member of the partnership and Partnership C did not have a partner organization that provided mental health services. The differences in the composition of the partners reflected the differences in the approaches provided by each partnership to meet the needs of their target population (Xue, Cole, Moiduddin, Lee, & Strong, 2018).

Table II.2. Profile of common activities reported by partner organizations

Activity conducted by partner organizations	Partnership[a]				Percentage of organizations conducting this activity[b]
	A	B	C	D	
Case management	Y	Y	Y	Y	34
Child welfare services	Y	Y	Y	Y	33
Substance use disorder treatment	Y	N	Y	Y	30
Mental health services	Y	Y	N	Y	28
Policy development	Y	Y	Y	Y	27
Family therapy	Y	Y	Y	Y	16
Research and evaluation[c]	Y	Y	Y	Y	20
Number of partners	**13**	**7**	**4**	**14**	

Source: RPG partnership survey.

Note: N = No, Y = Yes.

[a] At least one organization in each partnership conducting a given activity.

[b] The percentage of organizations conducting this activity is an average of each of the percentages within each partnership (n = 4), such that all four partnerships contributed equally to each reported percentage, regardless of the number of respondents within each partnership. The full sample size across partnerships was 38.

[c] All grantees were working with a local evaluator within their partnerships.

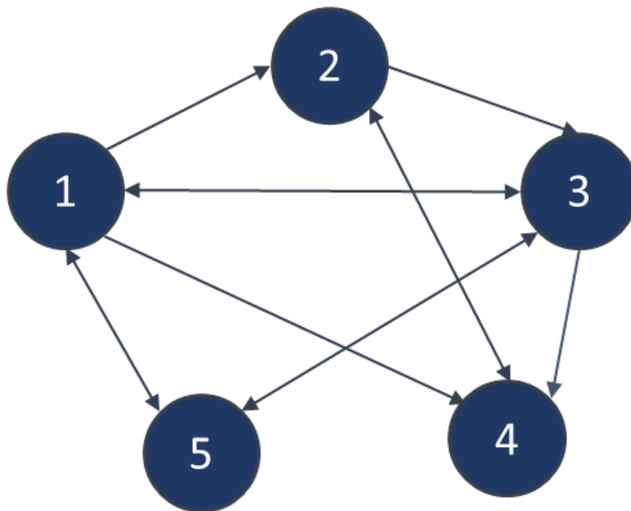
2. Prior relationships

Of the 38 organizations surveyed, only one did not have any prior working relationships with any other organization in its RPG partnership. Most organizations had prior relationships with multiple partner organizations before the start of the RPG program.

To measure working relationships, the partnership survey contained a series of questions about a respondent organization's relationships with every other organization in its partnership. For example, each of the 13 partner organizations in Partnership A was asked whether it had a prior working relationship with the other 12 partner organizations before the start of the RPG program.

Organizations had multiple prior working relationships with several of their RPG partners. Across the four partnerships, 63 percent of all possible relationships among RPG partners existed prior to the start of the project. This density of relationships among partner organizations is measured and visualized using social network analysis methods (see Appendix A for more details on the methods used and for summary statistics on interorganization relationships). The visual representation of density shows the relationships that did exist, relative to the ones that could possibly exist. Figure II.2 illustrates a hypothetical partnership of five organizations in which 12 (60 percent) of the 20 possible relationships (100 percent) between partners are observed.[5] In this figure, circles represent organizations in the hypothetical partnership, and arrows show the actual relationships. Double-headed arrows indicate that both organizations stated that a relationship existed; single-headed arrows indicate that only one organization in the pair stated that a relationship existed.

Figure II.2. Example visualization of a hypothetical partnership of five organizations, where 60 percent of all possible relationships (12 of 20) are observed



Note: Organizations are represented as circles, and lines between them indicate a relationship. Double-headed arrows indicate that both organizations stated that a relationship existed; single-headed arrows indicate that only one organization in the pair stated that a relationship existed.

[5] The figure represents a hypothetical partnerships and does not represent any of the RPG3 partnerships.

B. Shared vision and common goals (level 1 of collaboration)

All four partnerships appear to have established elements of the first level of collaboration. Collaboration elements measured by the cross-site evaluation in this first level included having (1) a shared interest in solving a common problem and a plan to address that problem, (2) ground rules for working together, and (3) formal communication opportunities both in and outside of RPG meetings as avenues for collaboration to occur.

These elements were measured in the partnership survey and discussed during site visit interviews. The survey asked how partner organizations perceived the status of collaboration foundation concepts as well as the extent to which organizations communicated across the partnership. During site visit interviews with grantee and partner organizations, cross-site evaluation researchers further explored how RPG partner organizations worked together.

1. Quality of foundational collaboration

Level 1 of the framework included three measures of collaboration derived from the Working Together Survey (Box II.2). The items used measured the degree to which partners agreed that (1) they were working together on an important topic (*context of collaboration*), (2) goals were in place and resources were available to meet these goals (*results of the collaboration*), and (3) shared communication norms and ground rules had been established (*structure of collaboration*).

On average, partners in each partnership agreed these three elements were in place.[6] Across the four partnerships, partner organizations most strongly agreed that they were working toward solving a common, important problem and that their collaborative partners were respectful and followed established rules (see Appendix A for survey results). The organizations in Partnerships B and C expressed the highest levels of agreement about achieving the three foundational elements of collaboration.

Box II.2. Measuring collaboration
Partners reported their perceptions of the collaboration within their partnership through the partnership survey.

Questions from the Working Together Survey (WTS) (Chrislip & Larson, 1994) in the partnership survey measured several elements of collaboration. The items captured five dimensions of positive collaborations: (1) context of the collaboration, (2) results of the collaboration, (3) structure of the collaboration, (4) collaboration process, and (5) collaboration members.

Questions from the Collaborative Capacity Instrument (National Center on Substance Abuse and Child Welfare, 2003) measured partners' perceptions of (1) daily practice in service coordination; (2) daily practice in screening and assessment; (3) shared principles, approaches, and time frames; (4) joint staff training across organizations; and (5) tracking and sharing information across organizations.

See Appendix A for more details on these instruments.

In response to an open-ended question, partners articulated several common goals. Multiple organizations within each partnership described the importance of implementing with fidelity the specific EBP they selected. In addition, a number of common goals occurred across the four partnerships. These commonly stated goals included improving cross-agency organization,

[6] Survey responses for these constructs ranged from 1 (strongly disagree) to 4 (strongly agree). The average scores for all partnerships for each construct were above 3 (the score indicating agree), suggesting a high level of agreement that these features of collaboration were in place.

improving child outcomes, assisting families, and improving the continuity of services for clients across organizations.

The site visit data reinforced these findings. For example, the organizations in Partnership A were able to develop a plan to achieve a common goal of keeping children out of foster care by providing parents with substance use treatment. At the onset of the project, each partner envisioned a slightly different process to achieve this goal: child welfare representatives focused on children's involvement with child welfare and their behavioral health while the substance use treatment provider focused on providing treatment to families. Partners reconciled these differences by continually returning to the common goal for their RPG project and communicating regularly about each other's processes and priorities.

2. Frequency of communication across partners

Frequent communication across a large proportion of partner agencies is necessary for interagency collaboration (Blakey, 2014; Cooper, Evans, & Pybis, 2016; Drabble, 2010; Fletcher et al., 2009; Green et al., 2008). All four partnerships reported regular communication among the majority of partner organizations. Across the four partnerships combined, organizations engaged in frequent communication with 79 percent of the other organizations in their partnerships. This was an increase in communication compared to practices prior to RPG, when 63 percent of partner organizations were communicating with each other. That is, after the start of RPG, three out of the four partnerships increased the density of communication. Although the density measure for the fourth partnership did not change, this partnership had the highest rate of interorganization communication prior to the start of RPG. In addition, the one organization in this partnership that did not have relationships with any of its RPG partners before the project began communicated with multiple organizations once the project began.

In interviews, grantees and partners described frequent, effective, cross-organization communication. For example, interviewees from Partnership B described regular and open communication across partners. They also emphasized the importance of cross-agency communication in order to find the best solutions to problems through listening to each partner's unique experiences, opinions, and expertise. Partnerships also described strategies they had used to improve their communications. Partnership C implemented ongoing, weekly conversations with partners and requested frequent feedback from their RPG evaluators on how to improve their communication and other collaborative processes.

C. Aligned operational practices (level 2 of collaboration)

Partnerships expanded their collaboration work beyond the foundational activities presented in level 1, and demonstrated successes in coordinating basic services and in having the right partner members represent their organizations. Across all partnerships, the findings suggest the partnerships were generally successful achieving the elements of collaboration found in level 2 of collaboration.

The second level of collaboration involves the alignment of activities and practices working with families. The cross-site evaluation measured operational alignment using items from the Working Together Survey and the Collaborative Capacity Instrument of the survey.

1. Collaboration process and members

On average, organizations in all four partnerships agreed that their processes for making decisions were effective. Moreover, respondents agreed that the members of their collaboration were strong representatives for their organizations. Partnerships B and C agreed most strongly that these two elements were in place, similar to the elements of collaboration presented in level 1.[7]

In interviews, respondents said they faced challenges in the initial stages of their RPG partnerships but were able to come to a shared process and to work collaboratively with partner organizations. For example, Partnership C faced difficulties recruiting clients. During partner meetings, organizations jointly identified the root of the problem and brainstormed solutions. The evaluator pinpointed which populations to target based on their geographic characteristics or the type of substance use treatment services provided. The child welfare coordinator made presentations about the partnership at various field offices in an attempt to increase referrals. Partners initiated a relationship within the department of the child welfare agency that provided the referrals to better understand their perspectives. The partners then jointly developed a solution that incorporated perspectives from what they had learned from these outreach efforts.

Another example is Partnership D's initial challenge due to frequent staff turnover. When key staff left partner organizations, other organizations within the partnership were unsure whom to contact. This slowed the partnership's abilities to work collaboratively to provide services to clients. In response, partners implemented regular refresher trainings in each frontline staff meeting so that partners had multiple staff with the same knowledge and understanding of how to collaborate with other partners. As a result of these trainings, cross-trained partner members could assume responsibilities resulting from the turnover of key staff and mitigate potential gaps in service provision.

2. Coordination in support of service delivery

On average, all four partnerships agreed that daily practices in service delivery were coordinated effectively, that screening and assessment were coordinated, and that staff training had been developed and implemented across multiple systems. Across all partnerships, organizations most strongly agreed that service coordination was occurring (namely, that staff from substance use treatment and child welfare conducted joint case management).[8]

Partnership C reported the highest achievement in all three constructs used to assess the coordination of service delivery. In interviews, members of Partnership C described the ongoing staff training they implemented across multiple systems as illustrative of one success in their service coordination. Ongoing trainings were mandatory for frontline staff across partner organizations and included training on individual EBPs, as well as training on integrating multiple services as a package of programs to be delivered. Having trainings that provided a

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[7] These findings are based on the analysis of the *collaboration process* and *collaboration members* scales of the Working Together Survey (see Box II.1).

[8] These findings are based on the analysis of the *daily practice in service coordination*, *daily practice in screening and assessment,* and *joint staff training across organizations* scales of the Collaborative Capacity Instrument (see Box II.1).

holistic perspective of all services and programs delivered by partners was perceived as a benefit to organizations within Partnership C. In addition, members of Partnership C reported that they were able to "align all [partner] organizations at all levels."

Organizations faced challenges in coordinating service delivery, which they described during site visit interviews. At the start of the RPG project, organizations within Partnership B determined client eligibility using a multistep process that spanned multiple partners (grantee, child welfare agency, and service coordinators) that each used separate inclusion criteria. The partners found that the delays in verifying client eligibility across organizations resulted in a number of families no longer meeting eligibility criteria because of changes in their circumstances. For example, some families' eligibility status changed because of changes in their case plan goals or based on family mobility within a geographic area. This issue was ultimately addressed by having child welfare determine eligibility and communicating directly with partner organizations rather than having the different partner organizations applying their own eligibility criteria independently.

D. Integrated service provision (level 3 of collaboration)

One goal of RPG was for partnerships to collaborate to provide integrated services addressing a range of child, adult, and family needs across the child welfare, substance use treatment, courts, and other systems. The literature on collaboration across agencies highlights the difficulties of providing integrated services across a number of partners (Byles, 1985; Coates, 2017; Herlihy, 2016; HHS, 2017). At the time of the partnership survey, results showed fewer elements of service integration (level 3 of the collaboration framework) across the RPG3 partnerships than elements at levels 1 and 2. As a result, the findings for level 3 suggest a combination of successes and challenges with respect to achieving fully integrated service provision. Three partnerships indicated success with aligning timelines and with sharing data. However, these aspects of collaboration do not appear to have been achieved within the remaining partnership. In addition, the findings on service coordination suggest that most coordination occurred across a small proportion of organizations within each partnership.

The third level of the framework describes how partners worked with one another on aspects of service delivery, such as sharing information, aligning principles and time frames, and coordinating various services (for example, screening and assessment, referrals, and substance use treatment services). This information was measured using survey scales, as well as detailed measurement of the types of coordination occurring among individual organizations within the partnership.[9]

Three out of the four RPG partnerships agreed with statements indicating they developed common approaches and timelines and implemented data sharing across organizations. However, the survey results indicated that on average, Partnership B members disagreed that these elements were in place.[10] In interviews, representatives of this partnership described

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[9] Similar to the measurement of interorganization relationships (previously described in sections A and B), organizations reported on the following types of coordination they were conducting with partners: (1) screening and assessment, (2) RPG program referrals, (3) cases or case management, (4) SUD treatment services, (5) mental health and trauma services, and (6) other social and family services.

[10] These findings are based on the analysis of the *tracking and sharing information across organizations* and *shared principles, approaches, and time frames* scales of the Collaborative Capacity Instrument (see Box II.1).

negative attention and scrutiny to the child welfare agency because of media reports of a family's poor quality care that resulted in the death of a child. This scrutiny limited their ability to align approaches and timelines across partner agencies. The situation affected staff morale, which was already low due to a lack of resources, funding, and recognition for their work.

