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

Partnering to Reduce Substance Use and Child Maltreatment:

2014 Regional Partnership Grants Final Report

U.S. Department of Health and Human Services

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Partnering to Reduce Substance Use and Child Maltreatment:

2014 Regional Partnership Grants Final Report

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Executive Summary

Adult substance misuse contributes to high rates of child maltreatment, adverse parenting practices, and poor child well-being outcomes (Cole, Burnett, and Strong 2021). To improve collaboration across child welfare, substance use disorder (SUD) treatment, and other service systems, Congress has, since 2006, authorized the Children's Bureau (CB) in the Administration for Children and Families, U.S. Department of Health and Human Services, to fund discretionary grants to partnerships working with families that included adults with diagnosed or potential substance use disorders and children at risk of maltreatment. CB first awarded these Regional Partnership Grants (RPGs) in 2007 (referred to as RPG1), and funded a second and third cohort of partnerships in 2012 and 2014 (referred to as RPG2 and RPG3, respectively).

RPG allows each local partnership to determine the best ways to meet the needs of the families it focuses on by selecting and implementing programs and services to meet these needs. Partnerships evaluate their own local programs and also participate in a national cross-site evaluation. This report uses data from the cross-site evaluation to describe the caseloads, partnerships, planned services, implementation experiences, and family outcomes for each of the four RPG3 projects CB funded in 2014. Table ES.1 briefly summarizes information about each project.[1]

Table ES.1. RPG3 projects, grantee agencies, location and service area, and total cases enrolled

Project	Grantee agency	State	Location and service area	Total number of cases enrolled*
Miami-Dade IMPACT Project	Our Kids of Miami-Dade/Monroe, Inc. (Our Kids)	Florida	Location: Miami Service area: Miami-Dade County	91
Kansas Serves Substance Affected Families (KSSAF)	University of Kansas Center for Research, Inc./School of Social Welfare (UKS)	Kansas	Location: Lawrence Service area: six locations in the state	303
Enhanced Family Treatment/ Rehabilitation (FT/R)	Montefiore Medical Center (Montefiore)	New York	Location: Bronx Service area: Bronx	84
Family Recovery Support (FRS)	Volunteers of America Oregon (VOAOR)	Oregon	Located: Portland Service area: Multnomah County	103

*For the RPG cross-site evaluation, a case is defined as the group of people who present themselves together as a unit for enrollment in RPG, whether or not they all live in the same household.

Because there were four projects in the RPG3 cohort, compared with 17 in RPG2 and more than 50 in RPG1, this report can describe in depth each project and the services it offered families, the characteristics of families it enrolled, partnership members and implementation experiences, and family outcomes.[2]

[1] The Children's Bureau funded new cohorts of grantees in 2017, 2018, and 2019. Future reports will describe these cohorts, and provide information on them from the national cross-site evaluation.

[2] The number of grant awards made in each cohort depended on the amount of funding available, the size of the awards the Children's Bureau planned to offer, and the number of grant applications submitted. A separate study did pool data from three of the four RPG3 grantees to estimate program impacts (Cole, Burnett, and Strong 2021).

- To plan and implement their projects, each grantee engaged five to eight other organizations as members of their RPG partnerships. As required by CB, every partnership included the state or local child welfare agency. Three grantees also partnered with behavioral health providers, and all four included one or more other public agencies or community-based organizations.
- To meet the needs of the families in their target populations, each project offered adults a single service or combination of services from the grantee agency or through their partners. Examples of these services are parent education, skills training, or support programs; SUD treatment; counseling; support from a peer specialist with relevant lived experience; and trauma screening and/or interventions designed to reduce the symptoms of trauma.
- Grantees focused on serving families that were at various stages of involvement with child welfare and/or SUD treatment. Two projects enrolled families in which an adult had a possible or diagnosed SUD, and the family was involved with child welfare, but no children had been removed from the home. One enrolled adults who had a young child already in foster care. The fourth project planned to enroll adults once they completed SUD treatment, broadening enrollment beyond this group midway through the grant to fill more program slots. The adults had to have one or more children at risk of maltreatment, whether or not they were already involved with the child welfare system.
- The biological parents each project enrolled in RPG were ethnically and racially diverse, yet most of them (89 percent) spoke English at home. The proportion who were Hispanic or Latino ranged from 16 percent to 57 percent depending on the project. The proportion who were non-White or identified with more than one race ranged from 25 percent to 72 percent.[3] This variation reflected the demographics of each project's service area and, to an extent, its chosen target population. Three-quarters or more of the biological parents in each project were female, and their average ages ranged from 27 to 33. Between 40 and 81 percent were unemployed at the time of enrollment.

Cross-cutting findings from analysis of the the partnerships and programs, the families each project enrolled and served, family outcomes, and the local evaluations are shown in Table ES.2. There are four main themes or takeaways for the Children's Bureau and future RPG projects, also shown in Table ES.2.

[3] Non-Whites were those who identified as Black or African American; American Indian or Alaska Native; Asian; or Native Hawaiian or Pacific Islander. The proportion of biological parents enrolled in RPG who identified as Black or African American was 12 percent in Kansas, 15 percent in Oregon, 37 percent in Florida, and 60 percent in New York.

Table ES.2. Findings and main takeaways from cross-project comparisons

Topic and findings	Main takeaways
Partnerships	
Partnerships were relatively small, and one or two partners provided core RPG services.	Close relationships with child welfare helped the RPG3 projects succeed.
Child welfare system agencies were partners in all four projects and played a central role in three of them.	
In two projects, the RPG evaluation addressed questions of direct interest to the state or local child welfare system.	
SUD treatment providers and/or behavioral health organizations were also key partners.	
Program models	
All four RPG3 projects offered parenting programs and support for SUD recovery.	
Model developers directly supported implementation and model fidelity for two projects.	
Enrollment and retention	
Three projects received referrals to RPG as part of their respective child welfare systems' operations, and their preexisting relationships within the systems helped these projects achieve their enrollment targets.	Projects must be proactive and persistent in addressing enrollment and retention challenges.
All four RPG3 projects diagnosed and proactively addressed enrollment shortfalls.	
Projects monitored retention and developed and tested strategies to improve it.	
Families served	
The safety and permanency of children at baseline differed for each project, reflecting its chosen target populations and the project's relative success in enrolling families with the desired characteristics.	Evaluation measures need to be interpreted in context.
Similarly, projects' different approaches to identifying families with adult substance use issues were reflected in differing rates of participation in SUD treatment and substance use, both before and after enrollment.	
Outcomes	
Similar to findings from the RPG2 cross-site evaluation (HHS 2020a), most outcomes for RPG3 participants improved between RPG enrollment and exit.	
There were some exceptions to these favorable outcomes.	
Positive and negative outcomes need to be interpreted with caution given the small samples from each project and the exclusion of comparison group data from the outcome analysis in this report.	
Evaluations	
RPG3 projects were strongly motivated to conduct rigorous evaluations, and all four did so successfully.	Projects should carefully balance their program and evaluation goals.
RPG3 shows some of the trade-offs between selected program approaches and the evidence evaluations can produce.	

I. Introduction

Beginning as far back as 1999 with a report led by six federal agencies, the intersection of adult substance misuse[4] and child welfare has been recognized as a major factor in child neglect and abuse, and as one of the formidable barriers to family reunification (U.S. Department of Human Services [HHS] 1999). Nearly two decades later, these findings are echoed in a study sponsored by HHS's Office of the Assistant Secretary for Planning and Evaluation (ASPE). The study (Ghertner et al. 2018; Radel et al. 2018) explored potential reasons for a 10 percent increase in the number of children who entered foster care after a decade of sustained declines in the foster care caseload. It also found an association between drug overdose deaths and drug-related hospitalizations and measures of the child welfare caseload.

Both the 1999 report and the 2018 study identified barriers that prevented families in the child welfare system from accessing substance use disorder (SUD) treatment.[5] Both reports also described barriers to collaboration between the child welfare and treatment systems that impeded efforts to meet the needs of affected families. And both studies described the difficulty that families face in navigating competing timelines for SUD treatment and child welfare services.[6]

To support better collaboration across the child welfare system, SUD treatment, and other systems, Congress since 2006 has authorized the Children's Bureau (CB) in HHS's Administration for Children and Families (ACF) to fund discretionary grants to improve the safety, well-being, and permanency outcomes for children who are either at risk of, or already in, out-of-home placement because of their caregivers' substance misuse. CB awarded the first Regional Partnership Grants (RPG) in 2007 and funded a second cohort in 2012. In 2012, CB contracted with Mathematica to conduct a national cross-site evaluation of the RPG program. In October 2014, CB funded the third RPG cohort, awarding 5-year grants to four partnerships. All four partnerships participated in the ongoing cross-site evaluation of RPG. In 2017, Mathematica published an interim report on the 2014 grantees' progress (Xue et al. 2018). The present report is the final cross-site evaluation report on this third cohort of grantees, referred to as RPG3.[7]

[4] This report uses clinical, non-stigmatizing language as set forth in a surgeon general's report (HHS 2016) and as recommended by the Office of National Drug Control Policy (Botticelli 2017), except when sources cited used other terms. Substance misuse is 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 would constitute misuse (for example, under-age drinking, or injection drug use).

[5] Substance use disorder is a medical illness caused by repeated misuse of a substance or substances.

[6] Access to treatment depends on the following: the timely assessment of a substance use disorder, the availability of slots in appropriate treatment programs or facilities, and, for most people, coverage by Medicaid or private insurance to pay for treatment. One or more courses of treatment are often necessary, and relapse is often part of the process of recovery. The Adoption and Safe Families Act of 1997 (Pub. L. 105-89) 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; that number of months is often too short a period for adults to access and complete the necessary treatment services and recovery periods.

[7] Mathematica has also published a peer-reviewed journal article that describes findings from an impact study using pooled data from three of the RPG3 grantees (Cole, Burnett, and Strong 2021: https://doi.org/10.1016/j.chiabu.2021.105069).

A. Overview of the RPG3 projects

Of the four RPG3 grantees, each of which is the lead agency that was awarded the grant, one is a university, and three are local service providers (Table I.1). They and their partners worked together to design their RPG projects, recruit families to participate, provide services, and evaluate their projects.

Table I.1. RPG3 projects, grantee agencies, and the geographic areas they served

Project	Grantee agency	State	Location and service area
Miami-Dade IMPACT Project	Our Kids of Miami-Dade/Monroe, Inc. (Our Kids)	Florida	Location: Miami Service area: Miami-Dade County
Kansas Serves Substance Affected Families (KSSAF)	University of Kansas Center for Research, Inc./School of Social Welfare (UKS)	Kansas	Location: Lawrence Service area: Six locations in the state
Enhanced Family Treatment/ Rehabilitation (FT/R)	Montefiore Medical Center (Montefiore)	New York	Location: Bronx Service area: Bronx
Family Recovery Support (FRS)	Volunteers of America Oregon (VOAOR)	Oregon	Located: Portland Service area: Multnomah County

Along with their partners, RPG3 grantees provided a variety of services to children and their caregivers. Services included, for example, parenting education or skills training programs, referral to SUD treatment or other needed services, counseling, support from peer specialists, and trauma interventions and/or trauma screening. One project offered a drop-in center as a hub for all services.

As the grant required, each partnership included the state or county child welfare agency as a partner. In addition to child welfare agencies, the most common members of RPG3 partnerships were state SUD treatment agencies and local treatment providers, and nonprofit or private child welfare service providers. Two of the four projects built their partnerships from existing community collaborations or partnerships focused on child welfare. One project included agencies that had also partnered under the first cohort of RPG grants awarded in 2007 (RPG1). Two partnered with the developer of the primary evidence-based or evidence-informed program or practice models (EBP) that they implemented under RPG.

B. Data sources and the adults and children in the analytic sample

This cross-site evaluation report on the RPG3 cohort uses data from a variety of sources on the full sample of families enrolled in the cross-site evaluation, which includes nearly all of those served by the RPG3 projects. For this report's analytic sample, projects collected detailed data on one or two adults and one child in each enrolled family. Mathematica also collected data on the partnerships and on implementation of the projects.

1. Data sources

The data for this report come from several sources used in three studies that were part of the cross-site evaluation. Mathematica collected some of the data directly, but grantees also provided much of the data for the cross-side evaluation (they could also use these data for their local evaluations). More information about data sources and the overall design of the cross-site evaluation appears in the RPG cross-site evaluation design report (Strong et al. 2014).

A **partnership study** was based on data from the following: a survey of representatives from each grantee and its partner agencies, information collected during site visits to each partnership, and data from progress reports filed twice each year by grantees. The study examined the extent and quality of collaboration among the partners, and progress toward cross-systems service coordination and integration. HHS (2019) presents aggregate partnership study findings from the four RPG3 projects.

An **implementation study** examined both the characteristics of RPG enrollees and how their core project elements, mainly the EBPs they expected to provide to all or most participants, were implemented. The goal was to understand (1) whether the partnerships reached their intended target populations; (2) whether EBPs were implemented according to certain best practices referred to as implementation drivers, as developed in implementation science (Fixsen et al. 2013; 2015); (3) the families' enrollment and participation in planned EBPs; and (4) the content received by families that participated in selected EBPs. The implementation study drew on data from site visits, a survey of staff who implemented the EBPs, and a web-based data collection system called the enrollment and services log into which grantees entered enrollment and participation information. Aggregate findings from the analysis of the implementation of EBPs are also included in the RPG Sixth Report to Congress (HHS, forthcoming). Findings from other components of the implementation study are presented in this report.

An **outcomes study** compared certain characteristics of adults and children at RPG enrollment and exit to measure whether changes occurred in up to five outcome domains: adult recovery, family functioning, and child safety, permanency, and well-being. In Table I.2, we show the constructs measured for the outcomes study in each domain and the source of data to measure the construct. The outcomes study used administrative data that grantees obtained from state child welfare and substance use treatment agencies, along with data from standardized instruments that grantees administered to one or more adults in each RPG family.[8] Grantees uploaded these data into the Outcome and Impact Study Information System (OAISIS). In this report, we detail outcomes for each project.

[8] A standardized test or instrument is one that requires all respondents or test takers to answer the same questions or a selection of questions from a common set or bank of questions in the same way. The test or instrument is also scored in a standard manner, making it possible to compare the relative performance of individuals or groups.

Table I.2. Constructs measured for the RPG cross-site evaluation outcomes study

Domain	Constructs	Source
Adult recovery	Severity of substance use	Addiction Severity Index (ASI), Self-Report Form (McLellan et al. 1992)
	Trauma symptoms	Trauma Symptoms Checklist-40 (TSC-40) (Briere and Runtz 1989)
	Substance use services received (treatment)	Administrative data on treatment for substance use
	Type of discharge from treatment	Administrative data on treatment for substance use
Family functioning	Depressive symptoms	Center for Epidemiologic Studies Depression Scale (CES-D), 12-Item Short Form (Radloff 1977)
	Parenting skills	Adult-Adolescent Parenting Inventory (AAPI-2) (Bavolek and Keene1999)
	Parent stress	Parental Stress Index–Short Form (PSI-SF) (Abidin 1995)
Child safety	Screened-in referral to child protective services	Child welfare administrative data
	Type of allegation	Child welfare administrative data
	Disposition of allegation	Child welfare administrative data
	Death	Child welfare administrative data
Child permanency	Removals from family of origin	Child welfare administrative data
	Placements	Child welfare administrative data
	Type of placement	Child welfare administrative data
	Discharge	Child welfare administrative data
Child well-being	Trauma symptoms	Trauma Symptom Checklist for Young Children (TSCYCY) (Briere et al. 2001)
	Executive functioning	Behavior Rating of Executive Function (BRIEF) and Behavior Rating of Executive Function–Preschool (BRIEF-P) (Gioia et al. 2000)
	Behavior	Child Behavior Checklist (CBCL)–Preschool Form and Child Behavior Checklist–School Age Form (Achenbach and Rescorla 2000; 2001)
	Sensory processing	Infant-Toddler Sensory Profile (ITSP) (Dunn 2002)
	Social and adaptive behavior	Socialization Subscale, Vineland Adaptive Behavior Scales, Second Edition, Parent-Caregiver Rating Form (Vineland-II; Sparrow et al. 2005)

2. Family members in the analytic sample for the outcomes study

For the cross-site evaluation, grantees collected outcomes data on one child in each family that enrolled in RPG even if more children in the family were part of the RPG *case* (defined as the group of people who presented themselves together as a unit for enrollment in RPG, whether or not they lived in the same household). This child is referred to as the focal child. A main reason for limiting outcome data to a single child in each family was to obtain detailed, in-depth information on outcomes of interest without overburdening the grantees and the families by asking them to obtain and provide data on more than one

child. Although safety and permanency data came from administrative sources, data on child well-being came from the child's parent or, if the child was not in the care of her or his parent for at least 30 days before the data were collected, from the adult who was the caregiver of the child during that time.

For the cross-site evaluation, RPG projects also collected outcomes data on adults in the RPG cases, depending on their relationship to the focal child and their participation in project services. Nearly every adult enrolled in an RPG project was a biological parent of a focal child, as discussed in Chapter II. If two biological parents of the focal child were enrolled, then the one who was the focal child's primary caregiver completed standardized instruments providing data on the focal child. That adult was also administered the instruments in the family functioning domain. If that adult was also the one who received RPG services, then she or he was also administered the recovery domain instruments. If not, then grantees administered the recovery domain instruments to the enrolled adult. In 98 percent of families in the analytic sample, the same adult was administered the family functioning and recovery instruments.

C. Limitations

The final report on the RPG2 cohort of partnerships (HHS 2020a) combined data from all 17 partnerships that received RPG grants in 2012 to provide an aggregate picture of RPG. Because only four projects received funding in 2014, the present report is able to provide a more detailed analysis and description of each project. It builds on findings from the RPG2 cohort but also provides a different perspective, with additional implications for partnership, program, and evaluation strategies as described in the final, synthesis chapter. However, several limitations affect the findings presented in the report.

- To describe the implementation experiences of the RPG3 projects, we primarily used data from site visits, which were limited to one visit per site. The site visits focused on changes in the implementation of the EBPs. Because there was only one visit per site, this report may not fully capture EBP implementation if changes took place after the visit and were not described in the other data sources.
- To examine outcomes, we analyzed data provided by the grantees on their enrollees. Although some of the projects also collected data from comparison groups, these data are not part of the outcome analysis. Because we did not compare outcomes in the program group to outcomes in a comparison group, we cannot attribute positive or negative changes described in this report to RPG. The lack of comparison group data is important to keep in mind when considering some unfavorable outcomes that will be described in this report, such as the lack of improvement in some measures for some projects. For instance, it is possible that RPG services prevented declines in these measures that might have occurred among children whose parents did not receive RPG services. To fill the gap in comparison data, Mathematica conducted a separate impact analysis using program and comparison group data from three of the four grantees (Cole, Burnett, and Strong 2021).
- Grantees and their evaluators enrolled families in their local evaluation into the cross-site evaluation. Kansas accounted for over 300 families in its evaluation, but the sample sizes for the other projects were smaller either by design or as a result of unexpected difficulties in recruiting families into the projects, as described in each chapter. Small sample sizes make it less likely to find statistically significant differences between outcome measures at enrollment (baseline) and follow-up (program exit), which is another possible explanation for the lack of improvement in some measures.