There were challenges with the coordination of services across organizations in all four partnerships. At the time of the survey, partners reported that they coordinated with fewer than half of the possible organizations in their partnerships (between 24 to 33 percent across service activities). That is, the density of coordination around service provision activities was limited across partner organizations, and the majority of partner organizations were not coordinating with each other on any individual activity. Partnerships reported the most coordination occurred around case management (across 32 percent of partner organizations) and other family services (across 33 percent of organizations). They reported the least amount of coordination around providing mental health services, where approximately 24 percent of organizations were coordinating with each other.

Partnership A reported the greatest extent of cross-agency coordination. Partnership A's grantee organization's role was to oversee the work of the partner organizations that provided services to clients. In other words, this partnership had a lead organization focused solely on ensuring that partners jointly coordinated services. Furthermore, the partner organizations were operating within a positive policy climate that offered funding for the provision of child welfare services. Finally, this service coordination was built on top of a strong service coordination effort that existed before the introduction of the grant.

E. Limitations

The grantees and their partners established common goals, set the stage for coordination, and achieved some elements of integrated service provision. The data from the partnership survey and the site visit interviews corroborate these broad takeaway points, but there are two limitations to these findings.

The data used to measure partnership progress, successes, and challenges were collected at one time point during the third year of the grant. By the end of the 5-year RPG grant period, additional elements of collaboration might have been in place. Therefore, this assessment should be seen as a snapshot of collaboration activity occurring before more complete coordination might be expected.

Second, the cross-site evaluation does not include the viewpoints of clients served by the RPG partnerships. It is possible that clients were served equally as well by RPG partnerships with few or many service providers. Similarly, clients may be served equally well by RPG partnerships with varying levels of collaboration in place. The information in this chapter focused solely on the work being done by the partner organizations.

III. BUILDING CAPACITY TO IMPLEMENT EBPs

After the reauthorization of RPG in 2011, HHS requested that projects applying for grants include specific, well-defined program services and activities that were evidence-based or evidence-informed. This request was consistent with efforts in many social science fields committed to identifying effective practices as documented by scientific research and integrating research evidence into daily service provision (Crayton, Wilson, & Walsh, 2012).

An important component of the inclusion of EBPs is proper or high-quality implementation. Merely including an evidence-based model is not enough to produce its intended outcomes if it is not implemented as it should be. Close adherence to an EBP's prescribed approach is necessary for the approach to bring about the desired outcomes for participants consistently (Metz, Blase, & Bowie, 2007). Assuring adherence involves multiple processes, including training staff to provide the EBP and monitoring their performance, supporting staff through organizational structures and resources, and having leaders that guide the organization and align the mission and values of the organization with the EBP (Metz et al., 2007).

One purpose of the RPG cross-site evaluation was to document the projects' delivery of selected EBPs, termed "focal EBPs."[11] To do so, the cross-site evaluation collected in-depth data on this subset of EBPs by examining written summaries of each project, conducting site visit interviews with grantee and EBP managers, supervisors, and staff, and administering a survey of staff members delivering these EBPs. The cross-site evaluation assessed the providers' potential ability to deliver these EBPs with fidelity by examining factors referred to as implementation drivers (Fixsen, Blase, Metz, & Van Dyke, 2013).

Box III.1. Site visits and survey
Site visits for the cross-site evaluation were made to each of the four RPG3 projects in fall 2017. Site visits included interviews with EBP managers and supervisors (16 respondents); evaluators (6 respondents); and with therapists, facilitators, and other staff who provide services directly to participants, referred to in this report as "frontline staff" (22 respondents).

The staff survey was given to 50 EBP staff from the provider agencies for the RPG3 projects. The staff survey asked for information on staff characteristics and information about staff training and supervision.

This chapter opens with a description of the EBPs studied and an explanation of how RPG3 projects selected their target populations and EBPs for their projects. Following that is a description of the projects' use of implementation teams and written implementation plans. After an overview of the National Implementation Research Network's (NIRN) implementation drivers framework, the remainder of the chapter applies the framework to examine implementation by the four RPG3 projects.

A. Overview of evidence-based programs

HHS provided projects with the flexibility to propose any number or type of EBP that was appropriate for the RPG program's target population and had an evidence base that showed

[11] RPG projects implemented multiple EBPs; HHS selected a subset, referred to as "focal EBPs," for the cross-site evaluation to examine in depth.

potential to achieve RPG's target outcomes (ACF, 2014).[12] Two of the projects offered one EBP, one project offered three EBPs, and the fourth project offered four EBPs. The cross-site evaluation studied one focal EBP for each RPG3 project. As shown in Table III.1, the focal EBPs (Multidimensional Family Therapy, Strengthening Families Program (SFP), Seeking Safety, and the Nurturing Parenting Program) provided substance use treatment or mental health, parenting, and family stability services. The programs ranged from 10 to 17 weeks long. Three of the four projects conducted weekly group sessions, and one project conducted in-home sessions three times a week for families. The EBPs were voluntary to participants, although some participants were ordered by a court to engage in child welfare or substance use treatment programs. The court-ordered participants had the option to choose the treatment program, whether the RPG project or another program.

Table III.1. EBPs examined for the RPG3 cross-site evaluation implementation study

		Target population characteristics						
Focal EBP name	Purpose	Family or parent focus	SUD	Age of children	Families at risk of child welfare involvement	Families with child welfare involvement	Length of focal EBP	Total number of EBPs offered
Multidimensional Family Therapy (MDFT)	Substance use treatment, mental health services, family stability	Family	Family members with suspected or verified SUD	Under 12 years	X		16 weeks	1
Strengthening Families Program (SFP)[c]	Life and parenting skills	Family	Parents with SUD	0–3 years	X	X	16 weeks	1
Seeking Safety	Substance use treatment, parenting skills	Parents	Parents with SUD	Not specified	X	X	10 weeks	3[a]
Nurturing Parenting Program (NPP)	Parenting skills	Parents	Parents receiving substance use treatment; emphasis on African American parents	Not specified	X	X	12–17 weeks	4[b]

Source: RPG site visits, fall 2017.

Note: Each row shows the EBP examined for a single project.

EBP = evidence-based program and practice; SUD = substance use disorder.

[12] RPG applicants were encouraged to select one or more models from several sources, such as evidence reviews, identified in the funding opportunity announcement (ACF 2012). Alternatively, applicants could provide information on research studies or from other sources, such as documents describing formal consensus among recognized experts. The cross-site evaluation refers to the named, published program and practice models implemented by RPG projects as evidence-informed or evidence-based. However, "evidence-based" can be defined in different ways and describing an intervention as an EBP in this report does not necessarily mean that an intervention is considered evidence-based for the purposes of the Title IV-E Prevention Program.

Table III.1 (continued)

[a] The other EBPs included Incredible Years and contingency management.

[b] The other EBPs included Beyond Trauma, Parents Anonymous, and Mindfulness Based Relapse Prevention.

[c] The RPG project used SFP specifically with families with children birth to 3 years old and referred to the EBP as SFP birth to three (SFP B3).

B. Selecting the target population and EBPs

During site visit interviews, project directors and implementation team members were asked how they selected the target population and EBPs. Respondents reported that they selected target populations based on a perceived need in their local areas. They said that they selected EBPs because of evidence of their effectiveness available in the sources they reviewed, or because the partners had previous success delivering the EBP.

1. Target population

The RPG program's focus is on children in or at risk of child welfare involvement due to a parent or caregiver's SUD, but individual projects could define a more specific target population. For example, projects (1) could focus on families with children at risk of child welfare involvement, already involved with child welfare, or both; and (2) within those families, could concentrate on individuals (either parents or children) or the entire family. As shown in Table III.1, all RPG3 projects targeted populations aligned with the intent of the RPG program, although there was variation in the populations targeted. For example, two of the projects provided services to families and two provided services to parents. Three projects targeted families with children at risk or already involved with child welfare, and one project focused solely on families at risk of child welfare involvement. In addition, two projects targeted children of a certain age, whereas the other two did not.

Each project selected target populations reflecting perceived local needs. For example, respondents from one project cited a lack of parenting programs in the area for families with children who were three years old or younger. A respondent from another project selected their target population after the local media reported a stark rise in child deaths in families with substance use issues. This project aimed to engage at-risk families before they became involved in the child welfare system. Members of one project felt the child welfare system in the local area did not provide culturally responsive services tailored to the needs of African American parents, such as practices provided by staff who received diversity training. This project defined its target population to meet that need.

2. Selecting EBPs

As required by HHS, all four projects proposed at least one EBP. Two of the projects selected their EBPs based on evidence of effectiveness from studies with experimental designs but also because they or a partner had previous experiences implementing the EBPs. The project that chose SFP had implemented it for older children already; thus, frontline staff were familiar with both the program and its delivery.

The other two projects did not consider evidence of effectiveness as the main reason they chose their EBP. Instead; RPG partners chose their EBPs because they had previous experience implementing the programs. This previous experience gave them confidence that frontline staff could implement the programs successfully and that the EBP was a strong fit for their target

population. Respondents from one project said an added benefit was their EBP's popularity with their clients.

C. Implementation teams and written plans

To help ensure that staff deliver the EBPs as intended by the developer or publisher of the program model, it is important to have (1) implementation teams that build staff capacity and oversee their work and (2) written implementation plans that provide guidelines for their work (Blase, Fixsen, Sims, & Ward, 2014). Implementation teams are made up of individuals who provide planning and oversight of RPG and EBP implementation, maintain institutional knowledge about the project and EBPs, and sustain relationships across agencies. Written plans are documented plans, policies, and procedures used by staff, supervisors, managers, and leaders to carry out their work consistently.

1. Implementation teams

Implementation of EBPs for the RPG project benefits from the ongoing engagement of and coordination among teams of project leadership,[13] partners, and staff who guide implementation, maintain institutional knowledge about the project and EBPs, and sustain relationships.

All four RPG projects had implementation teams. These teams typically included the RPG project director, a director of the partner providing the EBP, and the project's evaluator. Other team members were leaders of partner organizations providing substance use treatment or child welfare services, additional evaluators from the evaluation organization, court judges, and representatives of partner organizations. The implementation teams played four main roles:

- Selecting and planning for the EBPs
- Managing service delivery, including daily operations and addressing challenges
- Informing other RPG partners about the EBPs and working through collaboration issues with partners
- Reviewing program data to identify issues and solutions

2. RPG project plans and EBP implementation plans

In addition to implementation teams, having written implementation plans that document staff roles, expectations, and policies and procedures helps ensure that frontline staff deliver services consistently across participants. Supervisors, managers, and agency leadership also benefit from written plans that document policies and procedures for carrying out work within the organization.

To obtain information about written plans, site visitors asked RPG project directors and implementation team members about their written plans. Respondents from all four projects said

[13] Leadership included RPG project directors, organization managers, and people who oversaw the frontline staff who provided the focal EBPs.

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:

- Project overview documentation, such as timelines, memoranda of agreement across the various agencies, and documentation of shared goals.
- Documentation to show staff and partners how participants get referred and enter treatment.
- Participant handbooks and brochures.

In addition to written plans to guide the overall RPG project, three of the four projects had written materials outlining the proper delivery and procedures specific to the implementation of their EBPs. These plans were program treatment manuals and other documents on policies and procedures designed to ensure consistent service delivery. Two projects worked directly with the developers of their EBPs, who provided written implementation plans. The project director and frontline staff developed EBP policies and procedures documents for the third project. The fourth project did not have written manuals. They said that they relied less on written documentation because they had used the EBP prior to RPG.

D. A framework for assessing implementation

To understand how the RPG3 projects followed up on their implementation planning, the cross-site evaluation collected data in the staff survey and during the site visits. The survey and site visits focused on areas defined by NIRN as implementation drivers. These implementation drivers are best practices that research has shown to be associated with successfully implementing EBPs. The drivers are interrelated processes that complement one another to help bring about high-quality implementation of an EBP, defined as following the developer's model to consistently achieve the intended outcomes of an EBP (Fixsen et al., 2010). These best practices fall under three categories: staff competency, organizational supports, and leadership (Fixsen et al., 2009; Metz et al., 2007):

- **Staff competency** consists of selecting and hiring appropriate staff, training staff, and coaching and supervising staff to build staff capacity to deliver an intervention with fidelity.
- **Organizational supports** are structures and systems that create an environment favorable to the successful delivery of EBPs. These include using written plans to guide work; having a data system (for example, a management information system) to support decision-making by tracking delivery and outcomes; and ensuring that frontline staff have adequate time, skills, funding, session space, and other resources needed to deliver an EBP without operational barriers.
- **Leadership** involves guiding frontline staff and identifying and solving barriers to service delivery as they arise.

The site visit and survey data show that approaches that the four projects used to build staff competency were influenced by their unique staff size, target populations, implementation plans, and the degree of participation by the EBP developer. The projects, however, were nearly uniform in how project leaders, managers, supervisors, and frontline staff described organizational supports and leadership experiences.

E. Building staff capacity to implement EBPs

1. Staff selection and hiring

Building staff capacity starts with hiring people with the qualifications and experience to provide the EBP as intended and to build rapport with participants. These factors help ensure EBPs can produce their intended outcomes (Metz, Bandy, & Burkhauser, 2009). Two projects (those with the smallest EBP staffs) hired new people as frontline staff to deliver the EBPs. One of them sought candidates through online job advertisements and outreach to their partner agencies. The other used their organizations' human resources department to find potential hires. The other two projects selected staff who already worked at the service provider agencies to join the RPG project. For example, in one of these projects, supervisors helped handpick staff who met the EBP's qualification requirements and whose previous performance showed they were a good fit for providing the EBP and working with the target population.

Staff qualifications and experience. As shown in Table III.2, across the four projects, 75 percent of the respondents had a graduate or professional degree, although only two of the projects specifically sought out staff with graduate or professional degrees.

Table III.2. Education levels and job titles of surveyed staff

Highest education level (n = 48)	Percentage
Less than a four-year degree	14
Four-year undergraduate degree	11
Graduate or professional degree	75

Source: RPG staff survey.

Note: The percentages in the table were calculated by finding the percentage for each project and then calculating the mean percentage across four project-level percentages. In this way, all four projects contributed equally to the analyses, regardless of their number of respondents.

The other two RPG projects sought staff who had experience working with children and families. In fact, most of the staff survey respondents from all projects reported having this prior experience. As displayed in Table III.3, the majority of EBP staff at all four projects had at least two years of relevant experience. Nearly half of the 49 respondents had five or more years of experience working at their current organization (45 percent) and providing services specifically to children and families involved in the child welfare system (46 percent). Fewer respondents (25) had experience providing substance use treatment, however 70 percent of those staff had five or more years of substance use treatment experience.

Table III.3. Percentage of staff with related experience

Years of experience	Working at current organization (n = 49)	Providing services to children and families involved in the child welfare system (n = 49)	Providing substance use treatment (n = 25)
Less than 1 year	8	8	12
1 year	6	7	2
2–4 years	41	39	17
5–9 years	30	22	27
10 or more years	15	24	43

Source: RPG staff survey.

Note: The percentages in the table were calculated by finding the percentage for each project and then calculating the mean percentage across four project-level percentages. In this way, all four projects contributed equally to the analyses, regardless of their number of respondents. These questions asked about staff experiences in general, rather than those related to the specific EBP they were implementing. Percentages may not sum to 100 due to rounding.

Openness toward EBPs. Some staff might not be open to using EBPs if the prescribed model differs from their preferred method of treatment or they feel an EBP's model is too restrictive. Hiring staff with negative attitudes toward EBPs can be detrimental to the EBP's successful and consistent implementation. Hiring staff with positive attitudes toward EBPs makes it more likely that they will adhere to an EBP's approach, improving the chances of achieving the EBP's intended outcomes.

Box III.2. The Evidence-Based Practice Attitude Scale

The Evidence-Based Practice Attitude Scale measures general openness and willingness to engage in new practices when required to do so. Staff survey respondents rated each item in the scale from 1 (not at all open) to 5 (open to a very great extent).

The staff survey measured levels of staff openness toward, and the appeal of, EBPs. The survey used the Evidence-Based Practice Attitude Scale, which gauges general openness to new practices and willingness to engage in new practices when required to do so (Aarons, 2004). As shown in Table III.4, staff rated general openness to using EBPs (a mean rating of 3.4) lower than they did their openness to adopting EBPs based on the appeal of the model and their openness based on agency or project requirements to use the model (both a mean rating of 4.0).

Table III.4. Mean ratings on attitudes toward implementing EBPs from 1 (not at all open) to 5 (open to a very great extent)

Evidence-Based Practice Attitude Scale constructs	Number of items in scale	Mean (standard deviation)
Openness to using EBPs (n = 49)	4	3.4 (0.6)
Adopt EBPs based on appeal of the EBP (n = 50)	4	4.0 (0.4)
Adopt EBPs based on agency or project requirements (n = 50)	3	4.0 (0.3)

Source: RPG staff survey.

Note: The means in the table were calculated by finding the mean response for each project and then calculating the mean across four project-level means. In this way, all four projects contributed equally to the analyses, regardless of their number of respondents.

EBPs = evidence-based programs and practices.

Staff turnover. Staff turnover can occur for various reasons: better opportunities, personal issues (such as a relocating spouse or partner), or lack of fitness for the job. Regardless of the reasons, the loss of a trained staff member who delivers an EBP requires recruiting, hiring, and training someone on the EBP all over again. Only one RPG3 project reported high levels of staff turnover.[14] During the site visits, interviewees from that project attributed the high turnover to not being able to offer a competitive salary and benefits and the challenges of hiring people with similar demographics to their target population—which was one goal of that project. The other three projects attributed their low staff turnover to their practice of hiring EBP staff from within the agency or having strong, supportive teams to help staff through challenges they might experience on the job.

2. Training on EBPs

An essential part of building staff capacity is training them on the specific EBP they will provide to participants. Training should prepare staff to work with participants, introduce them to the EBP's content, and teach them how to deliver the EBP in the way intended by its developers. Effective training 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). Ongoing training, provided after the initial training on a new EBP, helps staff refresh and solidify their skills and their knowledge of an EBP's content.

While all four projects provided training to frontline staff, the training processes varied. Two projects had the developers of their focal EBPs train their staff. Another project engaged a certified trainer[15] of the EBP to conduct training. The fourth project had the person who supervised frontline staff provide their training; that supervisor had already been formally trained in the EBP prior to joining the RPG project.

Staff perceptions of preparedness. During the site visits, staff from all four projects said they felt prepared to deliver the EBP after their training. While some felt nervous about delivering a new program, none felt unprepared to deliver the model.

Ongoing training. Three of the projects also provided staff with ongoing training to solidify their knowledge of the EBPs. The ongoing training varied in structure, ranging from check-ins with the EBP developer to sessions on advanced and special topics. Staff at the fourth project had completed initial training just prior to the site visit, so ongoing training was not discussed.

Supervisor training. Supervisors, even if they do not deliver the EBP themselves, also need knowledge about the EBP in order to supervise frontline staff delivering that EBP and assess their performance. Supervisors from all four of the projects said they received the same EBP training as their frontline staff. However, none of the supervisors received any supervisor-specific EBP training because the EBPs they were using did not offer it. Supervisors thus had to

[14] The site visitors asked respondents generally to describe the level of staff turnover and did not use a specific cutoff to define low versus high staff turnover.

[15] A certified trainer is someone who the developer or publisher of an EBP certifies as qualified to train others.

use general supervisory practices combined with their knowledge of the EBP rather than specific supervisory practices tailored to the projects' EBPs.

3. Coaching for EBPs

While training, both initial and ongoing, provides staff with knowledge about how to deliver an EBP, coaching has also been shown to support staff in delivering an EBP with fidelity as they work with participants (Bertram et al., 2014; Metz et al., 2007). Without coaching, staff might deviate, whether intentionally or unintentionally, from the EBP's delivery specifications.

Coaching involves providing staff, either as individuals or groups, with on-the-job observations, instruction, modeling, feedback, debriefings, and emotional support, all of which are often adapted to fit their individual needs. It is distinguished from supervision, which involves oversight and performance assessment.

The two projects working with the EBP developers used those developers to coach staff. The developers helped frontline staff strategize about how to build rapport with participants and instructed them on how to improve the delivery of the EBP. Other coaching activities that staff described receiving from the EBP developers (and also from their managers and supervisors) included debriefings, feedback, and on-the-job observations. Frontline staff less frequently described emotional support as part of the coaching they received from the EBP developers. At one project that was not working with the EBP developer, frontline staff reported that their supervisor provided some or all of the same coaching activities. The other project provided little to no coaching to the frontline staff. In interviews, these staff expressed interest in receiving coaching.

4. Supervision of frontline staff

Supervision involves the process of monitoring staff performance, reviewing staff timesheets, and scheduling staff. Most supervisors also conduct performance reviews. None of the four agencies that delivered the EBPs, however, had a formal performance review process for frontline staff in which supervisors and staff talk about successes and challenges and set goals. While the only supervisor at one project said she lacked the time to conduct a formal review process, supervisors at the other three projects did not mention any barriers to having a formal review process. Given those responses, the lack of such a formal process may have been just agency preference.

Supervisors from three projects reported assessing staff performance periodically in other ways. For one project, EBP participants were asked to provide feedback on forms they completed at the end of their receipt of services. A supervisor with a second project said she informally asked participants for feedback, and a supervisor for the third project occasionally sat in on sessions between staff and participants to observe staff performance.

Frontline staff described an informal performance review process in which supervisors held check-in meetings. As shown in Table III.5, nearly half (48 percent) of staff survey respondents reported check-in meetings with their supervisors at least once per week. However, 30 percent of staff respondents met one-on-one with their supervisors less than once per month. There was a higher percentage of staff who reported participating in group supervision once or twice a

month, with 24 percent saying they meet with their supervisors once a month and 17 percent saying they meet with their supervisors twice per month.

Table III.5. Percentage of staff reporting participating in each type of supervisory meeting

	Percentage of staff	
Frequency of meeting	One-on-one meeting with supervisor (n = 48)	Group supervision meetings (n = 46)
Once per week or more	48	43
Twice per month	5	17
Once per month	18	24
Less than once per month	30	17

Source: RPG staff survey.

Note: The percentages in the table were calculated by finding the percentage for each project and then calculating the mean percentage across four project-level percentages. In this way, all four projects contributed equally to the analyses, regardless of their number of respondents. Percentages may not sum to 100 due to rounding.

Box III.3. Supervisor Support Scale

The Supervisor Support Scale from the staff survey asked staff to rate whether their supervisor provides team support (2 items), emotional support (5 items), and technical support (10 items). Respondents rated each item from 1 (strongly disagree) to 6 (strongly agree)

Rating supervisor support. Respondents to the staff survey rated supervisor support highly. As shown in Table III.6, staff rated their supervisors' provision of technical support highest, with team and emotional support being rated somewhat lower. 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.

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

Supervisor support scale	Number of items in scale	Mean (standard deviation)
Supervisor provides technical support (n = 47)	10	5.1 (0.5)
Supervisor provides team support (n = 46)	2	4.8 (0.8)
Supervisor provides emotional support (n = 48)	5	4.5 (1.1)

Source: RPG staff survey.

Note: The percentages in the table were calculated by finding the percentage for each project and then calculating the mean percentage across four project-level percentages. In this way, all four projects contributed equally to the analyses, regardless of their number of respondents.

F. Supporting staff to implement EBPs

Once staff are hired and trained, they might receive additional types of support that have been associated with effective use of evidence-based models. Two of these supports involve

(1) organizational structures and processes, and (2) effective leadership. The cross-site evaluation examined where focal EBPs stood in both domains and found less variation across the four RPG3 projects than in the elements related to staff competency. Working directly with the developer of their focal EBP, which distinguished two of the projects and heavily influenced some elements of staff competency, did not influence organizational supports and leadership. In addition, the cross-site evaluation also asked staff from the RPG projects to rate their organizational climates.

1. Organizational supports

The literature on implementation science suggests that certain structures and processes, such as a way to track participation and outcomes, and various administrative supports help ensure that frontline staff have adequate resources to serve participants and deliver an EBP (Collins & Metz, 2009; Metz et al., 2007). These resources include time, skills, funding, and space to meet with participants. Organizational supports such as these enable staff to focus on delivery of the EBP.

Data systems. Tracking participation and outcomes of an EBP aids frontline staff in delivering a model consistently to all participants (Bertram et al., 2014). A data system, such as a management information system, can be used to track participant flow through a program. By tracking where participants are at in their services, including which elements of a model participants have received and which elements remain to be delivered, staff can work to try to ensure that participants receive the full array of services in the EBP. During the site visits, none of the RPG3 projects indicated that they used a comprehensive electronic data system to track participants and report on performance of delivering an EBP.

While an electronic data system was not in use by any of the four EBP providers in this study, some tracking did take place. Staff from two projects reported recording case notes and administering risk assessments. Staff at another project said they completed, for their supervisors, paper forms about each session that they provided to participants. Largely, frontline staff were not involved in the collection and analysis of participation data. Frontline staff did not report any instances of hearing about the outcomes of data analysis at the time of the site visits. While the projects reported information on services using the ESL and OASIS systems for the cross-site project, the frontline staff reported little interaction with those or other data systems.

Administrative supports. Administrative supports are structures, processes, and supplies that create an environment that is favorable for high-quality implementation of a model (Collins & Metz, 2009). Administrative supports, such as adequate session and office space, cultural competency training, and even the assistance of receptionists and other support staff, are important for helping to reduce implementation barriers and support creating an organization that allows frontline staff to focus on providing an EBP.

Almost all staff said that the administrative supports at their agency were adequate. Staff at two projects, though, said that session space was inadequate at some of their service delivery locations. At one RPG project, staff delivered the EBP in participants' homes. Session space was variable and sometimes participant homes were not favorable environments for delivering services. In home settings, optimal conditions for service delivery might not be available or staff must address issues, such as the presence of other people or distractions, before delivering services. Staff at another project that is providing group services in community locations outside

of the agency offices said sometimes there was not enough space for all of the families in a session or not enough space to store the materials used when delivering the EBP. Other than service delivery locations, however, staff from all four projects did not describe substantial barriers to implementation or needs for additional administrative supports.

2. Leadership

Leadership is important for guiding staff and fixing service delivery problems or barriers that arise. Effective leaders can clearly identify and understand problems, gather relevant information and resources to address problems, assign tasks to alleviate problems, monitor task completion, and communicate with staff throughout the process (Bertram et al., 2014; Fronk, Gurko, & Austin, 2013). To resolve barriers to implementation of EBPs, effective leaders bring together groups of staff to identify and understand problems and to work toward a solution (Bertram et al., 2014).

During the site visits, staff from all four projects described similar leadership characteristics. Staff said project and agency leadership were knowledgeable about the technical aspects of the EBPs and provided adequate opportunities for staff to develop their skills delivering the program. Staff reported that leaders addressed barriers when they arose, such as finding alternative services if a family did not meet the criteria to participate in RPG, addressing staffing needs and problems, and making sure staff had supplies needed to deliver an EBP. Staff said leaders communicated regularly with them and staff did not report problems with communication within the RPG project.

3. Organizational climate

Research links positive organizational climate with the organization's ability to achieve successful outcomes (González-Romá, Peiró, & Tordera, 2002; Schneider, Salvaggio, & Subirats, 2002). 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). Building and maintaining a positive organizational climate involves aligning staff roles with the mission of an agency, building a safe and satisfying work environment, and giving staff decision-making autonomy.

Box III.4. Dickinson and Painter scales

The Dickinson and Painter scales measure organizational climate across five areas: (1) agency vision and mission, (2) compensation, (3) safe and satisfactory work environment, (4) public image, and (5) decision-making autonomy. Respondents to the staff survey rated each item in these areas from 1 (strongly disagree) to 6 (strongly agree).

The staff survey included items used to measure organizational climate. These items asked about factors such as the agency having a positive public image, the degree of decision-making autonomy, and staff descriptions of the organizational climate. Generally, the organizational climate ratings from the staff survey aligned with the experiences described during the site visits. These ratings are shown in Table III.7. For four out of the five areas of organizational climate, staff agreed with positive statements about the agency vision and mission, the safety and satisfactory nature of the work environment, positive public image, and decision-making autonomy. The average rating for staff compensation was lower, indicating that fewer staff agreed that compensation was adequate.