D. Organization of the report

In the next chapter, we describe the target populations selected by each grantee, including the demographics of the focal children and of the adults who are caregivers of the focal child in each family. The chapter shows how enrollees differ across the four RPG3 projects. In Chapters III through VI, we present evaluation findings for each RPG3 project, such as the members and structure of the partnerships, services offered, the partnerships' experiences in implementing their RPG projects and providing services to enrolled families, and family outcomes. In Chapter III, we examine the Miami-Dade IMPACT Project; in Chapter IV, we look at the Kansas Serves Substance Affected Families (KSSAF) project; in Chapter V, we consider the Montefiore Medical Center Enhanced Family Treatment/Rehabilitation (FT/R) program; and, Chapter VI, we examine the Volunteers of America Oregon's (VOAOR) Family Recovery Support (FRS) program. We synthesize the findings across the four projects in Chapter VII and discuss four main takeaways.

II. Background

The Child and Family Services Improvement Act of 2006 (P. L. 109-288), which established the RPG program, focused broadly on families in which adults had either a diagnosed SUD or potential substance misuse issues that might put the children in their care at risk for maltreatment and removal from their homes.[9] The RPG program was motivated in part by the recognition, emerging since about 1999 (HHS 1999), that such families often become involved in both the SUD treatment system and the child welfare system. One or both of these systems acting alone cannot effectively address these families' needs. Each RPG project specifically defines a local population of need and selects one or more programs to provide services to that population.

In this chapter, we place the 2014 partnerships in context by giving background on each partnership and reporting the distinct characteristics of each. In Section A, we describe the target populations and service offerings of the four partnerships. In Section B, to describe the participants enrolled by the partnerships, we use the demographic data collected from RPG participants by the grantee agencies at the time of participants' program enrollment.

A. Target populations and proposed service models

RPG was broadly designed to work with families that are involved with the child welfare system—or at risk of becoming involved—as a result of a parent's or caregiver's SUD or substance misuse. The four RPG3 projects served families with a continuum of needs within the broader RPG target population (Table II.1). The project-specific target groups varied along two dimensions: (1) the status of the adult's substance issue, identification, or treatment and (2) the maltreatment risk or child welfare status of children.

Adult substance issue. Projects focused on serving adults at different levels of risk for substance misuse or at different phases of addressing an SUD. The Miami-Dade IMPACT Project in Florida and the KSSAF project in Kansas sought to enroll families in which an adult had a suspected or verified substance use problem, whether or not the individual was in treatment. Montefiore Medical Center in New York planned to serve families in which an adult was currently in or needed treatment for SUD. The FRS project in Oregon aimed to serve families with an adult who had completed or was close to completing SUD treatment.

Child maltreatment risk or child welfare status. The child maltreatment risk and child welfare status of children also varied depending on the project. Three projects (the Miami-Dade IMPACT Project, Montefiore's RPG enhanced FT/R project, and the Oregon FRS project) served families in which children were either in, or at risk of involvement with, the child welfare system or out-of-home placement. KSSAF, on the other hand, exclusively served families with a child already in out-of-home care, but whose cases had a goal of family reunification.

[9] As defined by the Surgeon General (HHS, 2016), substance use disorder (SUD) is a medical illness caused by repeated misuse of a substance. It is characterized by clinically significant impairments in health and, social function, and impaired control over substance use. Substance misuse is the use of any substance in a matter, situation, amount, or frequency that can cause harm to users or to those around them.

Table II.1. Target population and program focus of each RPG3 project

State and RPG project	Target population	Program focus
Florida: Miami-Dade IMPACT Project	Families in which an adult had a suspected or verified substance use problem and that included children from birth through age 11 who were referred through the child protective investigation process for diversion or prevention	Families had access to a suite of services consisting of (1) Multi-Dimensional Family Therapy-Family Recovery (MDFT-FR; formerly known as the Engaging Moms/Parenting Program), (2) engagement with a peer specialist, and (3) referral to the area's Motivational Support Program.
Kansas: KSSAF	Families in which a member had a suspected or verified substance use problem and there were children up to age 47 months in foster care or at risk of out-of-home placement	Families received the Strengthening Families Program: Birth to Three (SFP B–3).
New York: Enhanced FT/R	Families in which a member with indicated or diagnosed SUD and with open and indicated child welfare cases in which children were at risk for removal	Families participated in the existing Family Treatment/Rehabilitation (FT/R) program but also received three program enhancements: Seeking Safety, Incredible Years, and contingency reinforcement.
Oregon: FRSP	Parents who had completed SUD treatment and were in recovery from SUD and who were either engaged with or at risk of engagement with child welfare	Families became part of a recovery-oriented system of care. Participants were matched to a certified peer recovery mentor if requested; some also worked with a resource specialist and/or a therapist.

Source: RPG3 grant applications, 2014.

Note: SUD = substance use disorder.

B. Services

To meet of the needs of their target populations, the projects offered a range of services. These included, for example, parenting education or skills training programs, referral to SUD treatment or other needed services, counseling, support from a peer specialist, and trauma interventions and/or trauma screening. Service offerings by the projects included at least one EBP, as required by CB. Two of the projects offered more than one EBP. The four projects were:

- The Miami-Dade IMPACT Project offered the Multi-Dimensional Family Therapy-Family Recovery (MDFT-FR) program, a home-based family-strengthening program. The aim of MDFT is to help an entire family, not just parents with substance use issues, by addressing the factors that might lead to children's removal from the household.
- KSSAF delivered the Strengthening Families Program: Birth to Three (SFP B–3). SFP B–3 is a family skills training program focused on increasing resilience and reducing risk factors in behavioral, emotional, cognitive, and social domains. It was an adaptation of Strengthening Families, which is an EBP.
- Montefiore's RPG project offered participants two EBPs: an Incredible Years Parenting Class and Seeking Safety. The latter treats co-occurring post-traumatic stress disorder and SUD. Combined with contingency reinforcement, the project aimed to reduce maltreatment risk and treat adult SUD.

- VOAOR implemented a recovery-oriented system of care. Its FRS program matched families with a certified peer recovery mentor if requested. Peer recovery mentors are people who have maintained recovery from SUD. Families could also work with a resource specialist and/or therapist, and they received one or more services from a menu of optional programs and services.

The cross-site evaluation collected detailed data on one EBP for each RPG3 project (identified in Table II.2).[10] The EBPs (MDFT-FR, SFP B–3, Seeking Safety, and the Nurturing Parenting Program) provided SUD treatment or mental health services, parenting and life skills training, and services to promote family stability. (More information about RPG projects is in Chapters III through VI.)

The EBPs, which are described in more detail in Chapters III through VI, ranged from 10 to 17 weeks in length and were offered either in group sessions or at home, varying by project. The EBPs were voluntary for participants, although a court ordered some participants to engage in child welfare or SUD treatment programs. Participants legally mandated to engage in services had the option to choose a treatment provider. The provider could be part of the RPG project or another agency.

Table II.2. EBPs examined in depth for the RPG3 cross-site evaluation

State and RPG project	Name of focal EBP	Purpose	Characteristics of persons the EBP was designed to serve				
			Family or parent focus	SUD	Age of children	Families at risk of child welfare involvement	Families with child welfare involvement
Florida: IMPACT Project	Multi-Dimensional Family Therapy–Family Recovery (MDFT-FR)	Family strengthening	Family	Family members with suspected or verified SUD	Under age 12	X	
Kansas: KSSAF	Strengthening Families Program Birth to Three (SFP B–3)	Life and parenting skills	Family	Parents with SUD	Birth to age 3	X	X
New York: Enhanced FT/R	Seeking Safety	SUD and trauma treatment	Parent	Parents with SUD	Not specified	X	X
Oregon: FRSP	Nurturing Parenting Program	Parenting skills	Parent	Parents receiving SUD treatment; emphasis on African American parents	Not specified	X	X

Source: RPG site visits, fall 2017.

Note: EBP = evidence-based program or practice.

C. Demographics of RPG3 participants

Each partnership set its own goals for the number of people to serve. The Kansas RPG project offered services in several locations in the state, and, as such, its planned enrollment was at least double that

[10] Given that partnerships offered many EBPs, the cross-site evaluation selected a subset, which included one EBP implemented by each RPG grantee for intensive study. RPG sites provided additional data on these focal EBPs.

expected by the other three grantees. The Kansas goal was to enroll 400 to 480 families over the five years of the grant. Florida, New York, and Oregon set initial goals of 144, 100, and 200 families, respectively. As Table II.2 shows, actual enrollment fell somewhat short of the goals of all four projects. The Florida, New York, and Oregon RPG partnerships enrolled 91, 84, and 103 families in the cross-site evaluation, respectively; Kansas enrolled 303 families.

For several potential reasons, the number of participants that each partnership enrolled in the cross-site evaluation differed somewhat from the partnership's original plans. Some partnerships conducted pilot phases or began program operations before they finished their evaluation plans and began enrollment in the evaluation. Further, they might have experienced enrollment delays, could have overestimated the size of the target populations in their planned service areas, or could have faced a combination of these obstacles. In addition, some projects may have served families that declined to enroll in the cross-site evaluation, making the reported number of enrolled families lower than the number of families served.

Each grantee defined a rule for selecting a focal child about whom to collect detailed data for the cross-site evaluation. The members of each RPG case were then identified in the data by their relationship to that focal child. Nearly all (99 percent) of the families included in the cross-site evaluation data (referred to as the evaluation analysis sample) included one or two biological parents of that child. Examining the characteristics of those enrolled by each partnership, and how they differed, helps in understanding information about implementation and outcomes presented for each project later in the report.

1. Adult demographics

In Table II.3, we show demographic characteristics for one biological parent in each family; in Table II.4, we show education, income, and employment characteristics for the same biological parent. When there were two biological parents enrolled in RPG (which occurred in 21 percent of all RPG families), we used data from the biological parent who identified herself or himself as the caregiver of the focal child. Although the majority of biological parents enrolled in RPG were women in all projects, the percentage of women ranged from 78 percent in Oregon to 98 percent in Florida. The average age of parents at the time of enrollment was similar across the projects, ranging from age 27 in Kansas to age 33 in Oregon.

Both race and ethnicity varied, reflecting the demographics of each partnership's service area and, to an extent, its target population. Sixty percent of adults in the evaluation analysis sample for New York reported their race as Black or African American, as did 37 percent in Florida. Three-quarters of the biological parents in Kansas RPG families were White. Large percentages (half or more) of adults in the Miami and New York projects were Hispanic/Latino. Only small proportions spoke Spanish as the primary language at home. Education levels were somewhat higher for the parents in the Oregon sample than for those in the other three RPG states. Almost 6 out of 10 adults in New York programs did not have a high school diploma.

RPG families faced economic challenges, though less so in Kansas. The poverty level for a family of two in 2015 was $15,930 in the 48 states (slightly higher in Alaska and Hawaii) (HHS 2015). It rose slightly each year until it was $16,910 in 2019 (HHS 2020b). From 62 to 86 percent of biological parents enrolled in the four RPG3 projects during this period reported incomes under $10,000 during the 12 months before they enrolled in RPG. Their income placed them at about two-thirds of the poverty level, although we did not collect data on whether other family members earned income. Two-thirds or more of adults enrolled in RPG projects in Florida and New York were receiving public assistance, such as Temporary Assistance for Needy Families (TANF), during the 12 months before enrollment. Forty-three percent of participants

received public assistance in Oregon. Just 8 percent received public assistance in Kansas, where 57 percent of adults in RPG were employed at some time during the 12-month pre-enrollment period. Except for the case of the Kansas project, at least 70 percent of adults served by each project were unemployed at the time of enrollment; in Kansas, 39 percent of adults served by the project were unemployed.

Table II.3. Demographic characteristics of biological parents enrolled in RPG3

	Percentage, unless otherwise noted			
Characteristic	**Florida**	**Kansas**	**New York**	**Oregon**
Total number of cases enrolled[a]	91	303	84	103
Average age at enrollment into RPG (years)	30	27	32	33
Gender				
Female	98	85	90	78
Race[b]				
White only	62	75	28	64
Black or African American only	37	12	60	15
American Indian or Alaska Native, Asian, or Native Hawaiian or Pacific Islander	0	2	9	8
More than one race	1	12	3	13
Ethnicity[c]				
Hispanic/Latino	57	16	50	25
Not Hispanic/Latino	43	84	50	75
Primary language spoken at home				
English	89	98	91	99
Spanish	11	1	9	1
Other	0	0	0	0

Source: RPG3 Enrollment and Services Log data from April 2019.

Note: We report on one biological parent in each case for the 99 percent of cases that include a biological parent. In cases with two biological parents, we limited our analysis to the biological parent identified as the caregiver of the focal child. Because of rounding, category percentages may add to slightly more or less than 100 percent.

[a] A case is defined as the group of people who present themselves together as a unit for enrollment in RPG, whether or not they live in the same household.

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

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

Table II.4. Education, income, and employment characteristics of biological parents enrolled in RPG3

Characteristic	Percentage, unless otherwise noted			
	Florida	Kansas	New York	Oregon
Highest level of education				
Less than high school	45	37	59	27
High school diploma/GED	37	36	20	37
Some postsecondary education[a]	14	25	20	33
Bachelor's degree or higher	5	2	1	4
Income in past 12 months				
$0–$9,999	73	62	65	86
$10,000–$19,000	16	22	21	8
$19,001–$24,999	6	7	6	4
$25,000 or higher	6	9	8	2
Income sources[b]				
Public assistance	66	8	78	43
Wage or salary	22	57	16	18
Disability	9	8	19	12
Retirement or pension	0	0	0	1
Other sources	7	7	10	9
None	13	22	3	29
Employment status				
Full-time employment	9	35	4	5
Part-time employment	12	17	9	8
Self-employed	1	4	4	0
Unemployed	71	39	81	77
Not in labor force	7	4	3	10
Relationship status				
Single, divorced, separated, widowed	57	62	68	76
Married to or cohabiting with focal child's biological parent	34	28	23	15
Married to or cohabiting with other individual	9	10	10	9
Residence at enrollment				
Private residence	97	74	71	51
Treatment facility[c]	0	2	0	18
Homeless/shelter	3	8	29	14
Other residence	0	16	0	16
Sample size (varies slightly by measure because of missing data)	87–90	301–303	78–80	89–100

Source: RPG3 Enrollment and Services Log data from April 2019.

Note: We report on one biological parent in each case for the 99 percent of cases that include a biological parent. In cases with two biological parents, we limited our analysis to the biological parent identified as the caregiver of the focal child. Because of rounding, category percentages may add to slightly more or less than 100 percent.

Table II.4 (*continued*)

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

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

[c] The type of treatment, such as for substance use disorder or mental health, was not specified.

The proportion of biological parents who were married to or cohabitating with the focal child's other biological parent was highest in Florida, at 34 percent. The percentage of biological parents who were living in a private residence was also highest in Florida, at 97 percent, and in the other RPG3 projects, the rate ranged from 51 to 74 percent. Twenty-nine percent of the biological parents in the New York sample were homeless or living in shelters; 14 percent of those in Oregon were homeless or living in shelters. Oregon enrolled the highest percentage of biological parents who were in treatment facilities at the time of enrollment, at 18 percent. This aligned with their intention to serve families of adults who were completing SUD treatment.

2. Children

On average, RPG3 cases included between one and three children. The percentage of cases with one child ranged from only 33 percent in Florida to 99 percent in New York. In Table II.5, we show demographic information for the focal children. Given the burden that grantees and families would face in providing wide-ranging data to the cross-site evaluation, we limited data collection to detailed demographic and other information describing only the focal child, even if there was more than one child in a case.

The ages of focal children in the four RPG3 projects reflect target population criteria established by each partnership and the rules the partnerships used to choose a focal child in families with more than one child enrolled in RPG. Just two partnerships included children's ages in their target population criteria. Florida aimed to serve families with children from birth through age 11, and Kansas served families with children up to 47 months old (younger than 4). The average age of the focal child in Florida was 3, and in Kansas it was 1. Florida designated as the focal child the oldest child age 11 or younger who was living in the home, and Kansas designated as the focal child the youngest child. In contrast, neither New York nor Oregon included children's ages as a criterion for enrollment. The average age of focal children in New York was 7, considerably older than that in the other sites. The reason is that New York implemented the Incredible Years program, which is intended for children ages 6 through 12. The project determined that the focal child would be the child closest to age 9, the midpoint of the age range served by Incredible Years.[11] Oregon designated the focal child as the child who had spent the most time in the care of the parent receiving services.[12]

The race/ethnicity and languages spoken in the homes of focal children reflected those of the biological parents, as shown in Table II.3. Similarly, to a degree, children's living arrangements followed those of the biological parents, but these also depended on the target populations the partnerships planned to serve. For example, the Kansas project was designed to serve families with a child in foster care or at risk of removal from the home. Thus, one-third of focal children in the Kansas sample were in foster care or a group home at the time of RPG enrollment. Thirty percent of focal children were described as

[11] If more than one child's age was equidistant from 9.0 years, the youngest child was the focal child.

[12] If more than one child met the first criterion, the focal child would be the one who currently or previously had a child welfare case; if more than one child met the second criterion, the focal child would be the youngest child between the ages of 3 and 12.

experiencing homelessness in New York, where 29 percent of the biological parents in the evaluation analytic sample were also experiencing homelessness (though they were not a specific target population).

Table II.5. Characteristics of focal children in the RPG3 projects

Characteristic	Percentage, unless otherwise noted			
	Florida	Kansas	New York	Oregon
Average age (years)	3	1	7	4
Age by category				
Younger than 1[a]	35	45	13	18
1 to 4	38	55	17	44
5 to 8	16	0	35	21
9 or older	10	0	36	17
Gender				
Female	44	46	46	50
Male	56	54	54	50
Race[b]				
White only	60	66	25	62
Black or African American only	40	11	63	16
American Indian or Alaska Native, Asian, or Native Hawaiian or Pacific Islander	0	1	6	4
More than one race	0	21	6	17
Ethnicity[c]				
Hispanic/Latino	57	20	58	30
Primary language spoken at home				
English	91	98	98	99
Spanish	9	1	2	1
Other	0	1	0	0
Residence at enrollment				
Private residence	97	5	70	38
Homeless/shelter	3	0	30	10
Foster parents' residence	0	73	0	15
Foster/group home	0	6	0	18
Treatment facility	0	0	0	8
Other residence	0	16	0	12
Sample size (varies by measure because of missing data)	90–91	301–303	83–84	56–103

Source: RPG3 Enrollment and Services Log data from April 2019.