Table III.7. 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	Mean (standard deviation)
Agency vision and mission is clear.	4	5.4 (0.5)
Compensation is satisfactory.	3	4.3 (0.8)
Agency is committed to a safe and satisfactory work environment.	4	5.0 (0.5)
Agency has a positive public image.	4	5.0 (0.6)
Agency gives workers decision-making autonomy.	4	4.9 (0.6)

Source: RPG staff survey.

Note: The sample size was 47 for each of the scales.

The means in the table were calculated by finding the mean response for each project and then calculating the mean across four project-level means. In this way, all four projects contributed equally to the analyses, regardless of their number of respondents.

G. Conclusions and limitations

All four of the RPG3 projects specified their target populations based on identified needs in their local areas. All four projects selected EBPs based on previous experiences implementing the EBP, though two projects also looked toward the EBP's evidence of effectiveness.

All four projects formed implementation teams that selected and planned for the EBPs, provided daily management, communicated across partners, and reviewed program data to improve processes and identify solutions. To build the capacity of staff to implement the EBPs, each of the projects had many of NIRN's best practices for implementation in place, as measured by the cross-site evaluation. All the projects, though, lacked the use of a data system to track and report on performance of participants in the EBPs. Outside of recording case notes and administering risk assessments, frontline staff said they did not use a data system and were not involved in the collection and analysis of participation data. Further, they did not report hearing about the outcomes of any data analysis that was conducted. Two projects also described having inadequate space for hosting program sessions. Additionally, staff rated compensation as less adequate than other aspects of organizational climate, on average.

The processes used varied by projects' unique combinations of staff sizes, target populations, and implementation plans. In terms of how the projects built the capacity of staff to implement the EBPs, two of the projects worked directly with the EBP developers, who were involved in implementation planning, training, and coaching staff, and two did not.

Despite taking different approaches to selecting and hiring staff, training, and coaching, staff from the RPG3 projects were nearly uniform in their description of organizational supports, leadership, and organizational climates.

One main limitation affects these findings. The cross-site staff survey and site visits occurred only once. Any changes in building staff capacity, organizational climates, or use of data since these data collection activities were not captured by these data. Nevertheless, these data provide a snapshot of how the projects had planned for implementation and their actual implementation experiences by the beginning of the fourth year of RPG3 funding.

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IV. RPG4 PROJECTS

In September 2017, HHS awarded a fourth round of regional partnership grants authorized by the Child and Family Services Improvement and Innovation Act (Pub. L. 112-34). As with previous RPG cohorts, the purpose of the 5-year grants is to improve, through interagency collaboration, the well-being, safety, and permanency of children at risk of or currently in out-of-home placements due to a parent or caretaker's substance misuse. To contribute to the knowledge base of how to serve these vulnerable families, grantees are required to conduct an evaluation of their grant program and participate in the national cross-site evaluation. This chapter provides an introduction and overview to the next cohort of grantees. Chapter V then describes the RPG4 evaluations. Information for both chapters is drawn from the grant applications and federally required semi-annual progress reports the grantees submitted in April 2018.

A. RPG4 recipients and locations

HHS funded 17 RPG4 projects, as shown in Table IV.1. Fifteen of the grants were awarded through the general RPG funding opportunity announcement (HHS-2017-ACF-ACYF-CU-1229) and two grants, in Alaska and Kansas, were awarded through a funding opportunity announcement for organizations offering RPG services to American Indian or Alaska Native (AI/AN) communities (HHS-2017-ACF-ACYF-CU-1230). The grantees span the continental United States and Alaska, including both urban and rural areas.

The RPG4 recipients include multiple types of organizations, though most are service providers. The type of grantee organization can shape many aspects of the project, including planned services, the service area and target population, and the types of organizations that the grantee will seek as partners. As shown in Table IV.1, across the 17 projects:

- Thirteen grantees are nonprofit organizations serving children, adults, or families. Of these, six are behavioral or mental health service providers, five provide child and family services, one is a substance use treatment provider, and one is a tribal organization.
- Three grantees are large, public research universities. One of these grantees is housed within a department of psychiatry, and two are housed within the school of social welfare or social work.
- One grantee is a state substance use services agency that funds and oversees the substance use treatment in the state and collects administrative data on participation in publicly funded substance use treatment.

Prior experience with RPG can be useful for grantees, because they may have established partnerships, protocols for coordinating services and sharing data, and experience with the RPG target population. Of all RPG4 grantees, seven participated in previous RPG rounds, including two grantees that participated in two previous rounds.

The annual grant award could range from \$500,000 to \$600,000 per year, or \$3 million across 5 years, with the required percentage of grantee matching funds increasing over time. The average total grant amount is near the maximum, \$2,988,663, or \$597,733 per year.

Table IV.1. RPG4 grantees

Grantee location	Area served	Congressional district(s)	Organization type	Previous RPG	Total program funding
Cook Inlet Tribal Council, Inc. Anchorage, Alaska	Anchorage	AK-1	Tribal organization	RPG1	$3,000,000
University of Alabama at Birmingham Birmingham, Alabama	Jefferson County	AL-7	Public university	No	$3,000,000
Children & Families First Delaware Wilmington, Delaware	Delaware	DE (at large)	Child and family services provider	No	$2,930,850
Broward Behavioral Health Coalition, Inc. Ft. Lauderdale, Florida	Broward County	FL-20, 22–24	Behavioral health services provider	No	$3,000,000
Northwest Iowa Mental Health dba Seasons Center Spencer, Iowa	Calhoun, Carroll, Cherokee, Crawford, Ida, Monona, Plymouth, Pocahontas, Sac, and Woodbury counties	IA-5	Behavioral health services provider	RPG2	$3,000,000
Youth Network Council dba Illinois Collaboration on Youth Chicago, Illinois	Boone, Kankakee, Will, and Winnebago counties	IL-1–3, 11, 14, 16–17	Child and family services provider	No	$2,954,115
Volunteers of America Indiana (VOAIN) Indianapolis, Indiana	Marion County	IN-7	Child and family services provider	No	$3,000,000
University of Kansas Center for Research, Inc. Lawrence, Kansas	Johnson, Wyandotte, Douglas, and Shawnee Counties; PBPN, Sac and Fox, and ITKN tribal sites	KS-2–3	Public university	RPG3	$2,986,808
Mountain Comprehensive Care Prestonburg, Kentucky	Johnson, Martin, and Floyd counties	KY-5	Behavioral health services provider	No	$3,000,000
Preferred Family Healthcare, Inc. Springfield, Missouri	Greene, Barry, Lawrence, Stone, Christian, and Taney counties	MO-7	Behavioral health services provider	RPG2	$2,988,170
The Ohio State University Columbus, Ohio	Fairfield and Pickaway counties	OH-3	Public university	No	$3,000,000
Oklahoma Department of Mental Health and Substance Abuse Services Oklahoma City, Oklahoma	Oklahoma and Tulsa counties	OK-5	State substance use services agency	RPG1 RPG2	$3,000,000
Helen Ross McNabb Center Knoxville, Tennessee	Knox County	TN-2	Behavioral health services provider	RPG1 RPG2	$3,000,000
Lund Family Center, Inc. Burlington, Vermont	Chittenden, Orleans, and Essex counties	VT (at large)	Child and family services provider	RPG1	$3,000,000
Catholic Charities of Spokane Spokane, Washington	Spokane County; Spokane, Kalispel, and Colville tribal sites	WA-4–5	Child and family services provider	No	$2,970,000
Meta House, Inc. Milwaukee, Wisconsin	Milwaukee County	WI-4	Substance use treatment provider	No	$3,000,000
Prestera Center for Mental Health Huntington, West Virginia	Cabell, Lincoln, and Wayne counties	WV-3	Behavioral health services provider	No	$3,000,000

Source: Grantees' RPG applications.

Note: dba = doing business as; ITKN = Iowa Tribe of Kansas and Nebraska; PBPN = Prairie Band Potawatomi Nation; SUD = substance use disorder.

B. Target populations and recipients of services

Although all RPG partnerships planned to serve families with a child affected by a caretaker's substance use issues, they could more narrowly define the population they intended to serve to meet the needs of their community and align with the population that would benefit from their intended services. For example, several partnerships intended to serve families with children in a specified age range:

- One partnership planned to target families with a pregnant mother.
- Two partnerships planned to target families with a newborn.
- Three partnerships planned to target families with a young child up to age 5 or 6.
- Two partnerships planned to target families with a child up to age 11 or 12.
- The remaining nine RPG4 partnerships targeted families with children of all ages or did not specify an age group for children in participating families.

Partnerships could also further refine their criteria based on level of involvement with child welfare and other factors. Table IV.2 shows that most partnerships planned to serve families with current or prior involvement with child welfare, or more broadly, families at risk of involvement. Five partnerships planned to serve families in which children are at risk for a child being removed from the home or in which a child has already been removed from the home, two planned to only serve families with a child at risk of removal, and the remaining partnerships did not specify in their applications. In addition, the two projects funded through the separate funding announcement for AI/AN communities planned to serve only those of AI/AN descent, and one other project included AI/AN families as part of its target population.

C. Planned services

Projects intended to draw from grantee and partner organizations' resources and experiences to meet the needs of their families in different ways. Although all RPG projects share a common goal of improving the well-being of children affected by a caregiver's substance use, they may seek to achieve this goal by providing services to the child, the adult in recovery, the family unit, or a combination of these. For example, one project may offer trauma-informed therapies for children who have experienced abuse, another may provide SUD treatment to the adult with substance use issues, and yet a third may provide family-strengthening activities to the family through home visits. Across the 17 RPG4 projects, 10 planned to serve both the child and adult separately or together, 6 planned to offer services only to adults, and 1 planned to only offer child-based services. Table IV.3 identifies the planned recipients of grantee services.

Despite the variation in approaches to services across the RPG4 projects, they show some commonalities in the types of services they planned to offer. Services generally fall into one of six categories: (1) family strengthening, such as parenting courses and family problem-solving activities; (2) substance use treatment; (3) trauma, behavioral, or mental health therapy or counseling; (4) case management; (5) peer coaching from a mentor with lived experience in recovering from substance use issues; and (6) medical care for a child's prenatal exposure to substances. Of these, the most common planned services across the 17 grantees are family

Table IV.2. RPG4 planned target populations and recipients of services

Grantee state	Target population for RPG4					
			Child welfare-related risk factors			
	Age of child at enrollment	AI/AN descent	At-risk for child welfare involvement	Current or prior child welfare involvement	At-risk for removal from home	Child residing outside the home
AK	Not specified	✓	✓			
AL	Prenatal		✓			
DE	Newborns		✓			
FL	0–11 years		✓			
IA	0–21 years		✓	✓		
IL	0–18 years				✓	
IN	Newborns			✓		
KS	0–18 years	✓			✓	✓
KY	Prenatal–17 years				✓	✓
MO	0–18 years				✓	✓
OH	Not specified			✓		
OK	0–5 years		✓	✓		
TN	Prenatal–5 years		✓	✓		
VT	0–6 years			✓	✓	
WA	Not specified	✓			✓	✓
WI	Not specified		✓	✓		
WV	0–12 years			✓	✓	✓

Sources: RPG4 grant applications; spring 2018 semiannual progress reports; and calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic technical assistance providers occurring from December 2017 through April 2018.

Note: AI/AN = American Indian/Alaska Native.

strengthening (15 projects), case management (14 projects), trauma and behavioral health (11 projects), and substance use treatment (10 projects). Table IV.3 provides a brief description of the services that each grantee plans to implement.

According to the funding announcement, grantees are expected to implement "specific, well-defined, and quality program services and activities that are evidence supported and/or evidence-informed." Grantees named 71 programs, curricula, and practices that they plan to implement (see Appendix B for more information). There is little overlap in the specific, named approaches across projects. More than half of the programs and practices (23 programs and practices or 58 percent) were offered by 1 project only; 15 percent of the services (6 programs or practices) were offered by 3 or more projects. The most commonly reported program, the Nurturing Parenting Program (a parenting course with curricula tailored to families with a parent in recovery from an SUD), was offered by 8 of the 17 projects. In addition, a few projects used the same substance use treatment programs, including Seeking Safety (4), Helping Women Recover/Helping Men Recover (3), and Living in Balance (3). Some grantees also use the same approaches to psychotherapy, such as motivational interviewing (5) and cognitive behavioral therapy (3).

D. RPG4 partnerships

By working together, child welfare, substance use treatment, and other agencies can draw from a wider array of resources to better meet families' needs. As shown in Table IV.4, as of April 2018, each project had an average of approximately 10 partners, including the grantee. Across projects, the number of partners ranged from 3 to 23 organizations, with a total of 164 involved agencies.

To meet the complex needs of the families they intend to serve, projects include an array of partners including state or county agencies and service providers. All projects included either a state or county child welfare agency, and most projects also included a public substance use services or mental health agency (10 projects) or a behavioral health or substance use treatment provider (13 projects).

Table IV.3. Planned services for RPG4 projects

			Types of services provided					
Grantee State	Targeted recipients of services	Description of planned services	Family strengthening	Substance use treatment	Trauma or behavioral health	Case management	Peer coaching or support	Medical care
AK	Family	The project will provide families with parenting classes and a navigator who will support families to engage in and follow the Team Decision Making process, support families during placement changes, and provide linkages to supports.	✓			✓	✓	
AL	Adult	Services will include universal screening, assessment, prenatal and postpartum care, medication for SUDs, and recovery support services.	✓	✓	✓	✓	✓	
DE	Adult	A peer recovery coach and nurse home visitor will provide services to mothers using a multidisciplinary, team-based approach.	✓	✓		✓	✓	
FL	Child and adult	The project will provide an integrated continuum of care, which will include a parenting curriculum, intensive family preservation services, and SUD treatment.	✓	✓	✓	✓	✓	
IA	Child	The project will provide evidence-based, trauma-informed therapies delivered by clinical therapists as well as case management services from a coordinator.			✓	✓		
IL	Adult	Intact family services (IFS) case managers and recovery coordinators will provide RPG families multidisciplinary case management and recovery planning.		✓		✓		
IN	Child, adult, and family	The project will provide wraparound services, case management, and residential treatment services to postpartum women with substance use issues and their children.	✓	✓	✓	✓	✓	✓
KS	Family	The project will provide a culturally adapted version of the Strengthening Families Program to Native American children.	✓					
KY	Adult	The project will provide an intensive outpatient substance use treatment. A team consisting of a clinician, peer support specialist, and case manager will provide treatment in three phases: (1) intensive treatment, (2) early recovery services, and (3) maintenance.	✓	✓	✓	✓	✓	
MO	Adult	The project will provide a core set of trauma-informed wraparound services, including case management, peer recovery mentors, in-home substance use and co-occurring mental health disorder treatment, parenting classes, and access to community supports.	✓	✓	✓	✓	✓	
OH	Adult	The project will provide (1) family drug treatment court (FDTC) and medication for SUDs; (2) peer recovery support; and (3) parenting skills training and support for kinship providers to RPG families.	✓	✓		✓	✓	

Table IV.3 (continued)

			Types of services provided					
Grantee State	Targeted recipients of services	Description of planned services	Family strengthening	Substance use treatment	Trauma or behavioral health	Case management	Peer coaching or support	Medical care
OK	Family	The project will provide the Attachment and Biobehavioral Catch-Up, a home-visiting program model, to address caregiver–child attachment and regulatory problems.	✓					
TN	Adult and family	The project will provide comprehensive assessments to determine client needs; provide residential and intensive outpatient substance use treatments, giving clients the ability to move from one modality to another; and provide case management for those in residential treatment.	✓	✓	✓	✓		
VT	Family	A licensed clinician and family engagement specialist will provide home-based services, including intensive case management and family-strengthening programming.	✓		✓	✓		
WA	Child, adult, and family	The project will provide wraparound services, including housing, case management and coordination, financial and material supports, trauma-informed therapies, and substance use treatment.	✓	✓	✓	✓		✓
WI	Child, adult, and family	The project will provide recovery housing and outpatient and in-home services. Outpatient services will include substance use treatment and trauma-informed therapies; in-home services will include parenting coaching and therapies for the child, adult, and family.	✓	✓	✓		✓	
WV	Adult and family	The project will provide in-home substance use treatment and wraparound services, which will involve developing and implementing a care plan with support from a care coordinator.	✓	✓	✓	✓		

Sources: RPG4 grant applications; spring 2018 semiannual progress reports, and calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic technical assistance providers occurring from December 2017 through April 2018.

Note: SUD(s) = substance use disorder(s).

Table IV.4. Number and types of organizations involved in RPG4 projects

Type of organization	AK	AL	DE	FL	IA	IL	IN	KS	KY	MO	OH	OK	TN	VT	WA	WI	WV	Total	
																		Organi-zation	RPG4 projects
Child and family services organization			3	1		2	1	1	1	1	1				2		1	**14**	**10**
Courts		1			1		1	1	2	2	2		1		2			**13**	**9**
Educational institution (non-university)							2		2					3	1			**8**	**4**
Government-run child welfare agency	1	1	2	2	1	1	1	1	1	1	2	1	1	1	1	1	1	**20**	**17**
Government-run substance use treatment or mental health agency		1	2	1		1		1	1	1		1		1			1	**11**	**10**
Healthcare			5							5				3	1			**14**	**4**
Housing							1		2	5				5	1			**14**	**5**
Mental health or substance use treatment		4		1	1	3		1	1	5	3		1	3	4	1	1	**29**	**13**
Private evaluator (non-university)	1		1	1	1	1	1							1		1		**8**	**8**
Tribal organization	1							3							1			**5**	**3**
University		1					1	2	1		1	3			1		1	**11**	**8**
Other types		1		5		1	1	3	2	3			1					**17**	**8**
Number of organizations	**3**	**9**	**13**	**11**	**4**	**9**	**9**	**13**	**13**	**23**	**9**	**5**	**4**	**17**	**14**	**3**	**5**	**164**	**NA**

Sources: RPG4 grant applications' spring 2018 semiannual progress reports, and calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic technical assistance providers occurring from December 2017 through April 2018.

Note: The projects column is a total of the number of projects that include each type of organization in its partnership. For example, there are three RPG4 projects (in Alaska, Kansas, and Washington) that include tribal organizations in the partnerships.

NA = not applicable.

V. RPG4 EVALUATIONS

Concerns that increases in foster care placements are driven, at least in part, by parents' or caregivers' substance use issues create an urgent need to understand how to best support vulnerable families (Children's Bureau, 2016a, 2016b). However, practitioners and funders have limited rigorous evidence to guide them on effectively serving families who are involved with child welfare because of caregiver substance use (for example, California Evidence-Based Clearinghouse for Child Welfare, n.d.[16]; Strong et al., 2013). The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) requires that HHS evaluate the services and activities provided with RPG funds. To address the legislation's goals and to contribute knowledge to the fields of child welfare and substance use treatment programming, HHS is continuing to require and support local evaluations, which are conducted by each project team, and a national cross-site evaluation. Both types of evaluations are described in this chapter.

A. Local evaluations

As with previous cohorts, HHS requires each RPG4 project team to work with an evaluator (either internal or a third-party) to conduct a local evaluation. As specified in the funding opportunity announcement, each project team must plan and conduct a rigorous evaluation to assess the effectiveness of activities and services on the well-being, permanency, and safety of children who are in an out-of-home placement or are at risk of being placed in an out-of-home placement as a result of a parent's or caretaker's substance use issues (ACF, 2017a, 2017b). Project teams must also examine project implementation to better understand project operations and their partnerships.

To measure impacts or effects of the project, an evaluation needs to include a treatment group that receives the services of interest and a comparison group that does not. The comparison group represents what would have happened to the treatment group if they had not received the services. RPG project teams might form treatment groups using a random process for a randomized-controlled trial (RCT) or a non-random process, such as self-selection or staff assignment, for a quasi-experimental design (QED).

The strength of both designs comes from the similarity of the treatment and comparison groups at baseline before the services begin, known as baseline equivalence. If the treatment and comparison groups are similar at the study's onset, then subsequent differences in outcomes are likely attributable to the services. With RCTs, random assignment creates two groups that are equivalent on all characteristics, on average. Factors such as missing data, however, can weaken the design. With QEDs, equivalence between both groups can be established using observable variables that researchers can measure. Because the groups may be different on characteristics that were not measured, QEDs are less rigorous than RCTs.

[16] The California Evidence-Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/) assesses and rates the quality of the research evidence for programs and practices as well as the research's relevance to families involved with the child welfare system.

Project teams will also examine project implementation to better understand project successes and challenges and provide context for the impacts. For example, implementation evaluations might examine the services delivered, staffing, and partners' collaboration as well as changes over time for any of these dimensions.

Although all project teams proposed an evaluation design in their RPG applications, HHS designated the first six months of the grant as a planning period, during which grantees and their partners were expected to refine and finalize their evaluation plans (ACF, 2017a, 2017b). The cross-site evaluation contractor worked with project teams to finalize, and, if possible, strengthen their local evaluation design plans. Contractor staff helped grantees and local evaluators develop and refine evaluation designs; responded to questions; and offered suggestions to more closely align evaluation designs with HHS's goals as described in the funding opportunity announcement.

As shown in Table V.1, at the end of the planning period, 4 of the 17 project teams planned to evaluate impacts with an RCT, 11 planned to use a QED, and 2 planned to conduct both an RCT and QED (19 impact evaluations total). All project teams plan to assess implementation. Most project teams also plan to assess aspects of the partnerships either as part of the implementation study (8 projects) or as a separate, complementary study (7 projects).

Table V.1. Summary of grantees' planned local evaluations

Grantee organization and state	Impact evaluation design: RCT	Impact evaluation design: QED	Treatment and comparison group services	Impact evaluation sample size	Data sources	Other local evaluation components
University of Alabama at Birmingham, Alabama		✓	Treatment group: Members of the treatment group will receive coordinated prenatal care and treatment for SUDs. This service model will include group prenatal care at a central clinic, case management from a peer recovery mentor, and intensive outpatient or residential treatment for SUDs. Following childbirth, mothers will continue to be eligible for peer mentoring, in-home trauma services, and group postnatal care. Comparison group: The members of the comparison group will receive business-as-usual health care and whatever community services they may access on their own.	Treatment group: 265 families Comparison group: 124 families Total: 389 families	Direct assessments Administrative records	Separate implementation and partnership studies
Cook Inlet Tribal Council, Alaska		✓	Treatment group: Families will receive an enhanced version of the Team Decision-Making (TDM) model: the Team Decision-Making Enhancements for Strong Native Families (TESNF). TESNF adds to TDM a family navigator and evidence-informed parenting classes. The family navigator helps support the family through pre- and post-TDM meetings to increase engagement in the process, provides support during child placement changes and reunification, and helps the family navigate referrals and service linkages. Comparison group: Members of the comparison group will receive the standard TDM model.	Treatment group: 160 families Comparison group: 132 families Total: 192 families	Direct assessments (program group only) Administrative records	Implementation study (including some examination of partnerships)
Children and Families First Delaware, Delaware	✓		Treatment group: Families will receive home visits from a nurse via the Healthy Families of America (HFA) model. They will also be assigned a peer recovery coach who will work with the nurse conducting home visits as a coordinated team. The peer recovery coach will help with case management and facilitating SUD treatment. Lastly, women in the program group will receive the Nurturing Parenting Program, a group-based parenting skills model. They will have access to services for up to three years after the birth of their baby. All women enrolled in the study will have access to medication for a SUD. Comparison group: Members of the comparison group will receive business-as-usual services through one of two providers of medication for SUDs. These services include access to either a peer recovery coach or care coordinator, as well as potential referrals to other community-based services.	Treatment group: 40 families Comparison group: 40 families Total: 80 families	Direct assessments Administrative records	Separate implementation and partnership studies

Table V.1 (continued)

Grantee organization and state	Impact evaluation design		Treatment and comparison group services	Impact evaluation sample size	Data sources	Other local evaluation components
	RCT	QED				
Broward, Behavioral Health Coalition, Florida	✓		Treatment group: Members of the treatment group will receive the Engaging Parents Program (EPP) and assignment to a continuing care parent advocate (peer specialist) in combination with two treatment-as-usual services—Intensive Family Preservation Services (IFPS) and the Motivational Support Program (including substance use treatment). Comparison group: Members of the comparison group will receive the treatment-as-usual services, which include IFPS and the Motivational Support Program (including substance use treatment).	Treatment group: 144 families Comparison group: 144 families Total: 288 families	Direct assessments Administrative records	Separate implementation and partnership studies
Youth Network Council Illinois Collaboration on Youth, Illinois		✓	Treatment group: Families will receive Intact Family Services (IFS), which is treatment-as-usual, plus specialized case management from a trained recovery coordinator for up to 18 months. Comparison group: Members of the comparison group will receive IFS (treatment-as-usual) for 6 to 12 months.	Treatment group: 240 families Comparison group: 240 families Total: 480 families	Direct assessments Administrative records	Separate implementation and partnership studies
Volunteers of Indiana, Indiana		✓	Treatment group: Members of the treatment group will live in the Fresh Start residential treatment facility, work with a family advocate who will represent them in court hearings, and work with a family coach who will provide wraparound case management services. The program consists of three phases. During Phase 1, mothers will reside at the Fresh Start facility and focus on acute stabilization of withdrawal symptoms. During Phase 2, mothers will continue to reside at the Fresh Start facility and receive group and individual counseling focused on short- and long-term recovery. Finally, during Phase 3, mothers will transition to independent living and continue to receive home visits from their family coach. Comparison group: Members of the comparison group will have access to the Fresh Start residential treatment program (which does not include a family coach or home visits following residential treatment), one of Volunteers of Indiana's outpatient treatment programs, or another program in the community.	Treatment group: 252 families Comparison group: 252 families Total: 504 families	Direct assessments Administrative records	Implementation study

Table V.1 (continued)

Grantee organization and state	Impact evaluation design		Treatment and comparison group services	Impact evaluation sample size	Data sources	Other local evaluation components
	RCT	QED				
Northwest Iowa Mental Health Seasons Center, Iowa		✓	Treatment group: Members of the treatment group will receive a referral to one or more of six planned available program models, which primarily focus on children in the families. They will also be assigned a trauma-informed care (TIC) coordinator, who will schedule appointments, conduct assessments, and refer them to other services in the community. Comparison group: Members of the comparison group will receive Season's business-as-usual services. These may include outpatient behavioral health or counseling services, but will not include any of program models being offered as part of the RPG project or assignment to a TIC coordinator.	Treatment group: 270 families Comparison group: 100 families Total: 370 families	Direct assessments Administrative records	Separate implementation and partnership studies
University of Kansas, Kansas		✓	Treatment group: Members of the program group will receive a culturally adapted version of the Strengthening Families Program (SFP), a group-based program designed for high-risk families that combines parent training, social skills training for children, and opportunities for families to practice the skills they are learning. Comparison group: Comparison group members will receive business-as-usual services, which may include aftercare, family preservation, and family or community services.	Treatment group: 225 families Comparison group: 225 families Total: 450 families	Direct assessments (program group only) Administrative records	Separate implementation and partnership studies
Mountain Comprehensive Care, Inc., Kentucky		✓	Treatment group: Members of the treatment group will receive intensive outpatient (IOP) substance use treatment delivered by a team of providers including a clinician, peer support specialist, and family case manager. RPG services consist of an initial orientation and intensive care in three stages moving from (1) intensive substance use treatment; (2) to early recovery services; (3) to maintenance, featuring integrated mental health care, trauma-informed care, case management, peer/recovery supports, parenting and life skills training; and, finally, continuing care. Comparison group: Members of the comparison group will reside in an adjacent and demographically similar county and receive typical outpatient substance use treatment.	Treatment group: 320 families Comparison group: 320 families Total: 640 families	Direct assessments Administrative records	Implementation study (including some examination of partnerships)