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

[a] All focal children had been born at the time the family enrolled in RPG.

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

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

III. Florida: The IMPACT Project

According to its grant application, the IMPACT Project aimed to develop a system of care to address the needs of families affected by SUD, specifically, those who were not seeking treatment and were at risk of losing their children because of abuse and neglect. Three other goals of the project were to:

1. Improve connections to and the retention of families in services.
2. Improve children's functioning and developmental outcomes, particularly related to mental health status, recovery from trauma, healthy attachment, and social development.
3. Reduce the parent's substance use and the child's risk of being maltreated, and prevent re-referral to or involvement in the child welfare system.

To work toward these goals, the grantee agency, Our Kids of Miami-Dade/Monroe Inc., collaborated with a range of partners to provide RPG-related services including Multi-Dimensional Family Therapy-Family Recovery (MDFT-FR). The target population was families in the Miami area with children ages 11 and younger who were at risk of removal from their homes. MDFT-FR is a home-based family-strengthening program.

A. Partner agencies

Our Kids oversaw the IMPACT Project and collaborated with 12 other partner agencies, including SUD treatment providers, child welfare agencies, an evaluator, and the developer of MDFT-FR. In Table III.1, we show each partner, including the type of agency and the agency's role in the project.

A local family court judge was familiar with Engaging Moms, the precursor to MDFT-FR. She knew the developer of the program and was instrumental in bringing her together with Our Kids and helping form the RPG partnership.

The grantee. Incorporated in September 2002, Our Kids was a 501(c)(3) nonprofit corporation created by the Miami-Dade and Monroe counties' child advocacy communities in response to the state's decision to privatize child welfare–related services. The advocates saw an urgent need for local leadership, oversight, and coordination of the foster care system. Our Kids oversaw a network of accredited providers of case management and other child welfare–related services. At any given time, these providers cared for and oversaw the well-being of 3,300 or more children who had been referred to Our Kids.[13]

Child welfare partner. The Florida Department of Children and Families (DCF), through the Office of Family Safety, is Florida's lead agency responsible for child protection and welfare. DCF is a privatized child welfare system; in other words, it contracts with private providers of child welfare services to deliver those services to local jurisdictions. DCF contracted with Our Kids to be the community-based organization that served as the lead agency for an integrated system of foster care and appropriate related services. DCF's child protective investigators referred families to Our Kids, including to the IMPACT Project specifically.

[13] The nonprofit organization Our Kids was incorporated in 2002 and served as the lead agency for community-based care in Miami-Dade and Monroe counties until 2019. In this role, Our Kids oversaw and directed a system of foster care services for children in the target counties under contract to the Florida Department of Children and Families. In 2019 the Florida Department of Children and Families shifted funding to a different agency, and Our Kids is no longer operating.

Table III.1. Main partner agencies in the IMPACT Project

Partner agency	Type of agency	Role in the RPG project
Our Kids of Miami-Dade/Monroe Inc.	Child welfare services provider	Grantee; received referrals to RPG and enrolled participants
Florida Department of Children and Families	State child welfare agency	Referred families to Our Kids of Miami-Dade/Monroe Inc., including for the IMPACT Project
South Florida Behavioral Health Network	Network of behavioral health treatment providers	Provided oversight and contract monitoring for numerous SUD treatment providers that were part of the project
Federation of Families, Miami-Dade Chapter, Inc.	Service and training provider	Provided project services such as peer support
Family Central Inc.	Child welfare services provider	Provided intensive family preservation services to families that participated in the project's local evaluation
AGAPE Network; The Village, Drug Addiction Treatment Center; Jessie Trice Community Health Center; Jefferson Reeves (Reeves House); Concept Health Inc.	SUD treatment providers	Provided treatment to parents; The Village Drug Addiction Treatment Center also became the provider of MDFT-FR
Community Based Care (CBC) Alliance	Child welfare community advisory group	Provided assistance and oversight to project operations
University of Miami/MDFT International	EBP developer	Licensed MDFT-FR to the project and provided training, technical assistance, and supervision for its implementation
University of South Florida, Department of Child and Family Studies	Evaluator	Evaluated and analyzed data and records to determine project outcomes

Notes: EBP = evidence-based program; MDFT-FR = Multi-Dimensional Family Therapy-Family Recovery; SUD = substance use disorder.

EBP developer. Gayle Dakof, Ph.D, was on the faculty of the University of Miami Miller School of Medicine, Department of Epidemiology and Public Health. She is the developer of MDFT-FR (and its precursor Engaging Moms) and is a licensed clinical psychologist. She is also an independent consultant providing training in MDFT-FR.

Evaluation partner. Our Kids engaged the University of South Florida Department of Child and Family Studies (CFS), Louis de la Parte Mental Health Institute, to evaluate the IMPACT Project.

Other partners. Our Kids also collaborated with a range of agencies that families could be referred to for needed children's or family services, but the agencies were not members of the partnership and are not shown in Table III.1).

B. Target population

Families were referred to the IMPACT Project as part of the child protective investigation process. To be eligible, families (1) had to be determined as "high to very high risk—with no safety threat" or "moderate to very high risk—and conditionally safe" through the investigation process conducted by DCF and (2) have suspected substance use or verified substance use indicators as assessed by the local DCF child welfare agency. In addition, families were eligible for the project if they did not have an open case in

dependency court (the court that makes determinations about whether children will be removed from the home). In other words, children would not have been removed from the family, and removal was not in process.

The IMPACT Project collaborators chose the target population in response to an investigation and report by the *Miami Herald* about a spike in children's deaths in child welfare cases involving substance use. The project leaders wanted to intervene with families at the beginning of their involvement with the child welfare system, before DCF removed children from their homes.

C. Intervention

The IMPACT Project delivered MDFT-FR. The aim of MDFT-FR is to help an entire family, not just parents with substance use issues, by addressing the factors that might lead to the removal of children from the household. Therapists work with the families, and, later during the program, peer support specialists typically meet with families three times a week to support each family's case management needs. (Peer support specialists have undergone training to support people with mental health, psychological trauma, or substance misuse and have "lived experience" with those issues.) Staff referred families to other services they needed, such as housing or transportation, or to children's services. Therapists who worked with the families also followed up with them to make sure the services families were getting fulfilled their needs.

The IMPACT Project's evaluation used a randomized controlled trial design to examine the effect of adding the Multi-Dimensional Family Therapy model to business-as-usual services. Thus, families eligible for the project were randomly assigned to either the RPG program of services or a comparison group. Members of both the treatment and comparison groups received referrals to SUD treatment and intensive family preservation services. For the treatment group, intensive family preservation services lasted for 16 weeks. For the comparison group, intensive family preservation services lasted for 9 weeks. Members of the treatment group also received Multi-Dimensional Family Therapy and support from a peer specialist.◢

D. RPG families at baseline

By April 2019, 91 families had enrolled in the IMPACT Project. Consistent with the criteria for the target population, nearly all focal children (98 percent) had at least one report of maltreatment in the year before enrollment, though none of the children were removed from the home during the year. The high rate of maltreatment at program entry was a byproduct of Miami's referral and enrollment process, whereby families were referred to RPG following a child protective services investigation. In turn, the fact that none of the children were removed from their homes reflected the program's intention to work with families before removal became necessary.

Fifteen percent of focal children presented post-traumatic stress symptoms.[14] In addition, nearly half (47 percent) of infants showed atypical sensory processing.[15] Atypical sensory processing can reflect either

[14] The Trauma Symptom Checklist for Young Children (TSCYC) is a standardized instrument that measures trauma symptoms in children ages 3 to 12 (Table I.2). According to the TSCYC user manual, total scores in the highest range indicate the presence of symptoms of post-traumatic stress disorder.

[15] The Infant-Toddler Sensory Profile (ITSP) is a standardized instrument that measures sensory processing in infants and toddlers up to 36 months old (Table I.2). Atypical sensory processing is an indicator of whether a child (continued)

under-responsiveness or over-responsiveness to stimuli and can be associated with the mother's alcohol use during pregnancy (Jirikowic et al. 2020).

Less than one-quarter (22 percent) of adults followed for the cross-site evaluation reported high levels of substance use in the 30 days before program entry.[16] However, 42 percent of adults reported using cannabis in the past month. (Cannabis did not become legal for medical use in Florida until 2019 [SB 182] and remains illegal for recreational use.) Cocaine (11 percent) and sedatives (9 percent) were the next most commonly used drugs. About one-quarter (26 percent) of adults had enrolled in a state-funded SUD treatment setting in the year before they enrolled in the IMPACT Project. Nearly one-third (30 percent) of adults reported severe symptoms of depression at program entry.[17]

Across all five parenting attitudes measured by the cross-site evaluation, 17 to 57 percent of the adults expressed attitudes classified as indicating a potential risk for child maltreatment.[18] In the five individual categories of attitudes about parenting, the RPG sample had slightly higher (worse) parenting attitudes, compared with the national average. On average, adults expressed attitudes suggesting that they (1) held inappropriate expectations for children (43 percent), (2) lacked empathy for children (48 percent), (3) did not value children's independence (57 percent), (4) believed that children should be treated more like adult peers than like children (43 percent), and (5) valued corporal punishment more than the typical caregiver does (17 percent).

E. Program participation

The IMPACT Project was intended to run for 9 to 16 weeks (63 to 112 days), and participation was voluntary, not mandated by a court or the child welfare office. During services, the family met as a group with IMPACT Project staff and worked on improving communication, building their relationships with each other, and developing as individuals.

Nearly all families (95 percent) that enrolled in the IMPACT Project were then enrolled in MDFT-FR. The average duration of enrollment in the IMPACT Project was 175 days, or about 6 months, with about two-thirds of the time (about 116 days) involving participation in MDFT-FR. For the cross-site evaluation, a case is considered closed when the family completes programming or discontinues it for another reason. By April 2019, most cases had closed (86 percent), and of these cases, 76 percent had successfully completed the IMPACT Project. Others exited the project without completing it when, for example, the family declined to participate (9 percent) or the project was unable to locate the family (5 percent). In Table III.2, we list these and other reasons for case closures.

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has scores suggesting sensory-processing difficulties, as drawn from the low-threshold score, a composite of the low-sensory sensitivity and sensation-avoiding scales.

[16] The Addiction Severity Index (ASI) is a standardized instrument that measures self-reported drug use within the last 30 days (Table I.2). We define high levels of substance use as scores on the alcohol use or drug use scales that were above the national averages of people in substance use disorder treatment settings described in McClellan et al. (2006).

[17] The Center for Epidemiologic Studies Depression Scale (CES-D) is a standardized instrument that measures adult depressive symptoms (Table I.2). According to the CES-D user manual, scores in the highest range are indicative of "severe symptoms of depression."

[18] The Adult Adolescent Parenting Inventory-2 (AAPI-2) is a standardized instrument that measures parenting attitudes (Table I.2). According to the AAPI-2 user manual, scores in the highest range indicate parenting attitudes that place the child at high risk for maltreatment.

Table III.2. Reasons for case closures in the IMPACT Project

Characteristic	Number of families	Percentage of families
Case closed (N = 91)	78	86
Of closed cases, reasons for case closure[a] (n = 78)		
Family successfully completed RPG	59	76
Family declined to participate further	7	9
Unable to locate family	4	5
Family moved from area	3	4
Transferred to a different service provider	2	3
Death (parent)	1	1
Other	2	3

Source: RPG Enrollment and Service Log data from April 2019.

[a] Percentages sum to more than 100 because grantee staff could select more than one reason for case closure. The calculations exclude open cases.

F. Implementation

1. Frontline staff were handpicked based on relevant experience and were trained and supported directly by the developer of MDFT-FR

All frontline staff (those who worked directly with participants) in the IMPACT Project were current employees of the agencies implementing the project. Agencies handpicked the IMPACT Project staff after determining that their experience made them best suited to the project. All staff held graduate or clinical degrees.

The developer of MDFT-FR trained staff in the model before they started working with participants and supported them during program delivery. Staff also had access to procedure and operations manuals and training documents. In implementing MDFT-FR, staff had the support of project leaders, their direct supervisors, and the program developer. Coaching on delivering the model came directly from the developer, who debriefed staff on their cases, modeled the delivery of services for them, gave them feedback on the model, and observed selected sessions with families. To ensure sustainability, an important goal of the project was to develop the capacity to conduct training on the model by themselves. By 2018, the project was able to transition training and implementation of the model from the developer to a staff therapist who had been learning the model since the outset of the project.

2. It was a challenge to recruit, enroll, and engage participants, but the project built momentum over time

In August 2015, the IMPACT Project began enrolling families referred to Our Kids by child protective investigators who worked for Florida DCF. In October of that year, the grantee reported that referrals were 33 percent lower than projected. Several changes to the DCF criteria for allowing referrals to Our Kids, along with a change in the agency providing MDFT-RF, created more stumbling blocks in the referral process. To boost referrals, during the third year of the grant, Our Kids staff reviewed the child welfare cases referred to the project to ensure that all cases meeting the criteria for referral to RPG were in fact referred to it. In fall 2017, the partnership held several recognition events honoring the

investigators and other partners who referred the most families to the IMPACT Project or contributed most to the enrollment of families in the project. The partnership also began providing small incentives in the form of prizes to the Our Kids intake staff and DCF protective investigators who were making the most referrals to the IMPACT Project. These and other efforts reinvigorated the desire to support RPG and increased the number of referrals to and enrollment in the IMPACT Project. Enrollment increased steadily, and the Children's Bureau was able to provide supplemental funding to the partnership to increase the program's capacity to serve participants during the grant's fifth year.

Sometimes delays in hiring staff, or staff turnover, disrupted enrollment. At several times during the grant period, Our Kids had to put RPG enrollment on hold for one or two months because of a shortage of therapists equipped to provide MDFT-FR. A related challenge was the flow of participants into services after enrollment. During the site visit for the cross-site evaluation, staff explained that one therapist would conduct an initial assessment and randomly assign families to the MDFT-FR program or the comparison group; then, a different therapist would engage the family in services. Staff said that having to work with a new therapist sometimes made families hesitant to engage in services. Once families did engage in services, however, staff reported little resistance in retaining the families in the project.

3. Partners made the difficult choice to move MDFT-FR to a new provider

Implementing MDFT-FR as a new practice model while participating in the randomized controlled trial conducted for the project's RPG evaluation proved to be a challenge for the small agency initially selected to deliver MDFT-FR. That agency had planned to provide MDFT-FR to participants randomly assigned to the evaluation's treatment group while providing "business as usual" intensive family preservation services to those assigned to the control group. Midway through the grant period, to reduce the stress on the organization and ensure meeting enrollment targets, the partnership selected a different organization to become the provider of MDFT-FR for treatment group families. The agency, The Village Drug Addiction Treatment Center, was an existing RPG partner providing SUD treatment to RPG families.

The change in providers represented the first time in Miami-Dade County that an SUD treatment provider crossed over to provide child welfare services. To support the transition, Our Kids provided The Village's staff with extensive training in child welfare.

4. Our Kids and its partners persisted, engaging the SUD treatment system and improving access to treatment for families in the child welfare system

From the beginning of its grant, the project reached out to community SUD treatment providers to encourage and enable them to work better with the child welfare system. For example, the project formed a task force with some treatment providers to identify and address barriers to cross-system collaboration. One specific barrier related to the provision of effective in-home outpatient treatment for families in the RPG project. The changes made locally to improve treatment access for child welfare families tended to focus on court-involved families (those families could not enroll in RPG), but the changes did not adequately address the needs of families that volunteered to receive treatment and other services. An advisory board put together by the RPG partnership to help guide its work wrote a letter to the South Florida Behavior Health Network, asking the network to consider creating a specialized child welfare in-home outpatient program. In response, the network agreed to release a request for proposals for those treatment services.

The RPG IMPACT Project team also worked closely with the network to maintain communication and collaboration during a staff transition. The person who represented the network in the RPG partnership left her organization. When the network hired a replacement, that person soon resigned. Our Kids expressed its support to the network during this time and helped keep other network staff aware of and engaged in the IMPACT Project.

5. The project worked directly with the model developer to help ensure fidelity

The developer of MDFT-FR worked directly with the IMPACT Project to ensure that frontline staff delivered the model as intended. A fidelity monitoring tool was still under development during the project; as a result, the program developer assessed fidelity directly. To do so, the team and the model developer had weekly check-in meetings in which the developer worked to ensure that participants received all components of MDFT-FR by coaching staff to respond to the challenges they faced. During the check-ins, the developer and frontline staff also created service plans for each family.

G. Changes in participants' outcomes

Families that enrolled in the IMPACT Project achieved improvements in outcomes in several key areas. On average, children had fewer reports of maltreatment, including substantiated maltreatment, and fewer emotional and behavioral problems. Most adults enrolled in SUD treatment after they enrolled in RPG and reported less substance use and fewer depressive symptoms after they left the program. There were fewer changes related to children's executive functioning and adaptive behavior, and no changes in adults' trauma symptoms and parenting stress. Table III.3 is an overview of whether there was a significant favorable or unfavorable change or no significant change for each outcome assessed at baseline and follow-up. A more detailed table of outcomes at baseline and follow-up appears in Appendix B.

Table III.3. Changes in key outcomes from baseline to follow-up for participants in the IMPACT Project

Outcome (standardized instrument used)	Favorable (+), unfavorable (-), or no significant change (0)
Adult recovery	
Drug use (ASI)	+
Alcohol use (ASI)	0
Adult well-being and family functioning	
Trauma symptoms (TSC-40)	0
Parenting stress (PSI-SF)	0
Depressive symptoms (CES-D)	+
Inappropriate expectations for children (AAPI)	0
Lack of empathy for children (AAPI)	0
Values corporal punishment (AAPI)	0
Treats children like adult peers, not like children (AAPI)	+
Oppresses children's independence (AAPI)	+
Child safety and permanency	
Any maltreatment: Abuse, neglect, and other types	+
Removed from the home	-
Child well-being	
Behavior problems (CBCL)	+
Socialization skills (Vineland-II)	-
Atypical sensory processing (ITSP)	0
Executive functioning (BRIEF)	0

Source: The IMPACT Project's administration of standardized instruments at baseline and exit, including data submitted to the cross-site evaluation through April 2019; administrative records in the years before and after RPG enrollment, or administrative data obtained from state or county child welfare agencies by the IMPACT Project and submitted to the cross-site evaluation through April 2019. Full names of instruments appear in Table I.2.