Table V.1 (continued)

Grantee organization and state	Impact evaluation design		Treatment and comparison group services	Impact evaluation sample size	Data sources	Other local evaluation components
	RCT	QED				
Preferred Family Healthcare, Inc., Missouri	✓		Treatment group: All members of the treatment group will receive a set of core services: trauma-informed enhanced case management from a family advocate; services of a peer recovery mentor; in-home treatment of SUDs as needed (offered only in rural areas); the Nurturing Program for Parents in Substance Abuse Treatment and Recovery; and primary and basic behavioral health care. About half of the treatment group will also receive Living in Balance (LIB) from their family advocate in addition to the core services. The other half of the treatment group will receive Helping Men Recover/Helping Women Recover from their family advocate in addition to the core services. Comparison group: Comparison group members will receive the same set of core services as the treatment group, but will not receive LIB or Helping Men Recover/Helping Women Recover.	Treatment group: 192 families Comparison group: 96 families Total: 288 families	Direct assessments Administrative records	Implementation study (including some examination of partnerships)
The Ohio State University, Ohio		✓	Treatment group: Members of the treatment group will participate in family drug treatment court, have access to medication for SUDs, and be connected with a certified peer recovery supporter. In cases where children have been removed and placed with kinship care providers, those caregivers will receive parenting classes and certain financial supports. Comparison group: The evaluation will have two comparison groups. One will receive Ohio Sobriety, Treatment, and Reducing Trauma (START) services, including pairing participants with a peer recovery supporter who will provide intensive case management and referral to drug treatment providers. Children in Ohio START will receive trauma counseling as needed. The second comparison group will receive business-as-usual services, which will primarily consist of meetings with a caseworker and referrals to other services. These families may also receive services focused on substance use, such as inpatient or outpatient treatment or substance use counseling, and some may be paired with a peer recovery supporter (this service is now covered by Medicaid).	Treatment group: 250 families Comparison group: 500 families (plus 100 convenience sample from START) Total: 850 families	Direct assessments (not including convenience START sample) Administrative records	Implementation study (including some examination of partnerships)

Table V.1 (continued)

Grantee organization and state	Impact evaluation design		Treatment and comparison group services	Impact evaluation sample size	Data sources	Other local evaluation components
	RCT	QED				
Oklahoma Department of Mental Health and Substance Abuse, Oklahoma	✓		Treatment group: Members of the treatment group will receive Attachment and Biobehavioral Catch-Up (ABC), a home-visiting program designed to address caregiver–child attachment and regulatory problems in young children. Comparison group: Members of the comparison group will receive business-as-usual services from community partners and child welfare agencies.	Treatment group: 315 families Comparison group: 315 families Total: 630 families	Direct assessments Administrative records	Implementation study (including some examination of partnerships)
Helen Ross McNabb Center, Tennessee	✓	✓	QED treatment group: Members of the QED treatment group will receive Great Starts, which includes family-centered substance use treatment services offered via residential treatment and intensive outpatient (IOP) treatment. Great Starts also includes several program models depending on family needs. These models include Seeking Safety, Hazelden Co-Occurring Disorders Program, dialectical behavioral therapy, and eye movement desensitization and reprocessing. Family and individual therapy are offered based on family needs using the Nurturing Parenting Program, Family Behavior Therapy, and child parent psychotherapy. QED comparison group: Members of the QED's comparison group will receive business-as-usual adult-centered IOP and residential services from the grantee, both of which will finish before the program group services. RCT treatment group: Members of the RCT treatment group will receive Healthy Families of America services, a model for providing in-home aftercare services. Families participating in the RCT will have already completed either Great Starts or another of the RPG services (Safe Baby Court). That is, the families who completed Great Starts will also have participated in the QED. RCT comparison group: Members of the RCT comparison group will receive Seeking Safety during in-home visits from the grantee, an alternative traditional aftercare program offered in the same county.	QED treatment group: 200 families QED comparison group: 100 families RCT treatment group: 45 families RCT comparison group: 60 families Total: 405 families	Direct assessments Administrative records	Implementation study (including some examination of partnerships)

Table V.1 (continued)

Grantee organization and state	Impact evaluation design		Treatment and comparison group services	Impact evaluation sample size	Data sources	Other local evaluation components
	RCT	QED				
Lund Family Center, Vermont	✓	✓	Treatment group: Members of the treatment group for both the RCT and QED will receive regular home visits from a two-person family recovery team including a family engagement specialist and a licensed clinician. The team will construct a detailed action plan after an intensive assessment process, and use it to structure home visits. The family engagement specialist will act as a caseworker and service coordinator, and the clinician will deliver the Attachment, Regulation, and Competency (ARC) model. Comparison group: Members of the comparison group will receive business-as-usual services which include periodic check-ins from Department of Children and Families caseworkers and referrals to other service providers in the area.	QED treatment group: 140 families QED comparison group: 140 families RCT treatment group: 220 families RCT comparison group: 220 families Total: 720 families	Direct assessments (not including QED comparison group, and more limited for RCT comparison group) Administrative records	Implementation study (including some examination of partnerships)
Catholic Charities, Washington		✓	Treatment group: Members of the treatment group will receive the Rising Strong program, a residential housing program designed to improve outcomes for families affected by alcohol and substance use. Services include case management and service coordination, support groups and workshops on personal development and life skills, therapy and counseling, financial planning, medical care, employment training, children's and adults' education, parenting programs, family activities, transportation, and financial or material supports. The set of services each family will receive will depend on that family's particular needs. Comparison group: Members of the comparison group will have access to business-as-usual services from existing providers in their counties and communities. These services typically do not include intensive substance use treatment for parents or provision of additional program models.	Treatment group: 150 families Comparison group: 150 families Total: 300 families	Direct assessments (program group only) Administrative records	Implementation study
Prestera Center for Mental Health, West Virginia		✓	Treatment group: Members of the treatment group will receive wraparound services, including case management, the Seeking Safety program (in an in-home setting), Motivational Interviewing, and EcoSystemic Structural Therapy. A care coordinator will provide wraparound services, possibly with assistance from a family aide/therapist or a peer recovery coach. Comparison group: Members of the comparison group will live in a West Virginia county not served by the RPG and receive treatment-as-usual services.	Treatment group: 200 families Comparison group: 75 families Total: 275 families	Direct assessments Administrative records	Separate implementation and partnership studies

Table V.1 (continued)

Grantee organization and state	Impact evaluation design		Treatment and comparison group services	Impact evaluation sample size	Data sources	Other local evaluation components
	RCT	QED				
Meta House, Wisconsin		✓	Treatment group: Members of the treatment group will receive supportive recovery housing and services for up to 12 months, including an apartment in the recovery housing community, outpatient SUD treatment and mental health services, and in-home parenting and therapy services. Women will also have access to a peer recovery support specialist and case management. Comparison group: Members of the comparison group will be drawn from the population of Meta House clients receiving business-as-usual outpatient SUD services and mental health services. These are the same SUD and mental health services received by women in the program group, but women in the comparison group will receive these services for approximately 4 months (on average).	Treatment group: 72 families Comparison group: 72 families Total: 144 families	Direct assessments Administrative records	Implementation study (including some examination of partnerships)

Source: Evaluability assessments.

Note: QED = quasi-experimental design; RCT = randomized controlled trial; SUD(s) = substance use disorder(s).

1. Rigor of the local impact evaluations

To assess the details of the proposed approaches, HHS worked with the cross-site evaluation contractor to conduct an evaluability assessment of each local impact evaluation. In assessing the strength of these designs, HHS considered the level of evidence on project effectiveness that the evaluations could provide if well implemented. HHS also considered factors that could interfere with the ability of the evaluation designs to detect project effects. These included whether the project teams would collect primary data directly from families served or obtain secondary, administrative, data collected by child welfare and SUD treatment agencies. Table V.2 describes each possible design rating for the local impact evaluations.

Table V.2. Impact evaluation design ratings

Impact evaluation design rating	Description	Applicable designs
Strong	If the evaluation is implemented well, the design will provide credible, unbiased effects of the contrasts being evaluated.	Well-conceived RCTs
Promising	If the evaluation is implemented well, the design will provide suggestive information on the effects of the contrasts being evaluated.	An RCT with likely issues or QED with substantial primary baseline data collection, which could be used to establish equivalence on many factors
Limited	If the evaluation is implemented well, the design will provide limited information on the effects of the contrasts being evaluated.	A QED that relied solely on administrative data to establish baseline equivalence
Descriptive	The design cannot isolate treatment effects from other factors, but can provide useful information on participant outcomes or other aspects of the RPG project and partnerships.	An RCT or QED design in which baseline equivalence seemed unlikely or a design that did not include a comparison group

Note: QED = quasi-experimental design, RCT = randomized controlled trial.

HHS assigned a rating to each of the 19 local impact evaluations across the 17 projects. The 6 RCTs received a strong rating. Of the 13 proposed QEDs, 7 received a promising rating, 4 received a limited rating, and 2 received a descriptive rating.

2. Characteristics of the local impact evaluations

The focus of the local impact evaluations varies, with some evaluations designed to assess the impact of one RPG service, such as enhanced case management, and others designed to assess the impact of a combination of services. The local evaluations reflect variations in needs of their clients, community partners, experiences, and available resources.

When all else is equal, the larger the sample size for an evaluation, the smaller the effects an evaluation can detect. If those in the treatment and comparison groups receive similar services, the effect could be small and thus an evaluation would need a larger sample to precisely estimate it. The anticipated size of projects' local evaluation samples varies:

- Three projects anticipate a local evaluation sample size of fewer than 200 families.
- Five projects expect to include 200 to 399 families in their impact evaluation.

- Seven projects expect a sample of 400 or more families.

In their local evaluations, all project teams will use administrative data and also collect data directly from families. As described in section B, project teams obtain administrative data from child welfare and substance use treatment providers. They will collect primary data directly from families using standardized instruments[17] measuring desired RPG outcomes such as child well-being and adult recovery from substance use issues. Most project teams (14 of the 17) plan to collect primary data from both the treatment and comparison groups. Three project teams are conducting the assessment with families in the treatment group only. They will use only administrative data to compare their treatment and comparison group outcomes.

B. Overview of the cross-site evaluation

The RPG4 cross-site evaluation will build on the previous cross-site evaluation design but will be tailored to the RPG4 projects and reflect HHS's current priorities. Through the RPG4 cross-site evaluation, HHS seeks to better understand the partnerships that form the basis of each project, who was served, how they were served, their outcomes, and the impacts of the projects. The cross-site evaluation will address the following research questions:

- **Partnerships.** Which partners were involved in each RPG project and how did they work together? How much progress did RPG4 projects make towards interagency collaboration and service coordination? How do the child welfare and substance use treatment agencies work together to achieve the goals of RPG?
- **Families served.** What referral sources did RPG projects use? What are the characteristics of families who enrolled in RPG? To what extent did RPG projects reach their target populations?
- **Services.** What core services (services defined by the local RPG project team as fundamental to its RPG project) were provided and to whom? Were core services that families received different than the services proposed in the RPG project applications? If so, what led to the changes? How engaged were participants with the services provided? Which agencies (grantees and their partners) provided services? What proportion of families exited RPG?
- **Improvement and sustainability.** What plans and activities did RPG projects undertake to maintain the implementation infrastructure and processes during and after the grant period? What plans and activities did RPG projects undertake to maintain the organizational infrastructure and processes after the grant period? To what extent were RPG projects prepared to sustain services after the grant period? What plans and activities did RPG projects undertake to develop funding strategies and secure resources needed after the grant period? How did the federal, state, and local context affect RPG projects and their efforts to sustain services after the grant period?

[17] A standardized measure or test is one that requires all respondents or test takers to answer the same questions, or a selection of questions from common set or bank of questions, in the same way, and is scored in a standard or consistent manner, which makes it possible to compare the relative performance of individuals or groups (adapted from the Glossary of Education Reform, http://www.edglossary.org/standardized-test/).

- **Outcomes.** What were the well-being, permanency, safety, recovery, and family-functioning outcomes of children and adults who enrolled in RPG projects?
- **Impacts.** What were the impacts of RPG projects on children and adults who enrolled in RPG?

To answer these questions, the cross-site evaluation will draw on multiple data sources (Table V.3). Data sources include surveys, semiannual reports on grant performance, site visits, and data collected directly from and about families served by the projects.

Table V.3. RPG cross-site evaluation data sources by research topic

	Cross-site evaluation topic					
Data source	Partnerships	Families served	Services	Improvement and sustain-ability	Outcomes	Impacts
Project documents: grantee applications, semiannual progress reports, memoranda of understanding	✓	✓	✓	✓		
Partner survey	✓					
Sustainability survey	✓			✓		
Site visits and phone interviews	✓		✓	✓		
Enrollment and service data		✓	✓			
Standardized data and administrative records for RPG participants		✓			✓	✓
Standardized data and administrative records for comparison groups						✓

1. Partnerships

The partnerships in RPG are intended to improve services and outcomes for families involved with both child welfare and substance use treatment systems. Collaboration between child welfare agencies and substance use treatment providers can result in close monitoring of families' access to needed resources and more informed decisions about the family's case, such as reunification decisions or relapse prevention or support (Green et al., 2008). In addition, families are more likely to hear consistent messages from service providers (Green at al., 2008).

Building on the lessons and findings from the cross-site evaluation of previous RPG cohorts, the RPG4 cross-site evaluation will assess the collaboration among partners and the coordination of services that RPG4 projects provided for families. The evaluation will examine which partners compose the partnerships and the roles that each partner plays. It will also investigate the extent of collaboration between partners, from sharing a vision and goals to sharing information across agencies to integrating assessment and treatment.

In addition, the evaluation will explore in depth the interagency collaboration and coordination of the child welfare and substance use treatment agencies. Advancing the collaboration and coordination across both systems is critical to the success of the RPG projects because they aim

to serve the same families and support their well-being. However, the relationship between child welfare and substance use treatment providers is historically difficult because of factors such as conflicting timelines for recovery and permanency decisions and limited data sharing between agencies (Green et al., 2008). Moreover, the agencies often view different people as their primary clients, with substance use treatment providers generally focused on adults and child welfare agencies focused on children.