1. Child safety improved

Children who enrolled in the RPG project and were followed for the evaluation (focal children) had fewer instances of both reported and substantiated child maltreatment during RPG. The rate of reported maltreatment decreased from 98 percent in the year before programming to only 2 percent during the year of programming. (Appendix A shows the baseline and outcome measures for all four partnerships.) The rate of substantiated maltreatment fell from 30 percent to 0. None of the children had been removed from their homes during the year before the family enrolled in the IMPACT Project, consistent with the project's eligibility criteria. In the year following enrollment, only 8 percent of the children were removed from their home. (Given their timing, these removals could have been related, at least in part, to maltreatment before enrollment in the IMPACT Project.)

2. Children had fewer emotional and behavioral problems

Focal children in the IMPACT Project showed improvements in emotional and behavioral problems, but they did not show improvements in other aspects of well-being. By program exit, no children exhibited internalizing, externalizing, or other behavior problems in the clinical range, even though 17 percent began the program in the clinical range.[19] However, children's social skills worsened slightly between entry and exit. The percentage of children lacking social and relationship skills increased from 0 percent at entry to 6 percent at exit. Children's levels of sensory processing and executive functioning were similar at entry and exit.

3. Adults had reduced rates of substance use and improved well-being

The majority of adults followed for the cross-site evaluation participated in publicly funded SUD treatment during the year after they enrolled in the IMPACT Project. Rates of participation in treatment increased from 27 percent during the year before program entry to 80 percent at exit. Consistent with the increased participation in treatment, self-reported drug use decreased in all major categories between program entry and exit. Among those adults with data at both program entry and exit, the proportion using marijuana fell from 41 percent at program entry to 15 percent at exit. Likewise, the percentage using cocaine fell from 15 percent to 1 percent, and the percentage using sedatives fell from 10 percent to 3 percent. In addition, the percentage of adults categorized as having high use of alcohol or drugs fell from 27 percent at program entry to 9 percent at exit.

Some measures of adult well-being and family functioning improved. Adults followed for the cross-site evaluation reported fewer depressive symptoms at program exit. Thus, the percentage of adults with severe symptoms of depression decreased from 31 percent to 17 percent between program entry and exit. Parenting attitudes improved in two of the five areas assessed. Adults were less likely to express certain negative parenting attitudes: that they did not value children's independence and that they believed children should be treated more like adult peers than like children. Adults did not show significant improvements in trauma symptoms or parenting stress.

[19] The Child Behavior Checklist (CBCL) is a standardized instrument from the Achenbach System of Empirically Based Assessment (ASEBA) that measures child behavior problems (Table I.2). The ASEBA user manual defines the "clinical range" for the CBCL total problems scale as scores that indicate more problems than those exhibited by 90 percent of the normative sample (*Manual for the ASEBA Preschool Forms and Profiles*; *Manual for the ASEBA School-Age Forms and Profiles*).

IV. Kansas: Kansas Serves Substance Affected Families (KSSAF)

Citing data provided in 2014 by the Kansas Department of Children and Families, the Kansas RPG grant application noted that parental substance use was prevalent in the households of children in out-of-home placements, exacerbated the risk of out-of-home placements, and was associated with longer stays in foster care. The data also revealed that reunification rates were lower for children in families affected by substance use (20 percent) than for children in nonaffected families (29 percent). Studies show that children of parents who misuse substances have poorer physical, intellectual, social, and emotional health and are at greater risk of abusing drugs or alcohol themselves as adults (HHS 1999; HHS 2009a; Niccols et al. 2012; Osterling and Austin 2008). For these families, the University of Kansas Center for Research and School of Social Work and its partners implemented an RPG project designed to support reunification by providing services to strengthen parenting capacities. The Kansas Serves Substance Affected Families (KSSAF) project set forth the following goals:

- Improve well-being, ensure safety, and accelerate permanency for young children and their families affected by substance use.
- Increase the child welfare and SUD treatment systems' capacity for collaboration and the provision of trauma-informed care.

To achieve these goals, KSSAF expanded the existing Strengthening Families Program by developing the Strengthening Families Program: Birth to Three (SFP B–3). SFP is a parenting and family strengthening program implemented in Kansas during the first cohort of RPG projects; the five-year grants were made in 2007. KSSAF planned to provide SFP B–3 to families with adult substance use issues and children from birth through age 3 (up to 47 months old) in foster care or at risk of out-of-home placement. KSSAF also provided parent SUD assessment, child and parent trauma assessments, and referrals to needed services. Two private child welfare service providers, KVC Behavioral Health and Saint Francis Community Services, delivered the program in each of the state's four child welfare service regions.

A. Partner agencies

In addition to the two service providers (KVC Behavioral Health and Saint Francis Community Services), the University of Kansas Center for Research and School of Social Work worked with Ahearn Greene Associates, the purveyor of SFP B–3, to support implementation (Table IV.1). Other key partners that made up the KSSAF Steering Committee included the Kansas Department for Children and Families, the Kansas Department of Aging and Disability Services, and the Kansas Head Start Association.

The grantee. The University of Kansas is a public and state-administered institution with more than 28,000 students and 2,600 faculty members on five campuses. The Center for Research is the entity responsible for submitting all proposals for external support of research, instructional, and service projects. In addition, the Center helps research investigators by negotiating contracts, providing proposal and post-award services, administering compliance oversight, managing and constructing research facilities, and handling financial services, including investment of corporation resources. The School of Social Work offers the only comprehensive program in social work in Kansas, with programs at the B.S.W., M.S.W., and Ph.D. levels. The grantee coordinated the project and conducted the RPG evaluation.

Table IV.1. Main partner agencies in KSSAF

Partner	Type of agency	Role in the RPG project
University of Kansas Center for Research, Inc. and the School of Social Work	Public university	Grantee; oversaw all project activities and conducted the required RPG local evaluation
KVC Behavioral Healthcare Inc. and Saint Francis Community Services Inc.	State-contracted child welfare providers	Delivered SFP B–3, conducted assessments, provided referrals, documented program processes and outputs, participated in the evaluation
Kansas Department for Children and Families	State child welfare agency	Provided data on child safety and permanence, promoted coordination across agencies, participated on the KSSAF Steering Committee
Kansas Department of Aging and Disability Services	State behavioral health agency	Provided adult recovery data and participated on the KSSAF Steering Committee
Ahearn Greene Associates	Strengthening Families Program: Birth to Three implementation specialist	Conducted training, monitored implementation fidelity, provided ongoing support and technical assistance for implementation of SFP B–3
Kansas Head Start Association	Early childhood service agency	Participated on the KSSAF Steering Committee to share expertise on the target population

KSSAF = Kansas Serves Substance Affected Families; SFP B–3 = Strengthening Families Program Birth to Three.

Child welfare partner. The Kansas Department for Children and Families (Kansas DCF) is the public child welfare agency. Its mission is to protect children, promote permanency, nurture families, and strengthen community partnerships to serve children. In Kansas, as in Florida, the child welfare system is privatized. It has a network of community-based providers throughout the state who are contracted to provide family preservation, foster care, and adoption services. This includes case management, service delivery to the child and family, child placement, and collaboration with community resources.

EBP developer. Ahearn Greene Associates is the sole authorized source in the United States and Canada for SFP B–3 training, evaluation, and technical assistance. For KSSAF, it licensed use of SFP B–3 and provided training and technical assistance for implementing and adapting it from SFP.

Other partners. In addition, the grantee partnered with KVC Behavioral Healthcare (KVC) and Saint Francis Community Services (Saint Francis) to deliver SFP B–3. Both of these agencies were under contract to the Kansas DCF as part of the privatized child welfare system. The grantee also partnered with the state's behavioral health agency, the Kansas Department of Aging and Disability Services. The department provided data on participation in SUD treatment for the local and cross-site evaluations, and its representative served on the project's steering committee. The Kansas Head Start Association worked with the partnership to support the focus on very young children.

B. Target population

KSSAF primarily served families with a child from birth to age 3 (up to 47 months) in foster care, with a goal of family reunification. The grantee also enrolled some families with children who were at risk of removal but not in foster care. To be eligible for services, families had to have an adult with an SUD that was identified as a contributing factor to a child's removal or risk of removal from the home. To find families with children at risk of removal, KSSAF received referrals from the service providers, KVC and Saint Francis. Each year of the project, KSSAF planned to serve a total of 80 to 96 families living within a 45-mile radius of the two service delivery sites.

C. Intervention

KSSAF examined the effects of Strengthening Families Program: Birth to Three among families with SUD and children ages birth to 3 (up to 47 months old) in foster care or at risk of out-of-home placement. To study the program effects, the grantee implemented a randomized controlled trial. Eligible families were randomly assigned to the program or control group. Those in the program group received the KSSAF program. Those assigned to the control group received services as usual. Outcomes were collected in two domains: child permanency and safety.◢

KSSAF implemented SFP B–3, a parenting and family strengthening program. Kansas had experience with the Strengthening Families Program before RPG3; in all four child welfare regions, Kansas used the earlier version of the program with families with children ages 3 to 12. Under KSSAF, the Strengthening Families developer worked with the partnership to adapt Strengthening Families for children from birth to age 3.

SFP B–3 is delivered in a group format, with 14 consecutive weekly sessions lasting about 2 hours each. Trained facilitators use a manualized child development curriculum. Sessions begin with a family meal (30 minutes); then, parents attend Parent Skills Training while children attend child care (60 minutes). Child care includes an hour of therapeutic and developmentally appropriate play led by trained group leaders. At the end of each session, the family is brought together again for play group/family skills training involving supervised practice and interaction (30 minutes). During this time, facilitators supervise parents in their interactions with children and help parents practice the parenting skills taught in the program. The play group/family skills training is designed to help parents empathize with and enjoy their children and to increase the quality of interaction and attachment for all family members.

In addition to SFP B–3, KSSAF offered assessments for adult SUD and for child and parental trauma and made referrals to needed services.

D. RPG families at baseline

Consistent with its target population, nearly all KSSAF enrollees (about 94 percent) were families with children who had already been removed from their homes in the year before they started the program. Thus, few children followed for the cross-site evaluation had experienced maltreatment during the year before they enrolled in the program (7 percent). Less than 1 percent of the children had a substantiated report during that time.

About 38 percent of KSSAF families included one or more adults with substance use issues, as indicated by their self-reported substance use in the 30 days before enrollment, their participation in publicly funded treatment in the year before RPG enrollment, or both. One-fourth (25 percent) of the adults followed for the cross-site evaluation participated in a publicly funded SUD treatment program in the year before programming began. Eighteen percent of adults had high levels of substance use in the 30 days before enrollment.[20] The most common substances that adults reported using were cannabis and amphetamines, used by 13 percent and 12 percent of adults in the sample, respectively. (As of 2018, one form of cannabis, cannabidiol [CBD] that does not contain tetrahydrocannabinols [THC], was legal in

[20] The Addiction Severity Index (ASI) is a standardized instrument that measures self-reported drug use within the last 30 days (Table I.2). We define high levels of substance use as scores on the alcohol use or drug use scales that were above the national averages of people in substance use disorder treatment settings described in McClellan et al. (2006).

Kansas for limited medical use [Kansas SB 282]. No other forms of cannabis were legal for medical or recreational use.)

Just under one-third (29 percent) of parents reported severe symptoms of depression at baseline.[21] Across all five parenting attitudes measured by the cross-site evaluation, 9 to 30 percent of adults expressed attitudes classified as indicating a potential risk for maltreating children.[22] In the five individual categories of attitudes about parenting, adults in the RPG sample had slightly higher average scores (worse parenting attitudes), compared with the national average. On average, adults expressed attitudes that suggested they (1) held inappropriate expectations for children (14 percent), (2) lacked empathy toward children (28 percent), (3) did not value children's independence (30 percent), (4) thought children should be treated more like adult peers than like children (19 percent), and (5) valued corporal punishment more than the typical caregiver does (9 percent).

E. Program participation

All families (100 percent) enrolled in KSSAF were also enrolled in SFP B–3, reflecting the process KSSAF established for enrollment. Families were not enrolled in KSSAF until they attended the first session of SFP B–3, at which time they were simultaneously enrolled in the project and SFP B–3. On average, families attended 12 SFP B–3 sessions, and the average session lasted about 2 hours. Adults attended all sessions, and children attended 88 percent of all sessions. The average duration of enrollment for all enrolled cases in KSSAF was 91 days, or about 13 weeks. By April 2019, nearly all KSSAF cases in the cross-site evaluation sample had been closed (92 percent), and of these cases, 76 percent had completed programming. Others exited KSSAF without completing the program; we show their reasons for leaving in Table IV.2.

[21] The Center for Epidemiologic Studies Depression Scale (CES-D) is a standardized instrument that measures adult depressive symptoms (Table I.2). According to the CES-D user manual, scores in the highest range are indicative of "severe symptoms of depression."

[22] The Adult Adolescent Parenting Inventory-2 (AAPI-2) is a standardized instrument that measures parenting attitudes (Table I.2). According to the AAPI-2 user manual, scores in the highest range indicate parenting attitudes that place the child at high risk for maltreatment.

Table IV.2. Reasons for case closures in KSSAF

Characteristic	Number of families	Percentage of families
Case closed (n = 303)	303	92
Of closed cases, reasons for case closure[a] (n = 280)		
Family completed KSSAF	280	76
Family was nonresponsive	280	14
Unable to locate family	280	5
Family declined to participate further	280	4
Family moved from area	280	1
Transferred to a different service provider	280	<1
Other	280	3

Source: RPG Enrollment and Service Log data from April 2019.

[a] Percentages sum to more than 100 because grantee staff could select more than one reason for case closure. The calculations exclude open cases.

F. Implementation

1. Overall, KSSAF reported that it was able to adapt Strengthening Families and implement SFP B–3 as intended

As mentioned in the previous chapter, the RPG partnership in Florida worked closely with the purveyor of its implemented EBP, MDFT-FR, to adapt it from its precursor (Engaging Moms) and implement it for RPG. Similarly, the Kansas partnership included the purveyor of SFP B–3, who worked closely with the University of Kansas and its two delivery sites to adapt and implement the adaptation. Both purveyors were interested in working with the RPG projects because it gave them an opportunity to perform a rigorous evaluation of their program models through the local evaluations conducted by each project. Based on fidelity reports provided to the University of Kansas by Ahearn, KSSAF reported high levels of implementation fidelity to SFP B–3. To implement a program with fidelity means to implement all components of the program in a manner that adheres to its intended content, approach, or principles. Implementation fidelity is important because, if a program is to achieve the positive outcomes that evidence-based programs demonstrated in research, it must adhere to the model. The KSSAF Management Team, KSSAF Steering Committee, and the SFP B–3 purveyor monitored implementation of SFP–3 to ensure that the project was carried out as planned.

For example, the SFP B–3 purveyor visited all participating sites and delivered site visit reports to both the management team and steering committee. The site reports contained observations and recommendations. The purveyor also held biweekly technical assistance calls that brought together the implementation teams at each service provider and representatives of the management team and steering committee; in addition, the purveyor provided the steering committee with regular updates on emergent issues. Further, SFP B–3 session facilitators completed weekly fidelity monitoring documentation that was monitored by the SFP B–3 purveyor and reported to both the management team and steering committee. The purveyor regularly reported to KSSAF on fidelity. In October 2017, feedback from the purveyor indicated that service providers had consistently scored above program standards and exceeded fidelity and other implementation benchmarks.

2. Along with program fidelity, overall implementation was informed by ongoing collection and review of detailed data

From the beginning of the project, KSSAF collected and used data from many different sources to monitor implementation. For example, during the first year of the grant, the University of Kansas performed a geographic analysis of child welfare data to ensure that the selected service sites would be able to reach the project's target population. The analysis showed that the catchment areas of the selected sites encompassed 6 of the 10 counties in Kansas with the highest percentage of children from birth to age 47 months in out-of-home placements linked in child welfare records to "parental substance abuse."[23] The university tracked participant retention rates by service site and program cycle. (Each cohort of SFP B–3 was one program cycle.) To support program evaluation, it tracked the collection of data from families at enrollment and again at program completion by site and program cycle so that it could either modify data collection procedures or provide additional resources to ensure complete data. For program fidelity, evaluation, and ongoing monitoring, the university also surveyed partnership members and program staff and conducted program satisfaction surveys among participating parents.

KSSAF adjusted implementation in response to careful monitoring. For example, the grantee identified a lack of buy-in for SFP B–3 among child welfare caseworkers at the service provision sites. The lack of buy-in stemmed from a limited understanding of SFP B–3 and its benefits for families, high caseloads, and concerns that only some families meeting the target criteria were assigned to receive SFP B–3, per the design of the RPG local evaluation. To increase buy-in and address caseworker turnover, KSSAF increased the frequency of training it provided to KVC and Saint Francis.

During implementation, KSSAF, in consultation with the SFP B–3 implementation specialist, increased the number of group sessions from 14 to 16. Participants still completed the SBP B–3 curriculum over the course of 14 sessions, but the two additional sessions gave participants time to complete the data collection instruments for the local and cross-site evaluations. Together, KSSAF and the implementation specialist also made minor changes to the curriculum to improve its alignment with the developmental stages of children. The changes also increased the number of staff providing child care so that services met the state's child care guidelines and parents could better satisfy the needs of their children.

3. Meeting enrollment targets proved difficult, especially in rural areas

KSSAF enrollment, like enrollment in Florida, lagged behind program targets. The management team and steering committee tracked enrollment and developed strategies to address low enrollment when targets were not met. To increase enrollment, the project added several locations where SFP B–3 could be provided within the areas served by KVC and Saint Francis. It also addressed enrollment by increasing the proportion of people assigned to the evaluation's program group. As part of RPG, KSSAF was conducting a randomized controlled trial of SFP B–3. Originally, random assignment procedures gave evaluation participants a 50 percent chance of random assignment to the program and a 50 percent chance of assignment to the control group, which received business-as-usual services. To increase program enrollment, KSSAF increased the proportion of evaluation participants randomly assigned to the SFP B–3

[23] The National Institute on Drug Abuse (NIDA) advises using the terms "substance use" or "misuse" and avoiding the word "abuse" because it has a high association with negative judgments and punishment (NIDA n.d.). This report only uses the term "substance abuse" when it is the actual term used in a source, such as a grant application, legislation, report and document titles, or organization or program names.

group from 50 to 66 percent.[24] Thirty-four percent of evaluation participants were then assigned to the control group for the remainder of the evaluation.

4. KSSAF implemented different strategies to keep participants engaged

The families served by KSSAF often faced many competing demands, including enrollment in other services. In addition, staff worried that, once families were reunified, they would have less interest in completing SFP B–3. To retain parents, KSSAF used a range of strategies, such as offering parents make-up sessions. KSSAF also made participation in the SFP B–3 sessions appealing to parents by providing dinner and sending leftovers home with families. On their own initiative, some session facilitators provided more incentives, such as gift cards, gas cards, or framed family photos.

5. Concerns about the Kansas child welfare system created a negative climate that challenged the partnership

Members of the RPG partnership, especially those who served on the steering committee, met regularly to coordinate the project, review data, and discuss any emerging issues. Their schedule was disrupted when, in June 2017, the governor of Kansas signed a bill establishing a task force to conduct a comprehensive review of the state's child welfare system (BBC Newshour 2017). The state legislature and governor created the task force in response to increases in the number of children in foster care in the state and concerns about the death of an abused boy. Moreover, an audit conducted the previous year concluded that the Kansas DCF failed to conduct background checks on foster families, that some foster homes had inadequate sleeping space for children, and that records on some monthly in-person visits to foster homes were missing. RPG partners, including representatives from the Kansas DCF, KVC, and Saint Francis, were called to give presentations to the task force on a range of topics, such as foster care contracts, making partners less available to coordinate with KSSAF.

In addition to time constraints, partners had to deal with negative reports in the press and anger from families, an experience that proved to be emotionally draining. Moreover, the controversy raised concerns among foster parents, led to higher-than-usual staff turnover in the child welfare system, and dampened the morale of KSSAF program staff. The secretary of DCF resigned, and an important member of the RPG partnership resigned her post and had to leave the partnership. The University of Kansas's long-standing relationship with DCF helped the partnership weather these challenges. The relationship also benefited the project in other ways. For example, the partnership was able to work through a series of problems and delays in obtaining the administrative data that the state collected and that were needed for the local and cross-site evaluations

6. KSSAF began planning for sustainability on day one

To increase the likelihood that SFP B–3 implementation could be sustained after expiration of the RPG3 grant, the KSSAF management team and steering committee began taking steps to sustain the program from the project's outset. In particular, during interviews conducted by the cross-site evaluation team, KSSAF reported that, by using staff already employed at KVC and Saint Francis, training several staff to deliver SFP B–3, and involving community agencies in implementation, the services were becoming more established.

[24]Moving away from a 50/50 treatment allocation increases the standard error of the impact estimate (a measure of the precision of the estimate). Overall, this change had minor implications for the analyses and allowed the grantee to continue with its plans to use a randomized controlled trial.

G. Changes in participants' outcomes

Families that enrolled in KSSAF improved on aspects of adult well-being, family functioning, and child permanency, but not in areas related to child maltreatment and adult substance use. On average, adults exhibited fewer trauma symptoms and better parenting attitudes. In the year following RPG enrollment, fewer children were removed from their homes, but there was more maltreatment than in the previous year. Adults' substance use was stable between entry and exit. In Table IV.3, we present an overview of whether there was a favorable or unfavorable change or no significant change for each of the outcomes assessed at baseline and follow-up.

Table IV.3. Changes in key outcomes from baseline to follow-up for KSSAF participants

Outcome	Favorable (+), unfavorable (-), or no significant change (0)
Adult recovery	
Drug use (ASI)	0
Alcohol use (ASI)	0
Adult well-being and family functioning	
Trauma symptoms (TSC-40)	+
Depressive symptoms (CES-D)	0
Inappropriate expectations for children (AAPI)	0
Lack of empathy for children (AAPI)	+
Values corporal punishment (AAPI)	0
Treats children like adult peers, not like children (AAPI)	+
Oppresses children's independence (AAPI)	0
Child safety and permanency	
Any maltreatment: Abuse, neglect, and other types	-
Removed from the home	+

Source: KSSAF's administration of standardized instruments at baseline and exit, including data submitted to the cross-site evaluation through April 2019. Full names of instruments appear in Table I.2.

Administrative records in the years before and after RPG enrollment from state or county child welfare agencies, obtained by KSSAF and submitted to the cross-site evaluation through April 2019.

1. Rates of reported maltreatment increased over time

Almost all of the children followed for the evaluation (94 percent) had already been removed from their homes in the year before programming. Consequently, only a few children (3 percent) were removed during the year after enrollment. However, rates of reported maltreatment among all focal children, while remaining low, increased from 6 percent in the year before enrollment to 13 percent in the year following enrollment.[25]

[25] We do not report on child well-being because KSSAF did not collect data on child well-being.

2. On average, adults' substance use was stable from program entry to exit

Rates of alcohol and drug use were similar for all types of substances, and the percentage of participants with high levels of alcohol or drug use stayed about the same from entry to exit (13.7 and 13.2 percent, respectively). Participation in publicly funded SUD treatment among adults who consented to the collection of these data dropped from 26 percent in the year before RPG programming to 17 percent in the year of programming. KSSAF programming did not include SUD treatment.

3. Adults showed improvements in some, but not all, areas of well-being and family functioning

Adults reported fewer trauma symptoms at program exit than at entry.[26] In that period, adults also improved significantly on two of the five parenting attitudes measured for the cross-site evaluation.[27] Adults were less likely to express attitudes demonstrating that they lacked empathy for children or believed that children should be treated more like adult peers than like children. Symptoms of depression were similar at entry and exit.

[26] The Trauma Symptoms Checklist-40 (TSC-40) measures the number and severity of symptoms from childhood and adult trauma (Table I.2). Mean total scores on the TSC-40 decreased by 15 percent from entry to exit.

[27] The five attitudes measured by the AAPI-2 are inappropriate expectations for child; lack of empathy for child; values corporal punishment; treats child like an adult peer, not a child; and oppresses child's independence.

V. New York: Enhanced Family Treatment/Rehabilitation (FT/R)

Montefiore Medical Center's RPG project aimed to improve child welfare outcomes among substance use–affected families in the Bronx that came to the attention of child welfare. In its RPG application, Montefiore stressed the immense need for these services:

> At any point in time, New York City has nearly 50,000 children in preventive or foster care services, including 15,000 in the Bronx, and there are 55,000 State Central Registry reports annually. Of these investigations, 14,000 per year are related to substance abuse, including 4,000 in the Bronx.[28]

To address this need, Montefiore's RPG project brought together the medical center as the grantee agency and several partner agencies to test an enhanced model of the Family Treatment/Rehabilitation program (FT/R) that New York City's child welfare agency had implemented. FT/R, a specialized program to prevent child abuse, is designed for parents experiencing mental health or substance use issues. The RPG project, called a Regional Partnership for New York City to Improve Child Welfare Outcomes among Substance Abusing Families, offered two additional evidence-based programs to FT/R participants with substance use issues: the Incredible Years Parenting Class and Seeking Safety. The project complemented the EBPs with contingency reinforcement.

A. Partner agencies

Montefiore partnered with the New York City Administration for Children's Services (NYCACS), which is New York City's child welfare agency, and with Metis Associates, a national research and consulting firm. As Table V.1 shows, several other agencies were also named as partners.

The grantee. The Montefiore Health System consists of 11 hospitals and a primary and specialty care network in more than 180 New York locations across Westchester County, the lower Hudson Valley, and the Bronx. Within the system, Montefiore Medical Center, in the Bronx, is the academic medical center, and it is the University Hospital for Albert Einstein College of Medicine. University Behavioral Health Associates, which is a not-for-profit behavioral management services organization founded by and housed within the medical center, provided RPG services (the enhanced FT/R program) to participants. The Division of Substance Abuse provided SUD treatment.

Child welfare partner. Montefiore partnered with NYCACS, whose jurisdiction encompasses the Bronx. NYCACS already funded the FT/R program at Montefiore before RPG. Thus, as Montefiore noted in its application for the RPG3 grant, it already had a strong partnership with NYCACS.

Evaluation. Montefiore engaged Metis Associates, headquartered in New York City, to conduct an evaluation of the enhanced FT/R program provided under RPG. Metis Associates had previously conducted an implementation study of the program for NYCACS.

Other partners. In addition to working together, the three core partners planned to collaborate with other government agencies, including the New York State (NYS) Office of Children and Family Services, the

[28] The National Institute on Drug Abuse (NIDA) advises using the terms "substance use" or "misuse" and avoiding the word "abuse" because it has a high association with negative judgments and punishment (NIDA n.d.). This report only uses the term "substance abuse" when it is the actual term used in a source, such as a grant application (such as this instance), legislation, report and document titles, or organization or program names (such as the name of this program).

NYS Office of Alcoholism and Substance Abuse Services, the New York City Department of Health and Mental Hygiene, and the Bronx Family Court. These organizations provided letters of support as part of Montefiore's RPG grant application, but the application did not specify the organizations' operational roles in the project. Some RPG participants received SUD treatment from other treatment providers in the Bronx, but these providers did not offer other FT/R, the enhancements, or other project-related services. Like the other RPG3 projects, Montefiore also planned to refer participants to ancillary services, which might include housing, transportation, employment, or mental health services, from providers not named in the application and not formal members of the partnership.

Table V.1. Main partner agencies in Enhanced FT/R

Name of partner agency	Type of agency	Role in the RPG project
Montefiore Medical Center	Medical center	Grantee; provided enhanced FT/R services and SUD treatment.
New York City Administration for Children's Services (NYCACS)	Local child welfare agency	Referred clients to the FT/R program. Provided information on treatment and comparison groups for the project's evaluation; was the source of the treatment and comparison group participants; helped coordinate between child welfare, substance abuse, and the grantee.
Metis Associates	Research and consulting firm	Designed and conducted the required RPG project evaluation.
New York State (NYS) Office of Children and Family Services	State child welfare agency	Gave general support for RPG and possibly provided administrative data on child maltreatment and removals.
NYS Office of Alcoholism and Substance Abuse Services	State substance abuse agency	Gave general support for RPG and possibly provided administrative data on participation in SUD treatment.
New York City Department of Health and Mental Hygiene	Public health agency	Gave general support for RPG
The Bronx Family Court	Family court	Gave general support for RPG, including providing information to court staff about referrals and FT/R and possibly providing additional help with coordination between Montefiore, the court, and child welfare and substance use treatment systems.

FT/R = Family Treatment/Rehabilitation; SUD = substance use disorder.

B. Target population

FT/R offers intensive preventive case management to families that are at risk of having their children removed to foster care as a consequence of neglect and abuse associated with a parent's drug use and/or mental illness. Montefiore's project received referrals primarily from the New York City Administration for Children's Services. The enhanced FT/R program at Montefiore served those with a presenting concern related to parental substance use. Within this population, it did not target any specific racial, ethnic, cultural, or linguistic groups or families with children in a specific age group.

The timing of referrals varied. Some families were referred to the project less than a month after their child welfare case was opened, whereas other families moved between SUD treatment programs they were referred to, and then ultimately were referred to the project.

C. Intervention

FT/R at Montefiore included services such as clinical assessments for potential SUD, referrals to SUD treatment or other services, home visits, and case management. To motivate and support parents to remain in and complete treatment (typically requiring 9 to 12 months), Montefiore's RPG project added three elements to the existing FT/R program: (1) contingency reinforcement, a practice that provides incentives (a voucher or gift card was used); (2) Incredible Years, a series of parenting skills workshops to help parents become more effective and less likely to use harsh discipline; and (3) Seeking Safety, a manualized treatment for adolescents and adults with a history of trauma and substance use issues. Participation in the program was voluntary.

The RPG implementation team and key personnel from Montefiore who work in SUD treatment clinics selected these enhancements for the RPG project based on recommendations from Montefiore clinicians. Montefiore already offered Incredible Years in conjunction with its mental health and relationship education services. In addition, key personnel favored Seeking Safety for its track record of easy implementation with groups or individuals. Montefiore had already used it and therefore could turn to staff already trained in the model. Enhanced FT/R added contingency reinforcement to improve parents' motivation for attending SUD treatment.

> Montefiore Medical Center's RPG project evaluation examined the effects of adding Seeking Safety and Incredible Years, which are two EBPs, along with contingency reinforcement. The evaluation used a quasi-experimental, matched comparison group design. Those in the treatment group received FT/R along with Seeking Safety, Incredible Years, and contingency reinforcement (enhanced FT/R), while those in the comparison group received business-as-usual FT/R services from Montefiore or other providers. The local evaluation collected information about implementation of the program and collaboration among partners.◢

For the RPG project, Montefiore provided Incredible Years and Seeking Safety in weekly group sessions. Participants occasionally received individual sessions, some of them in their homes if they so requested or if there were not enough families to form a new group. University Behavioral Associates provided the enhancements.

D. RPG families at baseline

By April 2019, 84 families had enrolled in enhanced FT/R. The majority of focal children (69 percent) had at least one report of maltreatment in the year before enrollment, and 57 percent had at least one substantiated maltreatment report. However, just 1 percent of focal children had been removed from their homes in the year before enrollment.

Based on data provided by parents, levels of cognitive functioning and internalizing and externalizing behavior problems among focal children were comparable to national averages for all children. However, a subset of focal children had more serious issues. About 21 percent had executive functioning levels

categorized as "clinically significant,"[29] and 24 percent had symptoms of externalizing behavior problems, internalizing behavior problems, or both, that were within the clinical range.[30]

About one-quarter (23 percent) of adults reported high levels of drug use, alcohol use, or both.[31] Among those who reported using drugs in the past 30 days, cannabis was the most commonly used drug. Forty-one percent of adults had used cannabis at least once in the last 30 days, whereas cocaine use, which was the second most commonly used substance, was reported by 7 percent of adults. As of 2014, cannabis was legal for medical but not recreational use in New York State (New York Title V-A, Article 33).

Across all five parenting attitudes measured by the cross-site evaluation, 22 to 49 percent of adults expressed attitudes classified as indicating a potential risk for maltreating children.[32] In the five individual categories of attitudes about parenting, the RPG sample had slightly higher average scores (worse parenting attitudes), compared with the national average. On average, adults expressed attitudes suggesting that they (1) held inappropriate expectations for children (35 percent), (2) lacked empathy toward children (49 percent), (3) did not value children's independence (36 percent), (4) believed that children should be treated more like adult peers than like children (37 percent), and (5) valued corporal punishment more than does the typical caregiver (22 percent).

E. Program participation

Most families (60 percent) who enrolled in Montefiore's enhanced FT/R program received at least one of the three enhancements available to families: (1) contingency reinforcement, (2) Incredible Years, and/or (3) Seeking Safety. Of the 60 percent who received at least one enhancement, all received contingency reinforcement, and most were also enrolled in Seeking Safety (90 percent) and/or Incredible Years (64 percent). Sixty-four percent received all three. The average duration of participation for all enrolled families was 250 days, or almost 9 months. By April 2019, 62 percent of enrolled families had their cases closed, and 77 percent of these families had completed the program. Others exited the project without completing it for reasons shown in Table V.2.

Because Seeking Safety was one of ten EBPs the RPG cross-site evaluation studied in depth, Montefiore collected more information about attendance and participation in Seeking Safety than about Incredible

[29] The Behavior Rating of Executive Function (BRIEF) manual describes that, for the Global Executive Functioning scale, a score that is 1.5 standard deviations above the mean of the sample used for standardizing the instrument is considered abnormally elevated and "clinically significant" (BRIEF Administration and Scoring Manual).

[30] The Child Behavior Checklist (CBCL) is a standardized instrument from the Achenbach System of Empirically Based Assessment (ASEBA) that measures child behavior problems (Table I.2). Scores on the total problems scale indicating the presence of more problems than in 90 percent of the normative sample are considered to be in the "clinical range" according to the ASEBA user manual (*Manual for the ASEBA Preschool Forms and Profiles*; *Manual for the ASEBA School-Age Forms and Profiles*).

[31] The Addiction Severity Index (ASI) is a standardized instrument that measures self-reported drug use within the last 30 days (Table I.2). We define high levels of drug and alcohol use as scores on the alcohol use or drug use scales that were above the national averages for people in SUD treatment settings as described in McClellan et al. (2006).

[32] The Adult Adolescent Parenting Inventory-2 (AAPI-2) is a standardized instrument that measures parenting attitudes (Table I.2). According to the AAPI-2 user manual, scores in the highest range indicate parenting attitudes that place the child at high risk for maltreatment.

Years).[33] The data showed that adults enrolled in Seeking Safety attended 9 sessions that ran for an average 58 minutes, ranging from 30 to 60 minutes. Seeking Safety targets adults, but a child was also in attendance an average of one session per family.[34]

Table V.2. Reasons for case closures in Enhanced FT/R

Characteristic	Number of families	Percentage of families
Case closed (n = 84)	52	62
Of closed cases, reasons for case closure[a] (n = 52)		
Family completed programming	40	77
Family was nonresponsive	6	12
Unable to locate family	3	6
Family declined to keep participating	3	6
Family moved from area	3	6
Other	3	6

Source: RPG Enrollment and Service Log data from April 2019.

[a] Percentages sum to more than 100 because grantee staff could select more than one reason for case closure. The calculations exclude open cases.

F. Implementation

1. Recruitment was a challenge, but contingency reinforcement and building rapport appeared to help retention

One challenge faced by Montefiore's RPG project was participant recruitment. The partnership planned to enroll 100 families, 20 each year beginning in the first year of the grant. The start of recruitment was delayed until July 2015 (the grant began in October 2014) because of the time needed both to complete memoranda of understanding between the core partners and to obtain approval for the project from the grantee's institutional review board. The project also faced some difficulty in recruiting participants, but the partners worked closely to simplify enrollment by recruiting families into the local and cross-site evaluations after enrollment in FT/R instead of simultaneously enrolling families in both the evaluation and FT/R, and expedite connections to key staff in the ACF referring agencies (see Chapter II of Xue et. al (2018) for more details on early implementation). In April 2018, the grantee reported that project understaffing had also contributed to lower-than-planned enrollment numbers, though recruiting had picked up during the reporting period. (It was not clear whether funding limitations, difficulties in filling positions, or staff turnover caused the initial understaffing.)

[33] The developer of Seeking Safety recommends that adults receive 25 to 30 sessions. However, in RPG, most partnerships incorporated Seeking Safety as a component of other services, not as a stand-alone intervention, and did not provide 25 to 30 sessions. For context, RPG2 participants received an average of five Seeking Safety sessions (HHS 2020a). The number of sessions people attended ranged from 1 to 10 at Montefiore and from 1 to 73 in the total combined RPG2 sites that offered Seeking Safety.

[34] Most RPG cases were composed of one adult (usually the biological mother of the focal child in the case) and one or more children. Given that Seeking Safety is not designed to include children, a child would be present only if, for example, the adult did not have child care available and had to bring the child(ren) with her.

Despite challenges in recruiting participants, retention efforts were successful. Project staff identified participants who might be likely to disengage early and worked to keep them engaged in services. During site visits conducted for the cross-site evaluation, staff remarked that the contingency reinforcement payments motivated most clients to stay engaged. Then, as project staff built relationships with other participants in their groups and the group facilitator, participants' commitment to the program increased. Staff credited both factors with supporting retention in the program.