An online survey administered to grantees and all partners in the fourth year of the grant will collect data on the partnerships. One person from each organization knowledgeable about the RPG project will be invited to participate in the survey. The survey will collect information about communication and service coordination among partners. It will also collect information on service coordination such as data-sharing agreements, colocation of staff, referral procedures, and cross-agency staff training.

Other data sources are site visits and document reviews. The cross-site evaluation team will visit up to 11 projects that have strongly integrated the services of child welfare and substance use treatment agencies. The team will use phone interviews with grantee staff and others from the remaining projects to gather similar information about their design and implementation. Documents reviewed will include grant applications, semiannual progress reports, and memoranda of understanding or data-sharing agreements.

2. Families served

The Child and Family Services Improvement Act of 2006 (Pub. L. 109-288), which established RPG, broadly targeted families with children in or at-risk of an out-of-home placement because of a parent's or caretaker's substance misuse. RPG projects can more narrowly define the families they intend to enroll, based on community needs and their planned services, expertise, and referral sources. For example, a project may aim to enroll only pregnant women who tested positive for substance use. However, families who enroll may not always match the project team's intended target population (HHS, forthcoming). In addition, the needs of the community or community resources can change, for example. However, if the enrolled families differ substantially from the intended RPG target population, projects may not be allocating funds the way that Congress intended.

To understand who was served by the RPG projects, the cross-site evaluation will examine the characteristics of projects' specified target populations and those of families who enroll in the projects. The cross-site evaluation will rely on four data sources:

- **Project documents.** The grantee applications have data on planned referral sources, partners, and target populations; the semiannual progress reports that grantees complete twice a year will provide data on changes to those plans over the course of the grants. The semiannual progress reports will also provide information on the number of families served and projects' enrollment targets.
- **Enrollment and service data.** To document participants' characteristics and their enrollment in RPG services, all project teams will provide data on enrollment of and services provided to families in their RPG project. These data will include demographic information on family members, dates of entry into and exit from RPG services, and

information on the type and extent of RPG services. These data are submitted on an ongoing basis by staff at the grantee organizations into an information system developed for the cross-site evaluation.

- **Standardized data and administrative records for RPG participants.** Project teams will ask an adult from each family enrolled in RPG to complete a set of standardized instruments measuring child well-being, adult recovery, and family functioning when they enter and exit the project. Grantee agencies will also obtain administrative data on child permanency and safety and adult recovery before, during, and after participation in RPG services. These data will provide details of the characteristics of families served by RPG.
- **Site visits and phone interviews.** Interviews during site visits and by phone will provide an opportunity for the cross-site team to discuss with staff their perceptions of how closely the enrolled population aligned with their intended target populations, whether the project changed its eligibility criteria over time, and, if so, why.

3. Services

As was the case in previous RPG cohorts, there is no distinct RPG4 model for serving families. In its RPG application, each project team proposed an approach to serving the target population in their community that would meet the overall grant objective and capitalize on the grantee's and partners' strengths and resources. These projects are typically complex, involving multiple services and, often, multiple service providers. Furthermore, given the complexity of the needs of RPG families, project teams might revise their plans. For example, previous RPG project teams made changes, such as adding a partner agency that served non-English speakers or changing from an office-based approach to home visits to serve a rural service area. All such changes are subject to HHS approval.

The cross-site evaluation will describe how families were served through RPG to better understand how grant funds were used, what was feasible in different contexts and communities, and the level and type of services families received. The implementation study conducted as part of the cross-site evaluations of RPG2 and RPG3 focused mainly on EBPs (as discussed in detail in Chapter III). Projects could, and often did, offer services in addition to the EBPs, but these services were not a focus of the cross-site evaluation. In RPG4, the cross-site evaluation will use a broader lens to provide a detailed picture of all core services provided to families enrolled in RPG. Core services are the services defined by the project team as comprising its main RPG project. These include, at a minimum, all services funded by the grant, and might also include in-kind services provided by partners. To better understand RPG participants' reactions to the services, frontline staff will be asked to assess participants' engagement in services, such as whether they actively participated in service activities. As a result, the RPG4 cross-site evaluation will also describe how engagement varied across participants and services.

The services analysis will use multiple data sources to describe the types and amount of services projects provided to families, and how those services evolved during the grants. Data sources include project documents, enrollment and service data, the partner survey, and site visits.

4. Improvement and sustainability

To maintain their projects in the short- and long-term, project teams should undertake two

activities: (1) using data to continuously improve services and (2) planning for sustainability of RPG services and partnerships. As part of their grant requirements, project teams must develop a plan for maintaining key elements of their projects after the period of federal funding ends. Such planning can enable organizations to offer continuity of services and continue building their and other agencies' capacities to support vulnerable families.

To describe plans for and actions taken to improve and sustain RPG projects (or key elements of the projects), the cross-site evaluation contractor will administer an online survey to grantees and selected partners once during the fourth year of the grants. Staff from grantee and partner organizations who are most knowledgeable about RPG will be invited to participate in the survey. The survey will collect information about supports within the partnership that can help improve and sustain RPG services, such as processes to collect, monitor, analyze, and report on project performance data, and will be asked to identify an organization to lead the project after grant funding ends. In addition, the survey will collect information about funding sources and resources needed after the end of the grant. The analysis will also include data from relevant project documents and interviews.

5. Outcomes

The analysis of outcomes will examine how families changed over time during their participation in RPG services. Grantees or their evaluators will collect data from families when they enter and exit services and submit it to the cross-site evaluation. They will also obtain administrative child welfare and substance use treatment data on participants for submission to the cross-site evaluation. The analysis of these data will measure outcomes in five domains: (1) child well-being; (2) safety; (3) permanency; (4) adult recovery; and (5) family functioning.

Child well-being. Using standardized data collection instruments, grantee agencies or evaluators will collect data from an adult in each family about child well-being. To limit the burden associated with data collection, projects will collect data on a single focal child in each family, even when there were multiple children in the household. Each project team will develop a decision rule for selecting the focal child and apply the rule consistently to all enrolled families. The child well-being domain includes measures of sensory processing and emotional and behavioral problems.

- **Sensory processing**. Sensory processing, the way the brain takes the information from the senses and turns it into appropriate behavioral responses, can be affected by prenatal substance exposure (Chasnoff, Wells, Telford, Schmidt, & Messer, 2010). Children who have difficulties processing sensory information or responding to the information through appropriate behaviors often have difficulties performing everyday tasks and have lower levels of adaptive social behaviors (Ben-Sasson, Carter, & Briggs-Gowan, 2009). Projects will use the Infant-Toddler Sensory Profile (ITSP) (Dunn, 1999, 2002) to examine the sensory processing of the focal child in each family. The ITSP, appropriate for children from birth to 36 months, identifies children who are over- or under-responsive to stimuli, both of which indicate sensory processing difficulties.
- **Emotional and behavioral problems.** Children's emotional and behavioral problems can be associated with caregiver substance use issues (Behnke, Vincent, Smith, Committee on Substance Abuse, & Committee on Fetus and Newborn, 2013), caregiver well-being, and

caregivers' parenting skills (Neece, Green, & Baker, 2012). Projects will use the Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2001) to measure children's emotional and behavior problems. A preschool version assesses children ages 18 months to 5 years, and a school-age version assesses children ages 6 to 17 years.

Safety. A key outcome for the RPG projects is the safety of children involved in the child welfare system—that is, the absence of maltreatment. Project teams will work with state child welfare agencies to obtain child welfare data for all children served in their RPG projects. Data elements are:

- Whether a child enrolled has a child protective services record.
- Information about the types of allegations of abuse or neglect reported (and whether the reports were substantiated) for children enrolled in RPG4, such as dates, maltreatment type (such as physical, emotional or sexual abuse, or neglect), and the disposition of the allegation (such as substantiated, unsubstantiated, indicated, or reason to suspect).

Permanency. As with safety data, grantees will obtain from state child welfare agencies administrative data on permanency (removals from the home and foster care placements) about all children enrolled in RPG. These data provide information on whether a child has been removed from his or her home in a given period (for example, within the past year or before RPG enrollment). For those who have been removed, data will show information about the removal, including dates, where the child was placed, if the child was discharged, and, if so, when and why (such as reunified with parents).

Adult recovery. Recovery from substance use is a process of change that permits individuals to make healthy choices and improve the quality of their lives (SAMHSA, 2012). RPG projects will use both standardized instruments and administrative data to measure selected aspects of recovery for adults enrolled in RPG, including substance use severity, trauma symptoms, and substance use treatment participation. Standardized data and administrative data will include:

- **Substance use severity.** Grantee agencies or RPG evaluators will measure the extent and severity of substance use of one adult from each family enrolled in RPG by administering the drug and alcohol use subscales of the Addiction Severity Index, Self-Report Form (ASI-SR). Examples of questions include, "How many days have you used more than one substance (including alcohol) in the past 30?" and "In the past 30 days, how many days have you experienced drug problems?" The ASI is widely used in clinical settings and by the Drug Evaluation Network System (DENS), a project that aims to gather clinical information on patients presenting for substance use treatment and the treatment programs they attend (Carise, McLellan, Gifford, & Kleber, 1999).
- **Substance use treatment**. Grantees will request administrative data on all adults enrolled in RPG projects about their participation in publicly funded substance use treatment before, during, and after participation in RPG. Data elements requested will include dates of service, substances used at admission and frequency of use, date of discharge, and reason for discharge (such as completing treatment or leaving against advice).

- **Parent trauma.** The Trauma Symptoms Checklist-40 (TSC-40) is an optional measure for the cross-site evaluation, which projects can use, if relevant. The TSC-40 measures aspects of post-traumatic stress and other symptom clusters in adults who have experienced childhood or adult traumatic experiences.

Family functioning. A parent or primary caregiver's mental health and attitudes can affect their parenting and the family's functioning and well-being. For the cross-site evaluation, project teams will collect data using standardized instruments for two measures: depressive symptoms and parenting skills.

- **Depressive symptoms.** Depression can be both the cause of and result from substance use (Grant & Harford, 1995). Parental depression may contribute to child maltreatment and poor child outcomes (Dubowitz et al., 2011; Sidebotham, Golding, & ALSPAC Study Team, 2001). Projects will measure adult depressive symptoms using the Center for Epidemiologic Studies Depression Scale (CES-D), 12-item short form (Radloff, 1977). The CES-D is a screening tool to assess the presence and severity of depressive symptoms occurring over the past week.
- **Parenting attitudes.** Negative attitudes about parenting or unrealistic expectations for children increase the potential for child abuse and neglect (Budd, Holdsworth, & HoganBruen, 2006). Projects will use the Adult-Adolescent Parenting Inventory-2 (AAPI-2) (Bavolek & Keene, 1999) to assess the attitudes about parenting and child-rearing. Based on the known parenting and child-rearing behaviors of abusive parents, responses to the measure provide scores that measure parents' risk of practicing behaviors known to be connected to child abuse and neglect.

6. Impacts

The cross-site evaluation will also assess the effects of the projects on the five domains described above. The cross-site evaluation will aggregate and analyze the treatment and comparison group data from projects that successfully complete local impact evaluations with sufficient rigor. To increase confidence that the results capture project effects and not other factors such as families' readiness for change or their receipt of other services in the community, this cross-site analysis will be restricted to local evaluations rated strong or promising (see Table V.2). That is, the cross-site analysis will only include RCTs or QEDs with established baseline equivalence on the analytic sample.

C. Technical assistance provided

To better enable RPG4 projects to meet the evaluation requirements, HHS has made providing evaluation-related TA a major responsibility for the cross-site evaluation contractor, Mathematica. Mathematica assigned four cross-site liaisons (CSLs) to provide one-on-one evaluation TA to the grantees and local evaluators. Each CSL is a researcher or senior researcher at Mathematica with one or more of three qualifications: (1) specialized training in assessing program evaluation designs, (2) experience evaluating programs serving children and families, and (3) experience providing training or TA to federal grantees. CSLs work with four to five projects each. They coordinate their activities with liaisons from NCSACW, which

provided program-related TA to the projects. The two contractors will provide evaluation and programmatic TA throughout the grant period.

During the grantees' planning period, much of the one-on-one TA was provided through conference calls with Mathematica and NCSACW liaisons, RPG project directors from the grantee agencies, their federal project officers (FPOs), and the local evaluator or other project staff. From September 2017 through March 2018, CSLs participated in 85 calls with or about grantees. In coordination with the NCSACW liaisons (who provide TA to the projects on their programs and partnerships), CSLs held monthly TA calls with project teams, check-in calls with FPOs, and additional ad hoc calls requested by grantees, local evaluators, or FPOs. On average, CSLs held about four calls with project teams during the planning period, with a range of three to eight calls across project teams.

Mathematica also provided group-based TA to address common issues across projects and to support project teams' participation in the cross-site evaluation. Group TA activities included:

- Four webinars on topics such as data collection planning, best evaluation-planning practices, and an introduction to the cross-site evaluation. Each webinar included time for questions and discussion.
- Three calls with subsets of grantees or local evaluators who participated in work groups to provide feedback on proposed measures and instruments for the cross-site evaluation, including client outcomes and service data. The cross-site evaluation team used this feedback to revise the measures, though HHS made the final decisions on measures and instruments.
- Eight presentations and small-group discussions held at an in-person annual RPG meeting in Washington, DC. Topics included tips on acquiring administrative data, putting evaluation plans into action, and using data for continuous quality improvement. In some sessions, grantee or local evaluator staff from RPG3 shared their experiences and lessons learned implementing their projects and evaluations with the new RPG4 attendees.

To offer thorough and seamless support to the project teams, the two TA providers coordinated and in some instances jointly conducted TA activities. For example, as described above, liaisons from Mathematica and NCSACW participated in TA calls. In addition, leadership from both TA teams, along with the HHS contracting office representatives, held monthly calls to coordinate work, discuss issues that arose during TA, and plan activities, such as the content and logistics for the annual grantee meeting. In addition to the separate presentations that Mathematica and NCSACW staff gave at the annual grantee meeting, a representative from both Mathematica and the NCSACW gave a joint presentation to model how project and evaluation staff should work together to identify, collect, and use data for project improvement.