Staff who worked directly with participants also sought to build rapport with them, an effort that sometimes proved challenging. Although the project's primary goal was to stop substance use and help participants become aware of and address the reasons for substance use, staff reported that participants were sometimes hesitant to discuss their reasons for using substances, even when staff believed that they had developed good rapport with participants.

2. A close working relationship between the three core partners advanced the project

Leaders from University Behavioral Associates, the arm of Montefiore that provided enhanced FT/R, the Einstein Division of Substance Abuse, and NYCACS were heavily invested and involved in the project. They met at least quarterly during the life of the project and maintained ongoing communication between meetings. The evaluators from Metis Associates contributed to and were part of this close collaboration. As noted, Metis had conducted an earlier evaluation of FT/R for NYCACS. The evaluators built on that relationship and expanded it to Montefiore, working with Montefiore and NYCACS to simplify recruiting and providing data to the partners on an ongoing basis. For example, during the July 2017 quarterly partners meeting, when senior leaders from NYCACS, Montefiore, and Metis were present, Metis disseminated results from its qualitative assessment of the partnership. In 2018, when it began analyzing preliminary data from participants, Metis presented information from the analysis in meetings and conference calls with the RPG team at Montefiore.

One goal of the close partnership was to help NYCACS identify practices and procedures that could be sustained after the grant ended. For example, the partnership could continue serving the community after the grant if a local evaluation revealed the partnership to be effective; if contingency reinforcement could be sustained; and, it was hoped, if interventionists trained in Seeking Safety and Incredible Years could be hired to continue the two programs with Medicaid and private insurance funding. To this end, Montefiore planned to disseminate evaluation findings throughout New York City's preventive services infrastructure.[35]

3. Montefiore assessed fidelity through clinical supervision, observations, and debriefings

Unlike the RPG projects in Florida and Kansas, the models selected by Montefiore for enhanced FT/R were well established and were not being modified for use in the project or with New York's target population. Although project staff received appropriate training in Seeking Safety and Incredible Years, support from the purveyors did not include fidelity assessment tools, such as measures of dosage or duration, participant satisfaction, or observation of sessions.

Even without developer-provided fidelity tools, Montefiore took a number of steps to ensure that implementation remained consistent with model specifications and maintained ongoing fidelity. A

[35] In 2018, Montefiore successfully applied for new RPG funding to sustain the partnership with NYCACS and to continue implementation of Incredible Years and the use of contingency reinforcement. The new project provides these and other services for pregnant women at risk of substance misuse and their babies.

consultant trained and certified in Incredible Years trained staff. Along with using manuals and materials provided by the purveyors of both EBPs, Montefiore purchased a DVD training series from Seeking Safety and used it for initial and refresher training. The project requested and received approval from its institutional review board to record Incredible Years and Seeking Safety sessions with participants. The recordings helped staff supervisors give feedback to workshop facilitators. Frequent staff meetings and one-on-one sessions between supervisors and facilitators were opportunities to debrief about sessions and about individual participants' issues. Supervisors also occasionally observed sessions in person.

G. Changes in participants' outcomes

Between program entry and exit, children in Montefiore's RPG project showed improvements in safety and executive functioning. However, adults in the project did not show improvements related to recovery or well-being. In Table V.3, we show whether there was a favorable or unfavorable change or no significant change for each of the outcomes assessed at baseline and follow-up.

Table V.3. Changes in key outcomes from baseline to follow-up for Enhanced FT/R participants

Outcome	Favorable (+), unfavorable (-), or no significant change (0)
Adult recovery	
Drug use (ASI)	0
Alcohol use (ASI)	0
Adult well-being and family functioning	
Trauma symptoms (TSC-40)	0
Parenting stress (PSI-SF)	0
Depressive symptoms (CES-D)	0
Inappropriate expectations for children (AAPI)	0
Lack of empathy for children (AAPI)	0
Values corporal punishment (AAPI)	0
Treats children like adult peers, not like children (AAPI)	0
Oppresses children's independence (AAPI)	0
Child safety and permanency	
Any maltreatment: Abuse, neglect, and other types	+
Removed from the home	-
Child well-being	
Behavior problems (CBCL)	0
Socialization skills (Vineland-II)	0
Executive functioning (BRIEF)	+

Source: Montefiore's administration of standardized instruments at baseline and exit, including data submitted to the cross-site evaluation through April 2019.

Administrative records in the years before and after RPG enrollment, obtained by Montefiore from state or county child welfare agencies and submitted to the cross-site evaluation through April 2019.

1. Child safety and permanency improved

The rate of reported maltreatment fell from 69 percent in the year before RPG programming to 36 percent in the year following enrollment in enhanced FT/R. The rate of substantiated maltreatment fell from 56 to 24 percent over the same time. Nine percent of children were removed from their homes in the year following enrollment, compared to none in the year before enrollment. Some of the removals during the year following enrollment were probably related to maltreatment that took place before enrollment.

2. Child executive functioning improved, but other aspects of well-being did not

The percentage of children with clinically significant deficits in executive functioning decreased from 21 percent at program entry to 5 percent at exit. Socialization skills and emotional and behavioral problems were similar at program entry and exit.

3. Adult recovery and well-being were similar at entry and exit

Twenty-three percent of adults had high levels of drug or alcohol use at program entry, and 18 percent had high levels at exit. Use of individual substances also remained similar at program entry and exit.

Standardized instruments administered to adults at enrollment and follow-up showed improvements in adult trauma symptoms, depressive symptoms, and parenting attitudes, though the changes were not statistically significant. Although these outcomes were moving in the right direction, because of the small sample sizes, any changes would have to be substantial to be detected.

VI. Oregon: Family Recovery Support Program

The Families Involvement Team (FIT) for Recovery was an existing coalition of state and local agencies in Oregon whose leaders and staff agreed that child neglect and abuse are often associated with parental substance use. The team also recognized that no single agency had the resources and expertise to respond comprehensively to the needs of the parent, the child, or the family as a whole. As an extension of coalition activities, FIT for Recovery created the Family Recovery Support (FRS) program during the RPG1 cohort. For RPG3, the coalition expanded its offerings by partnering with The Miracles Club (TMC, a recovery center). In partnership with TMC, FRS provided trauma-informed parenting support and a recovery-oriented system of care to families in recovery following SUD treatment, with a special emphasis on culturally specific services for African Americans. Specific goals of the Family Recovery Support (FRS) program for RPG3 were:

- Increase the collaborative capacity of the participating organizations.
- Provide trauma-informed, culturally responsive, and strengths-based services to families.
- Help parents and families sustain recovery.
- Improve the well-being of children and parents, children's permanency and safety, and family functioning and stability.
- Reduce the number of African American children entering or returning to foster care.
- Create an enhanced and sustainable recovery-oriented system of care.

FRS was intended to extend FIT by matching participants with a certified peer recovery mentor if they asked for one, and a resource specialist and/or therapist if needed. Each participant's recovery support plan would then link the participant to selected services from a menu of available options, including some added with RPG funding. Service providers were Family Recovery Support, a drop-in center operated by VOAOR that provided recovery-oriented services, and TMC.

A. Partner agencies

VOAOR and TMC partnered to extend support to families as they left treatment, noting in their grant application that the termination of treatment is a key transition point and that people newly in recovery are susceptible to relapse at this time. VOAOR had developed the Family Recovery Support drop-in center as a safe community of extended recovery for families served by FIT for Recovery. FIT was formed in 2000 by the Multnomah County Family Court and a group of professionals working for child welfare, alcohol, and drug treatment providers. The partners were concerned that the Adoption and Safe Families Act would create special challenges to reaching timely permanence for children whose parents faced substance use issues. At the time of the RPG application, FIT for Recovery had evolved into a collaboration of nine state, county, and nonprofit partners that equally shared responsibility for serving families whose children were at risk because of parental substance use. It provided coordinated court and treatment efforts to help families reach timely permanence when children had been placed in out-of-home care and parental substance use was a primary factor in their removal from the home.

For RPG, leaders of the FIT collaboration invited TMC into the partnership to create a targeted, recovery-oriented system-of-care model for parents involved with the child welfare system who are in SUD recovery. A recovery-oriented system of care is a framework in which different types of organizations

across a community partner to provide a full continuum of care, with individualized services for prevention, intervention, treatment, and continuing care and recovery (Substance Abuse and Mental Health Services Administration 2010). For the grant application, VOAOR partnered with TMC, the Multnomah County Mental Health and Addiction Services Division (MHASD), the Multnomah County Department of Human Services, and Portland State University's Regional Research Institute to form FSRP (Table VI.1).

Table VI.1. Main partner agencies involved in FRS

Partner agency	Type of agency	Role in the RPG project
Volunteers of America Oregon	Chapter of national nonprofit organization	Grantee; operated the drop-in center that provided RPG-related services and delivered Mindfulness Based Recovery Support
Family Involvement Team (FIT) for Recovery	Child welfare collaboration	Provided support for data sharing and evaluation, coordination of resources, staff participation and support for collaboration meetings, referrals, and outreach
Multnomah County Department of Human Services	County child welfare agency	Provided in-kind services, including case management, case consultation, support with data access and collection, augmenting accessibility to TANF, housing Services, and intensive safety and reunification services
Multnomah County Mental Health and Addiction Services Division	County behavioral health agency	Provided funding, assistance with data collection, staff participation, and support for collaboration meetings
The Miracles Club	SUD treatment provider	Provided certified recovery mentors and outreach to African American families
Portland State University, Regional Research Institute	University-based evaluation and research institute studying human services	Designed and conducted the evaluation of the RPG FSR program.

The grantee. Headquartered in Portland, Oregon, VOAOR is a branch of Volunteers of America, a national nonprofit faith-based organization founded in 1896. VOA's mission is to reach and uplift all people by involving a combination of paid professional staff and community volunteers in the delivery of services. VOAOR helps families in the greater Portland, Oregon, and Vancouver, Washington, areas by delivering services focused on three main areas: children and family, public safety/SUD treatment, and seniors. It was a member of the FIT for Recovery collaboration.

Child welfare partner. The Multnomah County Department of Human Services (DHS) was a member of the FIT for Recovery collaboration and provided in-kind and other services to the FRS. For example, each year it dedicated one full-time equivalent (FTE) of a case manager and one FTE of a social services specialist to the project. It also pledged the time of a policy analyst and executive manager to support data collection and alignment of policies with other DHS-provided programs such as TANF, housing, and intensive safety and reunification services.

Evaluator. The Regional Research Institute at Portland State University was the evaluator of FRS. The institute conducts research, evaluation, and training to improve the design, management, practice, and evaluation of human services and social service delivery systems. Through the institute, Portland State faculty and students work with community partners to conduct research.

Other partners. TMC, VOAOR, and the Regional Research Institute were FRS's key operational partners. TMC described itself in the grant application as a peer recovery social organization. Founded in 1993, it is a community recovery center that offers the African American community peer services for treating SUD. It also makes available a fellowship hall and a meeting space for community recovery meetings and offers community events. FIT was a well-established collaboration (founded in 2000) of the Oregon Department of Human Services, the Multnomah County Department of Human Services, VOAOR, the Multnomah County Family Court, and providers of behavioral health and other services. VOAOR also partnered with the Multnomah County Mental Health and Addiction Services Division of the Multnomah County Department of Human Services, which provided support for data collection and other work. FRS obtained referrals into the RPG program from several SUD treatment providers and other organizations and programs in the service area and referred participants to other service providers in the county, but these entities were not partnership members.

B. Target population

FRS aimed to serve 136 parents in SUD recovery annually (totaling over 680 in the five years of the grant). The project focused on families with a parent in early recovery who completed or was close to completing SUD treatment. However, partners also expected that some parents referred to and enrolled in the project would be further along in their recovery.

The RPG partnership planned to serve parents in Multnomah County who were not only in recovery but also either involved with or at risk of becoming involved with child welfare services. The project planned to devote considerable effort to reaching out to and engaging African American parents and families because of their disproportionately high rate of foster care placement. Data in the RPG application indicated that, although only 2.1 percent of the population in Oregon was African American, 8.2 percent of children in foster care were African American. Moreover, 30 percent of children in foster care in Multnomah County were African American. To be eligible for FRS (as opposed to services as usual), parents were supposed to:

- Be recovering from SUD.
- Be part of either a past or current case with the Multnomah County Department of Human Services child protective services or be at risk of having a case opened.

> To evaluate services, VOAOR and TMC used a matched comparison group design to test the impact of the Family Recovery Support Program. Comparison group families were recruited through a subset of the agencies and organizations that conducted outreach for families in the program. However, comparison group members did not access the drop-in center because of constraints such as geography and the time pressures faced by families. Outcomes were collected in each of five domains for both program and comparison groups: child well-being, permanency, safety, recovery, and family functioning.◢

C. Intervention

FRS provides a network of ongoing support for families in recovery. The drop-in center offers supervised visits between parents and children not in their custody; parent coaching; recovery meetings; meals; child care; family recreation; computers; a resource board with information posted on local services, programs, and agencies; and an opportunity to connect with other parents and families. Under the program, parents first developed a recovery support plan with their FRS primary point of contact. The recovery support plan included services selected from a menu of options that were aligned with that family's needs and

available at the drop-in center. The menu of options extended to motivational interviewing, individual and family counseling, Parents Anonymous,® Beyond Trauma, life skills development, housing support, employment support, and two new services: the Nurturing Parenting Program and Mindfulness-Based Relapse Prevention (MBRP). Of these options, the cross-site evaluation tracked three: Nurturing Parenting, MBRP, and Beyond Trauma. Nurturing Parenting is a parenting class, and MBRP is a recovery program for those who have already undergone SUD treatment. Beyond Trauma is designed to help women and girls recover from the effects of trauma in their lives.[36]

The project chose these program models because key project leaders were familiar with them from previous work; moreover, the models responded to the needs of FRS's target population of adults in recovery. For example, Nurturing Parenting is a family-based program for the prevention and treatment of child abuse and neglect. It focuses on developing parents' knowledge, awareness, and skills in five areas. Participants attend 90-minute sessions once a week for 15 weeks. FRS planned to offer the program to 14 of its clients each year (7 parents in each of two sessions) at the drop-in center.

MBRP, delivered by VOAOR, is described as a treatment approach developed for individuals in recovery from addictive behaviors. MBRP practices promote recovery from SUD by cultivating mindful awareness and fostering greater sensitivity to triggers, destructive habitual patterns, and "automatic" reactions.

Services were designed to be trauma-informed, culturally responsive, and strengths-based. Parents started FRS after they finished SUD treatment. Upon request, parents were matched to a certified peer recovery mentor employed by TMC. Recovery mentors are peers with more recovery experience than the person whom they serve. They encourage, motivate, and support a person who is seeking to establish or strengthen his or her recovery (HHS 2009b). Certified recovery mentors met the standards established by the Oregon Health Authority. Parents could also work with a resource specialist and/or a therapist.

D. RPG families at baseline

FRS was designed for parents, but since the Children's Bureau set an RPG goal to improve child outcomes, for the cross-site evaluation the project identified a focal child of each RPG participant for data collection. About 37 percent of focal children in the RPG cases had at least one substantiated report of maltreatment in the year before the family enrolled in FRS. Twenty-nine percent of focal children had been removed from their homes in the year before enrollment. Thirty-six percent of focal children presented symptoms of post-traumatic stress at program entry.[37] Only 1 percent of focal children, however, exhibited deficits in age-appropriate social and relationship skills.[38]

Nearly half (48 percent) of adults had been enrolled in a state-funded SUD treatment setting in the year before enrollment, reflecting FRS's strategy of enrolling parents after completion of treatment.

[36] Parents Anonymous® is a prevention and treatment program intended to strengthen families at risk of becoming (or already) involved in the child welfare system; the families face behavioral health challenges or other family issues(parentsanonymous.org).

[37] The Trauma Symptom Checklist for Young Children (TSCYC) is a standardized instrument that measures trauma symptoms in children age 3 to 12 (Table I.2). According to the TSCYC user manual, total scores in the highest range indicate the presence of symptoms of post-traumatic stress disorder.

[38] The Socialization Subscale of the Vineland Adaptive Behavior Scales measures social and adaptive behavior (Table I.2). The composite score on the Socialization Subscale places children into one of five adaptive behavior levels. We report the percentage of those scoring in the lowest of the five levels, indicating low levels of age-appropriate social and relationship skills.

Consequently, self-reported substance use in the past 30 days was low at enrollment. Among those who did report use, 12 percent said that they used cannabis, the most commonly used substance, followed by amphetamines (9 percent). More than 4 percent of respondents reported the use of no other drugs. In Oregon, cannabis has been legal for medical use since 1998 through the Oregon Medical Marijuana Act and for recreational use since 2014 through Oregon Measure 91. Since the passage of Measure 91, adults age 21 and older may legally purchase cannabis from licensed retailers and use it recreationally in private areas.

E. Program participation

Almost one-fourth (23 percent) of adults who enrolled in FRS enrolled in at least one EBP as part of the services they received. Of those enrolled in an EBP, most (88 percent) enrolled in only one, with 46 percent enrolled in Beyond Trauma, 42 percent in Nurturing Parenting, and 25 percent in MBRP. During site visits conducted for the cross-site evaluation, program staff explained that, beyond the fact that participation in any of the three EBPs was voluntary and dependent on the goals families set in their service plans, clients did not want to attend more than one EBP at a time. Depending on how often new session cohorts began, when sessions were held, and how long families stayed active in FRS, families might not be able to participate in more than one EBP during their enrollment period. Those not enrolled in an EBP might have participated in one or more of the other services not tracked by the cross-site evaluation, such as support from a peer mentor, motivational interviewing, individual and family counseling, or Parents Anonymous.® However, a substantial proportion of enrollees did not participate in any program services.

By April 2019, 44 percent of cases enrolled from the beginning of the program had been closed. Of these, 71 percent of cases had completed the program. Others exited FRS without completion for reasons shown in Table VI.2. The average duration of enrollment in FRS for all cases, including those still open, was 383 days, or about 13 months. Program staff said that recovery support is not time-limited, but, for purposes of the cross-site evaluation, the project set the formal end of programming at 6 months, at which time the project staff would collect follow-up data. Seventy-nine percent of cases were enrolled for at least 6 months.

Table VI.2. Reasons for case closures in FRS

Characteristic	Number of families	Percentage of families
Case closed (n = 103)	45	44
Of closed cases, reasons for case closure[a] (n = 45)		
Family completed the Family Recovery Support Program	32	71
Unable to locate family	10	22
Family was nonresponsive	7	16
Family declined to keep participating	6	13
Other	1	2

Source: RPG Enrollment and Service Log data from April 2019.

[a] Percentages sum to more than 100 because grantee staff could select more than one reason for case closure. The calculations exclude open cases.

F. Implementation

1. Staff turnover was an ongoing challenge at many levels

VOAOR and TMC faced ongoing turnover among staff in a variety of positions, but particularly among the certified recovery mentors. The program attributed the turnover among mentors to the availability of higher-paying jobs in other recovery support programs in Oregon. At the same time, VOAOR and TMC sought to hire staff who resembled the community they planned to serve, but they had difficulty in recruiting and retaining African American staff. To address the challenge of staff turnover, VOAOR and TMC increased the salaries offered to new hires. They also began cross-training all staff so that they could continue offering services to families despite staff turnover.

Staff turnover at organizations outside the partnership also posed a problem. When staff turned over at agencies that had agreed to refer potential participants to FRS, VAOR had to introduce FRS to their successors and encourage them to keep referring people.

During site visit interviews, project leaders also cited the turnover of child welfare staff as a challenge. A change in DHS leadership disrupted DHS's participation in the FIT collaborative. It led to additional staff changes at several levels in the child welfare system, including among direct service staff, making it difficult for the project to schedule outreach appointments at local DHS offices. Despite these changes, the project built a good relationship with DHS, chiefly by including a DHS representative at weekly project staff meetings. But the enormous demands on the child welfare system's time and resources meant that DHS could not participate as actively as partners had hoped. Turnover among the child welfare staff only amplified the time and resource constraints. Turnover either increased the burden on those who would otherwise have contributed to FRS or made it necessary to educate new staff members about RPG and engage them in the project.

2. Developing enrollment processes for the drop-in center model required creativity and flexibility

When VOAOR and TMC began implementing FRS, staff devoted considerable time to collecting information from participants and creating a recovery support plan for them during their first visit. However, many of those individuals never engaged in services. In response, VOAOR and TMC developed a new two-step enrollment process. People making their first contact with the program received a pre-enrollment packet with information about services, a contact sheet, a demographic questionnaire, and a release-of-information form (if they were in SUD treatment). Staff then used the contact information collected at the pre-enrollment stage to reach out to clients. If potential participants returned for a second visit, staff enrolled them in FRS and then collected more information to develop a recovery support plan.

3. Enrollment fell short of plans, but not for lack of effort

As with the other RPG3 projects discussed in this report, the Oregon project did not enroll the number of participants it expected to serve. The project had planned to enroll 136 parents per year, for a total of 680 parents over five years. In total, 103 adults were enrolled in the program, according to records kept by the cross-site evaluation. By October 2018, the grantee reported a total enrollment of 291 adults. Several reasons explain the discrepancy between the numbers reported by the grantee and the numbers in the cross-site evaluation. First, FRS began enrollment in January 2015, but because the Children's Bureau did not receive Office of Management and Budget clearance for RPG3 data collection until June 2015, six

months elapsed before enrollment could be tracked in the cross-site evaluation data collection system. In addition, project staff did not enroll participants in the local and cross-site evaluations at the same time that they enrolled them in FRS. Instead, they notified evaluation staff at the Regional Research Institute once someone enrolled in FRS; evaluation staff then contacted the enrollee and asked her also to participate in the local and cross-site evaluations. Evaluation staff members were not always able to contact all new enrollees, and some of the contacted enrollees declined to participate in the evaluations.

The gap in evaluation enrollment aside, the grantee noted in its April 2017 progress report that the project was working with people who, though at risk of involvement with the child welfare system, had not necessarily completed treatment but instead were at various stages of recovery from SUD when they were referred or recruited to FRS. In addition, some parents were still using substances, including some who might have been experiencing homelessness or in other unstable situations that made it too difficult for them to participate in the RPG-related services offered by the project (if they were still using substances, they would not be part of the target population). Project staff examined referral data and reported that half of the new referrals for the reporting period received at least one service and might have had a pre-enrollment folder opened, but never enrolled in FRS.

To meet its enrollment goals, the project therefore had to obtain many more referrals than it had projected. Notably, the project cast a wide net, conducting active outreach to 100 or more local entities and programs, either seeking referrals from staff or directly recruiting adults served by these entities and programs. Planned outreach began early in the grant period and extended to several recovery clubs and recovery housing providers, DHS child welfare case workers and social service providers, the county public defender's office and department of community justice, and several treatment centers. To improve enrollment later in the grant, the project sought referrals from an even wider range of organizations and programs, even contacting correctional facilities, career or health fairs, youth clubs, and local professional associations. Sometimes the project was able to recruit directly from the adults served by local programs; at other times, it informed program or organization staff about FRS and encouraged them to refer clients or the parents of youth they served who might be part of the RPG target population.

4. Retaining families in services was a challenge, but retention improved over time

Retaining eligible families in services was also an ongoing challenge. During site visit interviews, project staff attributed the challenge partially to the voluntary rather than mandatory nature of services. Project staff also reported that their target population included mostly low-income single parents who faced several barriers to participation such as irregular work schedules and the lack of child care.

To help retain families, VOAOR and TMC provided transportation (in the form of bus tickets) and worked to make services enjoyable and engaging for families. They held celebrations such as an annual holiday party and a summer picnic. They also offered participation incentives such as toys, food, clothes, and gift cards. Project staff tried to create a sense of community among families and promote the drop-in center as a place where parents could spend time with other parents.

G. Changes in participants' outcomes

Families who enrolled in FRS improved on aspects of adult well-being and child safety, permanency, and well-being. On average, both adults and children exhibited fewer trauma symptoms than at program entry. Children were subject to less maltreatment and fewer removals in the year following RPG enrollment, compared to the previous year. Adults' levels of substance use were similar at program entry and exit. In

Table VI.3, we provide an overview of whether there was a favorable or unfavorable change or no significant change for each of the outcomes assessed at baseline and follow-up.

Table VI.3. Changes in key outcomes from baseline to follow-up for FRS participants

Outcome	Favorable (+), unfavorable (-), or no significant change (0)
Adult recovery	
Drug use (ASI)	0
Alcohol use (ASI)	0
Adult well-being and family functioning	
Trauma symptoms (TSC-40)	+
Parenting stress (PSI-SF)	0
Child safety and permanency	
Any maltreatment: Abuse, neglect, and other types	+
Removed from the home	+
Child well-being	
Socialization skills (Vineland-II)	0
Trauma symptoms (TSCYC)	+

Source: FRS's administration of standardized instruments at baseline and exit, including data submitted to the cross-site evaluation through April 2019.

Administrative records in the years before and after RPG enrollment from state or county child welfare agencies and SUD treatment agencies, obtained by grantees and submitted to the cross-site evaluation through April 2019.

1. Child safety improved, and trauma symptoms lessened over the course of RPG programming

Reports of substantiated maltreatment declined. Although 39 percent of focal children had a substantiated report of maltreatment in the year before programming, just 11 percent had a report during the year after program enrollment. Similarly, although 34 percent of focal children had been removed from their homes at some point during the year before RPG entry, only 2 percent were removed during the year following enrollment.

Children's trauma symptoms also declined over the course of RPG programming. At program entry, 38 percent of children were at risk for PTSD, as indicated by the number and severity of trauma symptoms, but 20 percent were at risk for PTSD by program exit. Children's social and relationship skills did not change, remaining close to national averages at both program entry and exit.

2. On average, changes in adult participants' outcomes on substance use and well-being were mixed from program entry to exit

The program served adults who had already completed SUD treatment. Participation in publicly funded SUD treatment therefore declined from 49 percent in the year before RPG programming to 22 percent during the year of programming. The percentages of participants with high levels of alcohol and drug use

decreased slightly between program entry and exit, but the change was not statistically significant.[39] Rates of use for the most frequently used substances were essentially stable. The rate of cannabis use was 12 percent at both program entry and exit, and the rate of amphetamine use was 9 percent at entry and 11 percent at exit.

Adults had fewer trauma symptoms at the end of the program than at program entry.[40] However, the percentage of adults with elevated levels of parenting stress was the same at program entry as at program exit (13 percent).[41]

[39] The Addiction Severity Index (ASI) is a standardized instrument that measures self-reported drug use within the last 30 days (Table I.2). We define high levels of drug and alcohol use if scores on the alcohol use or drug use scales were above the national averages of people in SUD treatment settings described in McClellan et al. (2006).

[40] The Trauma Symptoms Checklist-40 (TSC-40) measures the number and severity of symptoms from childhood and adult trauma (Table I.2). Mean total scores on the TSC-40 decreased by 24 percent between entry and exit.

[41] The Parenting Stress Index-Short Form (PSI-SF) measures stress specifically related to the adult's role as a parent (Table I.2). Those with elevated levels of parenting stress were those whose total scores were in the "clinically significant" range described in the PSI-SF manual.

VII. Synthesis

In Chapters III through VI, we examined partnerships, populations served, implementation experiences, and participant outcomes for each of the four partnerships awarded RPG funding in 2014. Even though we can learn a lot from the individual experience of each RPG3 project, we can also benefit from additional insights with a different perspective. The final cross-site evaluation report for the RPG2 cohort of 17 RPG projects aggregated data to draw conclusions about RPG as a whole (HHS 2020a), but could not describe the partnerships, projects, implementation, and outcomes for each site. This report does not aggregate outcome data across sites.

This chapter provides a look across the more detailed, site-specific results presented in Chapters III through VI. It reveals overall findings—along with four overarching themes or takeaways—that might be important for future RPG partnerships, and for the Children's Bureau when refining its funding strategies and overseeing projects. Going forward, we generally refer to the projects by the states they were located in (Florida, Kansas, New York, and Oregon).

A. Partnerships

Partnerships were relatively small, and one or two partners provided the core RPG services. The cross-site evaluation of RPG2 found that the most connected RPG2 partnerships, as measured by their communication and coordination, were small to moderate in size (HHS 2020a), with between 4 and 12 partners. Less connected projects had from 18–24 partners. For RPG3, the number of main partners ranged from 6 to 9 (including the grantee) and varied slightly over time in each project.[42] In addition, each project relied on no more than two partner organizations to deliver its selected program model or models. In three states, the lead agency provided the RPG-funded intervention (New York) or contracted with one agency (Florida) or two agencies (Kansas) to do so. In Oregon, the grantee together with one other agency provided RPG core services. (All projects sometimes referred families to external support services.) Other RPG3 partners played a variety of roles—referring families to RPG, offering SUD treatment or other supplemental services, providing leadership on steering committees, supporting buy-in or collaboration with related service systems or agencies such as behavioral health or family courts, providing administrative data for the local and cross-site evaluations, or designing and conducting evaluations required under the terms of the grant. All RPG3 projects successfully implemented their programs and completed rigorous evaluations, including addressing challenges. Thus, keeping partnerships small or modest in size, and minimizing the number of core service providers, might be a good idea for future RPG projects.

Takeaway 1: Close relationships with the child welfare system helped projects succeed.

A distinguishing characteristic of the RPG3 cohort of partnerships was the strength of partnerships' links to the child welfare system in their respective states. Some grantees or RPG providers were part of those systems and therefore already served families who were eligible for RPG.

Furthermore, in two of the four RPG3 projects (Kansas and New York), the state or local child welfare agency had an active interest in the outcomes of the projects and their evaluations, motivating them to refine their child welfare programs. ◢

Agencies in the child welfare system were partners in all four projects, and played a

[42] Grantees could add or drop partners as they implemented and refined their projects.

central role in three of them. Even though several types of entities are eligible to be lead applicants for RPG, all partnerships must include the state child welfare agency.[43] However, the RPG terms do not spell out the type and degree of involvement for the child welfare agency, and both vary. Although 3 of the 17 projects in the RPG2 cohort were led by state or county child welfare agencies as grantees, some RPG2 projects had difficulty engaging with their child welfare systems (HHS 2020a). In three of the four RPG3 states (Florida, Kansas, and New York), the grantee or its contracted RPG providers were part of the child welfare system, and in the fourth, child welfare also played an active role. In Florida, Our Kids of Miami-Dade/Monroe, Inc. was part of Florida's privatized child welfare system. The Florida Department of Children and Families already contracted with Our Kids to oversee a network of accredited providers of case management and other child-welfare–related services. Therefore, Our Kids had both access to child welfare families and experience working with them.

In Kansas, the grantee (University of Kansas School of Social Welfare) partnered with KVC Behavioral Healthcare and Saint Francis Community Services to deliver its program model. Similar to the situation in Florida, both agencies were under contract to the Kansas Department of Children and Families as part of that state's privatized child welfare system, and already served families involved with the system.

Montefiore Medical Center already enjoyed a strong partnership with the New York City Administration for Children's Services before the grant. It was providing services to families in the child welfare system under the Family Treatment and Rehabilitation program, which was the basis for enhanced services provided for RPG.

Though not responsible for providing the RPG program models or referring participants, the Multnomah County Department of Human Services was part of the Oregon RPG partnership. It provided some in-kind services such as case management, and it expedited RPG participants' access to TANF, housing services, and intensive safety and reunification services. Oregon's partnership focused on families already in the SUD treatment system; some of the families were already involved with child welfare, and others were at risk of child maltreatment.

In two projects, the RPG evaluation addressed questions of direct interest to the state or local child welfare system. The Kansas and New York RPG projects received strong support from their child welfare agency partners for rigorous evaluations because both entities wanted to test the program models implemented under RPG3. As described in Chapters IV and V, Kansas was already using a version of Strengthening Families in all child welfare regions, and the RPG project tested a version for very young children for potential use in the child welfare system. In New York, the New York City Administration for Children's Services was interested in testing an enhanced version of an existing program for child welfare families; Montefiore implemented and evaluated the enhancements under RPG.

SUD treatment providers and/or behavioral health organizations were also key partners. Three of the four projects (Florida, New York, and Oregon) partnered with SUD treatment providers or behavioral health coordinating entities. Florida partnered intentionally with a network of SUD treatment providers to obtain and ultimately expand the number of treatment slots available to RPG families in particular, and to families in the child welfare system in general. Moreover, Florida shifted its contract for provision of its RPG program model to a treatment agency. The change in providers represented the first time in Miami-Dade County that an SUD treatment provider crossed over to provide child welfare services. The New

[43] Specifically, the state child welfare agency responsible for the administration of the state plan under Title IV-B or Title IV-E of the Social Security Act had to be a partner, except in the case of partnerships entered into by tribes or tribal consortia. No tribes or tribal consortia were part of RPG3.

York grantee, Montefiore Medical Center, provided SUD treatment within its system. Montefiore expected to provide SUD treatment to all RPG participants in need of treatment, but, as implementation proceeded, some participants received treatment elsewhere. The Oregon project, which planned to serve families once an adult completed SUD treatment, included numerous SUD treatment providers as planned referral sources. One such provider also operated one of the core recovery support components of the RPG project.

B. Program models

All four RPG3 projects offered parenting programs and support for SUD recovery. As shown in Table VII.1, all four projects offered program models designed to strengthen parenting or families (Multidimensional Family Therapy, Strengthening Families, Incredible Years, and Nurturing Parenting).[44] New York and Oregon also offered program models designed to support SUD treatment and/or recovery after treatment (Seeking Safety, Mindfulness-Based Relapse Prevention, and Beyond Trauma). In addition, three of the four projects (excluding Kansas) offered peer or group recovery supports, and New York provided motivational incentives through contingency reinforcement.

Model developers directly supported implementation and model fidelity for two projects. For a sound evaluation or successful replication of an evidence-informed or evidence-based model, implementation must adhere to the model's specifications and guidelines. Both Florida and Kansas benefitted from the relationships they established with the purveyors of their models, who worked closely with them to support implementation and monitor model fidelity. The developer of Multidimensional Family Therapy-Family Recovery met weekly with program staff in Florida to provide coaching and help develop participants' service plans. The purveyor of Strengthening Families Program: Birth to Three (SFP B–3) made site visits to and held regular technical assistance calls with providers while also reporting to the project's steering committee on implementation and fidelity. With session facilitators documenting their group workshops or other activities, the SFP B–3 purveyor was able to report regularly to the grantee on fidelity.

[44] Family strengthening was the most common type of program model offered by RPG2 grantees (HHS 2020a). Fourteen of the 17 projects enrolled families into family strengthening programs, and nearly half (48 percent) of all RPG families enrolled in programs of this type. Even projects that provided SUD treatment included curriculum-based family strengthening programs as part of RPG.

Table VII.1. Key program models and services offered by RPG3 projects

State (and project name)	Program model(s) (and percentage of participants who enrolled in this model)[a]	Description of program model and other core service(s) offered
Florida: Miami-Dade IMPACT Project[b]	Multidimensional Family Therapy-Family Recovery (95%)	Trauma-informed, home-based SUD treatment and family strengthening program to address the factors that might lead to the removal of children from the household
		Support from a peer specialist
Kansas: Kansas Serves Substance Affected Families[b]	Strengthening Families Program: Birth to Three (100%)	Family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems
New York: Enhanced Family Treatment/ Rehabilitation	Incredible Years Parenting Class (64%)	Parenting skills workshops to help parents become more effective and less likely to use harsh discipline
	Seeking Safety (90%)	Manualized treatment for adults and adolescents with a history of trauma and substance use issues
	Contingency reinforcement[c]	Incentive payments for attendance or attaining program goals goals
Oregon: Family Recovery Support[d]	Nurturing Parenting Program (42%)	Family-centered, trauma-informed program designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices
	Mindfulness-Based Relapse Prevention (45%)	Designed as an after-care program integrating mindfulness practices and principles with cognitive-behavioral relapse prevention skills
	Beyond Trauma (46%)	Program to help women and girls recover from the effects of trauma in their lives
	Parents Anonymous®[e]	Support group
		Support from a peer recovery mentor

Note: The cross-site evaluation tracked RPG3 enrollment in program models that were core elements of the grantee's RPG services and were formally named and specified or manualized by their developers. This excluded peer support and contingency reinforcement, for example. Partnerships provided additional models, services such as peer support, or activities not tracked for the cross-site evaluation as well as referrals outside the partnership for additional services.

[a] Excludes participants who were never enrolled in any program model that was tracked for the cross-site evaluation.

[b] Partnership worked with model developer to adapt and/or evaluate the model.

[c] All of the 60 percent of RPG participants in New York who enrolled in at least one program model also received contingency reinforcement payments; however, the cross-site evaluation did not track participation in this program.

[d] Instead of enrolling all participants in one or more intervention models, the Oregon partnership planned to provide a recovery-oriented system of care that offered several alternative program models depending on participant needs and interests.

[e] Not tracked by the cross-site evaluation, so percentage of participants enrolled is unknown.