D. Future reports to Congress

The RPG4 national cross-site evaluation will produce three reports to Congress, of which this report is the first. HHS will report on implementation and early cross-site evaluation findings after the third year of RPG4, in 2021. A final report on this cohort, with all remaining cross-site evaluation findings, will be submitted at the end of the 5-year grant period, during FY 2023.

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APPENDIX A:

PARTNERSHIP DATA AND METHODS

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This appendix briefly describes the RPG3 partnership survey data and analytic approaches, focusing primarily on differences in data or approaches used for the RPG3 grantees. The combination of Chapter II and Appendices A and B of the fifth report to Congress on the RPG program (HHS, forthcoming) provide a detailed description of the data sources, analytic approaches, and the framework used to describe RPG partnerships for the 2012 cohort of 17 RPG grantees (RPG2). The same analytic approach and framing were used in Chapter II of the current report to describe the 2014 cohort of four RPG partnerships (RPG3).

A. Partnership survey data

The grantees and all of the other partners for each of the four RPG projects responded to the partnership survey. It was conducted in spring 2017, after sites were in operation for 3 years and had achieved full implementation of the elements of their RPG projects. One representative from each grantee or partner organization identified as the most knowledgeable about their RPG project received a survey. All 38 invited respondents completed the survey, for a 100 percent response rate.

The partnership survey administered to RPG3 grantees was identical to the one administered to the RPG2 grantees. It included data on characteristics of respondent organization, and questions from two established measures used to describe collaboration, the Working Together Survey (Chrislip & Larson, 1994) and Collaborative Capacity Instrument (NCSACW, 2003). It also collected social network data on communication and coordination across a variety of RPG-specific activities such as referrals, case management, SUD treatment, and mental health services.

B. Analysis of collaboration scale scores

Responses to individual items from the Working Together Survey and Collaborative Capacity Instrument were combined to produce more reliable versions of underlying constructs of interest. For RPG2, a confirmatory factor analysis was conducted to identify the items that would be combined together for each instrument: A total of 10 factors (containing between one and eight items per construct) were identified across the two instruments, which was consistent with the literature on these instruments. For the RPG3 analysis presented in this report, the same factor structure was employed. Individual item responses for a given factor were averaged to produce a factor score for that respondent. To produce a partnership-level score, the scores of all respondents within a partnership were averaged.

A partnership average score less than 2.5 on any given Working Together Survey and Collaborative Capacity scale indicates that the partnership members did *not* agree that the construct was achieved (a score of 2.5 represents the midpoint between disagree and agree on each scale). Therefore, the cross-site evaluation use this threshold to define whether a partnership did or did not achieve collaboration on a particular element from the framework.

The *RPG3 cohort average* is the average of the four partnership averages. The cross-site evaluation also reports a standard deviation as a measure of the variability across the four partnership-level averages. Tables A.1 and A.2 provide descriptive statistics for these constructs, based on the RPG3 data.

Table A.1. Partners' perceptions of collaboration based on the Working Together Survey

Working Together Survey scale	RPG3 cohort mean	RPG3 cohort standard deviation	Number of partnerships (of 4) reporting score lower than 2.5	Internal consistency reliability (Cronbach's alpha[a])
Context of the collaboration (2 items)	3.72	0.24	0	0.84
Results of the collaboration (2 items)	3.38	0.20	0	0.54
Structure of collaboration (8 items)	3.48	0.46	0	0.93
Collaboration process (4 items)	3.37	0.39	0	0.88
Collaboration members (5 items)	3.32	0.31	0	0.82

Source: RPG partnership survey.

Note: The statistics are based on unweighted project averages (n = 4), such that all 4 RPG3 projects contributed equally to the analyses, regardless of the number of respondents within each project. The full sample size for all grantees was 38.

[a] The Cronbach's alpha values were calculated based on the RPG3 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.

Table A.2. Partners' perceptions of service coordination based on the Collaborative Capacity Instrument

Collaborative Capacity Instrument scale	RPG3 cohort mean	RPG3 cohort standard deviation	Number of partnerships (of 4) reporting a score lower than 2.5	Internal consistency reliability (Cronbach's alpha[a])
Daily practice in services coordination (3 items)	3.36	0.40	0	0.92
Daily practice of screening and assessment (2 items)	2.95	0.23	0	0.63
Joint staff training across organizations (1 item)	3.17	0.36	0	n.a.[b]
Shared principles, approaches, and timeframes (3 items)	2.95	0.41	1	0.92
Tracking and sharing information across organizations (3 items)	3.04	0.67	1	0.91

Source: RPG partnership survey.

Note: The statistics are based on unweighted grantee averages (n = 4), such that all four RPG3 projects contributed equally to the analyses, regardless of the number of respondents within each project. The full sample size across grantees was 38.

[a] The Cronbach's alpha values were calculated based on the RPG3 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.

[b] Cronbach's alpha value cannot be computed on a single item.

n.a. = not applicable.

C. Social network analysis

Social network analysis allows for measurement of the relationships between partner organizations. It analyzes the range of responses across all partners, rather than responses from each partner in isolation. Social network analysis captures which partner organizations have

relationships with others in their partnership. For example, an SUD treatment organization and the child welfare organization within a partnership might have a relationship in which they coordinate to provide services to families; however, the SUD treatment organization might not have a relationship with the children's mental health organization, even if that organization has a relationship with the child welfare organization. Social network data quantify these types of relationships among partners.

In addition to enabling a broader examination of relationships across the partnership, the RPG Partner Survey collected data about relationships at two time periods and on individual types of activities. For example, although the SUD treatment organization might have a relationship with the child welfare organization to coordinate case management, these two organizations might not have a relationship providing mental health and trauma services. For this reason, the survey measured (1) the extent the partnerships worked together before the RPG grant, (2) the partners' current communication other than during formal RPG meetings, and (3) the partners' relationships with one another on coordinating services in six specific areas. These analyses yielded eight social network measures.

For the analysis, the cross-site evaluation team produced a matrix for each social network for a given partnership. For illustrative purposes, Table A.3 shows a matrix for a hypothetical partnership of four organizations.

Table A.3. Example of social network data for a hypothetical partnership

Identifier	Organization 1	Organization 2	Organization 3	Organization 4
Organization 1	—	1	1	1
Organization 2	0	—	0	1
Organization 3	0	0	—	0
Organization 4	0	0	1	—

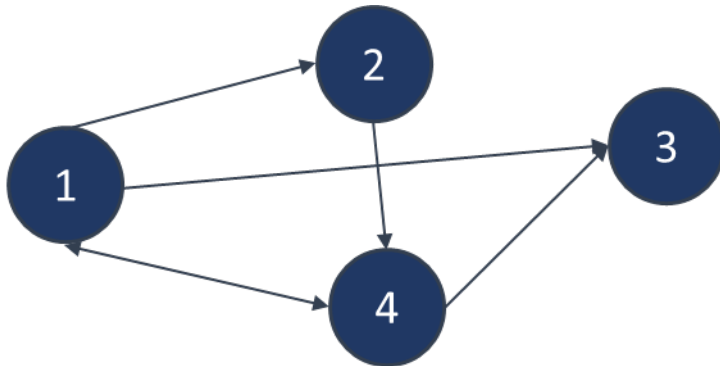
Note: A 0 represents no connection between organizations and a 1 represents a connection. The dash (—) indicates the relationship is not-applicable, since it would be a relationship of an organization to itself.

This hypothetical matrix shows whether each organization has indicated a connection with the other organizations in the partnership for each network measured. In this example, organization 1 (row 1) has indicated connections to Organizations 2, 3, and 4. Organization 2 (row 2) has indicated a connection to Organization 4. Organization 4 has indicated a connection to Organization 3. Importantly, the matrix represents the perceptions of each responding organization about its relationships with other organizations, which may not be shared by corresponding organizations in the partnership. For example, in Table A.3, Organization 1 has indicated that it has a connection with Organization 2, but Organization 2 has not indicated a connection with Organization 1.

The matrix can be represented visually as shown in Figure A.1. Circles represent each of the four organizations, and arrows indicate the relationships among them. These arrows specify the direction of the relationship: whether a responding organization indicated a relationship with another organization. For example there is an arrow from Organization 1 to Organization 2, but this arrow is not bi-directional, suggesting that Organization 2 did not indicate a relationship

with Organization 1. A bi-directional arrow, like the one between Organizations 3 and 4 indicates that both organizations indicated a relationship with the other.

Figure A.1. Example visualization of the network data



1. Analysis

Each network's density score measures the proportion of organizations that reported relationships, out of the total possible relationships in the partnership. The score is the ratio of the number of connections that exist between partners compared to the total number of connections that could possibly exist in a partnership of that size. Using the example in Table A.3, there are 5 observed connections (5 relationships identified in the matrix), and a total of 12 possible connections. Therefore, the density for this network is 0.4 (5 divided by 12). If every partner connected to all of the other organizations, then the density score would be 1. If none of the organizations connected with the other organizations, the density score would be 0.

The cross-site evaluation calculated a density score for each of the eight collaboration networks covered by the survey. The density score for each network were then averaged across the four partnerships. Table A.4 presents the average density scores for each network across all four partnerships. It shows the standard deviation of the density scores, which indicates the variability in these scores across partnerships.

Table A.4. Social network analysis results based on communication and coordination data

Network	RPG3 cohort average density	RPG3 cohort standard deviation
Worked together before the RPG grant	0.62	0.14
Communicated outside of formal RPG meetings	0.79	0.11
Screening and assessment	0.29	0.08
RPG program referrals	0.27	0.09
Case management or coordination	0.32	0.11
Substance use disorder treatment	0.29	0.14
Mental health and trauma services	0.24	0.08
Other social and family services	0.33	0.06

Source: RPG partnership survey.

Note: Density scores were computed for each network (area) for each partnership and then scores were averaged across networks to produce the average density score for all four projects.

D. Measures and items incorporated into the partnership framework

As described in the chapter (see Figure II.1), the cross-site evaluation used items from the Working Together Survey, the Collaborative Capacity Instrument, and social network scores, to examine where RPG partnerships stood on the continuum of collaboration. The three levels of collaboration examined included shared vision and common goals (level 1), aligned operational processes (level 2), and integrated service provision (level 3).

Table A.5. Survey constructs and items included in each level of the collaboration continuum

Level of framework	Partnership survey data source	Construct or item
Level 1. Shared vision and common goals	Working Together Survey	Context of the collaboration
		Results of the collaboration
		Structure of the collaboration
	Social network items	Extent to which an organization communicated with another organization outside of formal RPG meetings
Level 2. Aligned operational processes	Working Together Survey	Collaboration process
		Collaboration members
	Collaborative Capacity Instrument	Daily practice in service coordination
		Daily practice in screening and assessment
		Joint staff training across organizations
Level 3. Integrated service provision	Collaborative Capacity Instrument	Tracking and sharing information across organizations
		Shared principles, approaches, and time frames
	Social network items	Extent to which an organization coordinated with the organization on screening and assessment
		Extent to which an organization coordinated with the organization on RPG program referrals
		Extent to which an organization coordinated on cases or case management with another organization
		Extent to which an organization coordinated with another organization to provide substance use disorder treatment
		Extent to which an organization coordinated with another organization to provide mental health and trauma services
		Extent to which an organization coordinated with another organization to provide other social and family services

APPENDIX B.

NAMED PROGRAMS AND PRACTICES OFFERED BY RPG4 PROJECTS

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Table B.1. Named programs and practices offered by RPG4 projects

Named program/practice	AK	AL	DE	FL	IA	IL	IN	KS	KY	MO	OH	OK	TN	VT	WA	WI	WV	All
Family strengthening																		
Attachment and Biobehavioral Catch-Up												✓						1
Celebrating Families																✓		1
Engaging Parents Protocol				✓														1
Family Group Decision-Making														✓				1
Healthy Families of America			✓										✓					2
HomeBuilders				✓											✓			2
Incredible Years															✓			1
Look Up and Hope							✓											1
Nurturing Parenting Program			✓				✓	✓	✓	✓	✓		✓			✓		8
Promoting First Relationships															✓			1
SafeCare		✓													✓			2
Strengthening Families Program								✓						✓				2
Triple P															✓			1
Substance use disorder treatment																		
Contingency management						✓										✓		2
Dialectical behavioral therapy													✓			✓		2
Hazelden Co-occurring Disorders Program													✓					1
Helping Men Recover								✓		✓								2
Helping Women Recover		✓						✓		✓								3
Living in Balance								✓	✓	✓								3
Medication-assisted treatment											✓				✓			2
Mind-Body Bridging Substance Abuse Program							✓											1
Motivational support program				✓														1
Relapse prevention therapy							✓											1
Seeking Safety									✓				✓			✓	✓	4

Table B.1 (continued)

Named program/practice	AK	AL	DE	FL	IA	IL	IN	KS	KY	MO	OH	OK	TN	VT	WA	WI	WV	All
Trauma and behavioral health																		
Attachment-based family therapy					✓													1
Attachment, Regulation, and Competency (ARC) framework														✓				1
Child–parent psychotherapy													✓					1
Cognitive behavioral therapy/trauma-informed cognitive behavioral therapy					✓	✓									✓			3
Ecosystemic family structural therapy																	✓	1
Eye movement desensitization and reprocessing					✓								✓					2
Family Behavior Therapy													✓					1
Filial therapy																✓		1
Functional Family Therapy															✓			1
LifeSpan Integration					✓													1
McGill Action Planning System														✓				1
Motivational interviewing						✓			✓						✓	✓	✓	5
Parent-child interactive therapy					✓										✓			2
Play therapy					✓											✓		2
Trauma Recovery and Empowerment Model							✓											1
Case management and navigation																		
Team decision-making	✓																	1
Total	**1**	**2**	**2**	**3**	**6**	**3**	**5**	**5**	**4**	**4**	**2**	**1**	**8**	**4**	**10**	**8**	**3**	**71**

Sources: RPG4 spring 2018 semiannual progress reports and calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic technical assistance providers occurring from December 2017 through April 2018.

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