C. Enrollment and retention

The Florida, Kansas, and New York RPG projects received referrals as part of their respective child welfare systems' operations, and their preexisting roles within the systems helped these projects achieve their enrollment targets. The RPG projects in Florida and New York relied on a single referral source: their state or local child welfare agency(ies). For both projects, the cognizant child welfare agency was already referring child welfare cases to the lead or implementing agencies, with a subset of those cases eligible for RPG. The Florida grantee and Kansas RPG providers were already under contract to the state child welfare agency to provide child welfare services. They added RPG services to their existing portfolios and enrolled appropriate clients, as did Montefiore in New York. As one result, all three projects were able to enroll their planned target populations, including the specific families they aimed to serve. For example, in Florida, a families they served did not have a child in an out-of-home placement, but in Kansas, the families served did have a child in such a placement. The three states' strategy of serving families already known to the child welfare system—whether or not families had open cases—and their close connections to the child welfare system helped them meet or approach their planned total RPG enrollment numbers. This is another way their close linkage to child welfare benefitted them.

All four RPG3 projects diagnosed and proactively addressed enrollment shortfalls. Despite having access to the child-welfare–involved groups they planned to serve, at some point during the five-year grant program, all four RPG projects had troubleexperienced difficulty in meeting their enrollment targets.[45] In Florida, a small agency faced considerable difficulty as it implemented a new program model as part of RPG while participating in the randomized controlled trial for the project's RPG evaluation. In New York, the start of recruitment was delayed by the need to complete memoranda of understanding between the core partners and to obtain project approval from an institutional review board. For Oregon's RPG project, staff turnover at the state's child welfare agency and within the SUD treatment agencies expected to refer families to RPG reduced enrollment considerably below the targets set by the project. And because enrollment was voluntary, a smaller-than-expected proportion of families referred to RPG chose to enroll in the program. Enrollment by staff at the grantee's drop-in center proved challenging because many families thought of the center as a source of as-needed resources rather than a program provider.

Takeaway 2: Projects must be proactive and persistent in addressing enrollment and retention challenges.

In virtually all RPG2 projects, enrollment was lower than expected, and RPG3 projects likewise faced shortfalls. Close relationships with the child welfare system, coupled with proactive responses to emerging enrollment shortfalls and retention challenges—such as adding locations, changing an RPG provider, or simplifying enrollment—helped three RPG3 projects meet or approach their enrollment targets. The fourth project, which faced the greatest struggle with enrollment, was also proactive. It shifted from a sharply focused outreach strategy to a much broader one that identified more potential RPG families, helping the project maintain enough momentum to complete the program and evaluation.◢

[45] This was not an uncommon problem for the RPG2 cohort either, and it has several possible causes. For example, initial grant application estimates of the size of the target population or the proportion that can be successfully referred, enrolled, and retained in RPG might be unrealistic. Unforeseen problems outside the partnership's control sometimes arise (HHS 2020a). In addition, issues within the partnership, such as difficulty filling staff positions, or turnover in project staff or in leaders of partner organizations, can disrupt recruitment and referral procedures (Xue et al. 2018).

The projects actively addressed these challenges, each using different strategies depending on the problem(s) it faced. The Florida partners put RPG recruiting on hold, tapped another provider agency, transferred RPG program operations to that agency, and then resumed enrollment. Agencies that provided RPG in Kansas offered the program in more locations. New York simplified its enrollment procedures and worked harder to establish and maintain connections to key staff in the child welfare offices, reminding and encouraging the offices to refer eligible participants to RPG. The Oregon partnership was not tied in as closely as other partnerships to the child welfare system but rather looked to SUD treatment providers to refer potential participants to RPG. It significantly expanded its outreach beyond SUD treatment providers to other agencies.

Projects monitored retention and developed and tested strategies to improve it. Projects instituted activities aimed at improving the retention of enrollees through program completion. In Florida, a therapist would enroll a family in RPG and then assign the family to a different therapist, who worked with the family during the program. Some families dropped out rather than begin working with a new therapist. In response, the project changed the practice so that families could stay with the therapist who enrolled them. Providers in Kansas worked hard to maintain attendance at group program sessions by providing dinner, sending leftovers home with families, and offering make-up sessions. They recognized that families could not realistically attend every session of their group. New York provided incentives through its contingency reinforcement program and established trusting relationships between project staff and participants. To help retain families, VOAOR and TMC in Oregon provided transportation (in the form of bus tickets) and held activities to make services enjoyable and engaging for families.

D. Families served

The safety and permanency of focal children at baseline reflected the chosen target populations of each project and the project's relative success in enrolling families with the desired characteristics. Families were referred to Florida's RPG project as part of the child protective investigation process. Families had to be at risk of having a child removed, but with no open case in dependency court. Analysis by the cross-site evaluation showed that 98 percent of focal children had one or more substantiated or unsubstantiated reports of maltreatment during the year before the family enrolled in RPG (Figure VII.1). The top bar of Figure VII.1 shows, the percentage of focal children with any reports of maltreatment during the year before enrollment in RPG, rising from 0 percent on the left to 100 percent on the right. The percentage for each grantee is shown in the boxes below that bar. The boxes along the top bar show that just 7 percent of the focal children enrolled in the RPG project in Kansas had reports of maltreatment the year before their families enrolled in RPG, whereas focal children in the RPG projects in Oregon, New York, and Florida had higher rates of maltreatment reports. Note that nearly all the focal children in the Florida project (98 percent, shown at the far right) had one or more such reports—consistent with the project's intended target population. The bottom bar in that figure shows the percentage of children who were in out-of-home placements at some point during the year before the family enrolled in RPG. Also consistent with the Florida RPG project's criteria, none (0 percent) had been removed from their homes during the year. The Florida percentage is shown at the far left side of the bar. These patterns reflect each project's chosen target population and its success in enrolling members of that population.

Figure VII.1. Maltreatment and removals from the home before RPG enrollment: Variation across projects

Percentage of focal children with reported maltreatment during the year prior to enrollment

Percentage of focal children removed from the home during the year prior to enrollment

Takeaway 3: Evaluation measures need to be interpreted in context

RPG serves families with a child in or at risk of out-of-home placement as a consequence of adult substance use issues. RPG3 projects sought to serve notably different subgroups of this population based on a family's child welfare and SUD treatment status. It is important to understand the projects' various strategies in order to accurately interpret differences in baseline measures across the projects, as illustrated in Figure VII.1, and to understand outcomes that seem counterintuitive, as seen in Figure VII.2. For example, in addition to the statistics in the two figures, there was a statistically significant increase in *maltreatment* in families enrolled in the Kansas project (Appendix Table A.2). However, Figure VII.2 shows the baseline rate of maltreatment in the Kansas project was low, at just 7 percent, because most children had been removed from the home before enrollment and thus were not exposed to possible maltreatment during that time. Starting from this low rate of maltreatment, the increase to 13 percent, though statistically significant, represents only a small number of removals. Similarly, there were statistically significant increases in removals in the Florida (from 0 percent at baseline to 8 percent at follow-up; Appendix Table A.1) and New York projects (from 1 percent at baseline to 9 percent; Appendix Table A.3). Again, this represents a small number of removals relative to a rare event at baseline. In these three projects, even though the direction of changes in maltreatment and removals appears unfavorable, the changes from baseline to follow-up do not necessarily represent an adverse effect of the program. Instead, increases were to be expected because with such low baseline rates, there was no real opportunity to show improvements in these outcomes. ◢

Kansas, on the other hand, sought to enroll families with a child from birth to age 3 already in foster care as it worked toward a goal of family reunification. Ninety-four percent of focal children had been removed from their homes at least once during the year before RPG. Given that those children were not in their homes during some or all of that period, just 7 percent had substantiated or unsubstantiated reports of maltreatment during that time. Thus, the Florida and Kansas enrollees were "mirror opposites" of each other at baseline: one with few removals and many reports of maltreatment, the other with a low rate of maltreatment but a high rate of removals.

Among New York's RPG families, maltreatment was fairly common at baseline: 69 percent of focal children had one or more such reports. However, only 1 percent of children had been removed from their home during the same period. This reflected the fact that the New York program (FTR) was an alternative to removal; in fact, removal of a child disqualified a family from FTR. The few removals had occurred before those families were referred to FTR. In Oregon, rates of maltreatment reports and removals were similar at baseline: 39 and 34 percent, respectively. Their eligibility criteria were broader than those used by Florida, Kansas, and New York; namely, the project sought to enroll families with an adult in recovery from SUD that were part of either a past or current case with child protective services or at risk of having a case opened.

Similarly, projects' different approaches to identifying families with adult substance use issues was reflected in differing rates of substance use and differing rates of participation in SUD treatment, before and after enrollment. Oregon's target population and referral sources differed markedly from those of the other RPG3 projects. Oregon's target population was families in which a parent or caregiver was completing or had completed SUD treatment.

Based on its strategy, Oregon served a larger proportion of adults who had been in SUD treatment the year before they enrolled in RPG (48 percent) than either Kansas (25 percent) or Florida (26 percent) did, as shown in the boxes under the top bar in Figure VII.2. (Treatment data were not available for New York). That bar shows the percentage of adults followed for the cross-site evaluation who were enrolled in SUD treatment at any point during the year prior to RPG enrollment. Because a relatively large percentage of these adults had recently participated in or completed treatment, only a small proportion of adults in the Oregon program reported high levels of drug or alcohol use (7 and 8 percent, respectively, as shown in Appendix Table A.4) in the 30 days before enrolling in RPG. Compared to Oregon, smaller proportions of adults followed for the cross-site evaluation in Florida and Kansas had participated in SUD treatment before enrolling in RPG, and higher proportions in both states (and in New York) reported high levels of drug and/or alcohol use before enrolling in RPG (shown in Appendix tables A.1 and A.2, respectively). As the second bar in Figure VII.2 shows, just 22 percent of adults in Oregon participated in publicly funded SUD treatment after enrolling in RPG; by design, many had completed treatment at the time of enrollment.

The proportion of adults who entered treatment after enrolling in RPG differed substantially between the Florida (80 percent) and Kansas (17 percent) projects. To be eligible for enrollment in Florida, families had to present with suspected substance use or verified substance use indicators as assessed by the local child welfare agency. Similarly, in Kansas, families had to include an adult with an SUD who was identified as a contributing factor to a child's removal or risk of removal from the home. Given these similar criteria, why was the proportion of adults in treatment after enrollment so much higher in Florida than in Kansas? There are several possible reasons.

As the only RPG3 partnership that did not include an SUD treatment provider, the Kansas project might not have placed the same emphasis on referring participants to treatment as some other RPG projects did.[46] The underlying rate of SUD might have been higher in the Florida target population than in the Kansas target population, or the families might have been referred to the Kansas project in the absence of a diagnosed SUD and instead with a suspected problem that, once assessed, did not require treatment.

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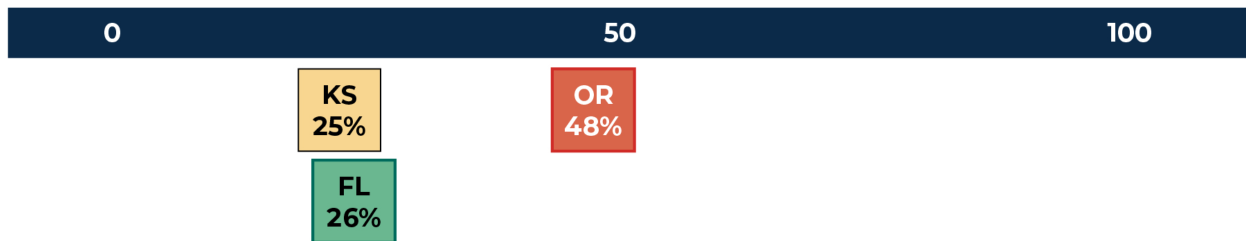
[46] No organization identified by the Kansas grantee agency for inclusion in the RPG partner survey described itself as an SUD treatment provider, though one of the agencies that operated the SFP-B3 program for RPG did address mental health, psychiatric disorders, and trauma.

Further, there may have been differences in the extent to which the families in each RPG project needed to comply with mandated SUD treatment, either as a condition of an open child welfare case or other court order. More treatment providers and open treatment slots might have been available in Florida. Also, the agency that provided RPG in Florida was a behavioral health agency that might have assigned a higher priority to assessing and treating SUD compared with one of the Kansas implementing agencies that did not provide SUD treatment as its traditional mission.

Figure VII.2. Participation in SUD treatment before and following RPG enrollment: Variation across projects*



* Data not available for New York.

E. Outcomes

Most outcomes for RPG3 participants improved between RPG enrollment and exit, which was similar to the findings of the RPG2 cross-site evaluation (HHS 2020a). Based on data aggregated across the 17 RPG projects funded in 2012 (RPG2), the cross-site evaluation found that most adult and child outcomes improved between baseline levels measured at enrollment and follow-up levels measured at program exit (HHS 2020a; Children's Bureau 2020). The current report did not aggregate outcomes across the four RPG3 projects because the analysis focuses on a better understanding of the findings associated with each grantee, not on the RPG3 initiative as a whole. Consequently, this report provides more nuanced findings about variation in outcome changes across projects, though with limited statistical power in the absence of pooled samples.

Project-specific RPG3 child and adult outcomes generally point in a favorable direction, with statistically significant improvements in several important outcomes. (The four tables in Appendix A show all measured outcomes for each project.) The decline in adults' drug use between baseline (RPG enrollment) and follow-up (program exit) was statistically significant in Florida. Declines in trauma symptoms were statistically significant in Oregon and Kansas. Adult depressive symptoms fell in all three projects that

measured it, with the decline statistically significant in Florida. Reports of child maltreatment fell in Florida, New York, and Oregon, and the declines were statistically significant.

There were some exceptions to these favorable outcomes. Removals increased from 0 percent before program entry to 8 and 9 percent, respectively, in the Florida and New York projects. The Florida project enrolled only families in which children were not at risk of removal, but it is not clear why there were no removals during the year before families enrolled in the New York project. Reports of maltreatment increased from 6 to 13 percent in the Kansas project. Maltreatment was low at program entry because the program focused primarily (but not exclusively) on families with a child already in foster care.

Children's socialization skills declined in all three projects that measured this child well-being outcome, but the decline was statistically significant only in Florida. For adults in Oregon, enrollment in SUD treatment declined from 49 percent the year before enrollment in the RPG project to 22 percent in the year after enrollment, but this statistically significant change reflected the project's design, which called for the enrollment of people who had recently completed treatment. There was also a statistically significant decline in SUD treatment participation in Kansas, though the reason is not clear, especially given that treatment status was not an enrollment criterion for the Kansas RPG project.

Positive and negative outcomes need to be interpreted with caution given the small samples from each project and the exclusion of comparison group data from the outcome analysis in this report. Grantees and their evaluators enrolled families that were part of their local evaluation into the cross-site evaluation and provided data on those families. Kansas counted over 300 families in its cross-site evaluation sample, but sample sizes for the other three projects were smaller, either by design or because of unexpected difficulties in recruiting families into the projects, as noted. Small sample sizes make it less likely to find statistically significant differences between outcome measures at enrollment (baseline) and follow-up.

Furthermore, without comparison group data, it is difficult to interpret outcomes. For example, it is possible to hypothesize that some statistically significant declines in outcomes would have been greater if families not been part of the RPG projects they enrolled in. That is, RPG might have protected children or adults from greater declines. (This is not to minimize concerns about the declines; RPG projects and future applicants might want to think carefully about selecting program models and services shown to improve the outcomes that declined in the RPG projects). Similarly, some improvements in outcomes, although noteworthy, might not be the result of the RPG projects but instead are associated with other factors, such as readiness for change among enrolled families.

An impact analysis using Florida, New York, and Oregon data from families enrolled in RPG and from families in comparison groups who received other services is part of a separate RPG3 cross-site evaluation study (Cole, Burnett, and Strong 2021). That study examines whether differences in the positive or negative outcomes between program and comparison group families may be attributable to participation in RPG. The present comparison of outcome measures at program entry and exit among families in RPG cannot address differences among treatment and control families.

F. Evaluations

RPG3 projects were strongly motivated to conduct rigorous evaluations, and all four did so successfully. The Children's Bureau requires all RPG partnerships to evaluate their projects. Though the bureau does not mandate rigorous designs, such as randomized controlled trials that can attribute participant outcomes to RPG, it does strongly encourage partnerships to use such designs for their local

evaluations whenever possible. In practice, conducting rigorous studies can pose great difficulties.[47] Projects sometimes lack adequate buy-in from partners or referral sources to conduct random assignment. Some projects face difficulties in finding suitable comparison groups or collecting data from members of comparison groups in addition to collecting data from target participants. Slower referrals or lower-than-expected demand for project services sometimes make it difficult or impossible to achieve enrollment targets. It is noteworthy, therefore, that all four RPG3 projects designed and successfully completed randomized controlled trial (Florida and Kansas) or quasi-experimental design (New York and Oregon) evaluations. Earlier chapters in this report and the analyses above suggest several factors that contributed to this success, including many of the factors described in Sections A through E, for example.

RPG3 shows some of the trade-offs between the selected program approaches and what evidence evaluations can produce. The program strategies chosen by RPG3 projects, and the evaluation opportunities created by them, illustrate the trade-offs RPG partners faced as they planned for both a program and its evaluation. As Table VII.1 shows, the Kansas and Florida RPG projects offered all participants a single family-strengthening program model. Thus, both projects enrolled virtually all RPG participants in their respective program models, making it possible to use the full evaluation sample to test the models' effectiveness. Kansas offered the program model on its own, without other core services. A benefit of the Kansas approach was the opportunity to conduct a rigorous evaluation of the effectiveness of one distinct model for serving its child welfare target populations and the model's fit with providers. The Florida project, in contrast, enhanced the model by making peer support specialists available to RPG families, meaning that its evaluation tested the Multidimensional Family Therapy-Family Recovery model combined with peer supports. To evaluate the effectiveness of the program model on its own, Florida would need to analyze the subsample of families, if any, that did not work with peer specialists.

Takeaway 4: Projects should carefully balance their program needs and evaluation goals.

Partnerships should design their programs to meet (1) their goals and (2) the needs of their target families; the type of evidence they can produce will follow. If families have comprehensive needs or needs that differ from those of other families, several program models and services may be required. The evaluation might then have to be designed to test a package of services, analyzing individual components only if sample sizes permit sound analysis of each component's contributions to outcomes. On the other hand, if the families to be served are relatively homogeneous in their needs, or partners express a strong desire need for evidence on a specific program model or service, then a simpler project and study may produce more useful (and easily interpreted) evidence. In either case, only a rigorous evaluation can attribute outcomes to RPG.◢

[47] Seven of the 17 RPG2 projects planned to conduct rigorous comparison group evaluations and contribute data on program and comparison groups' outcomes for a cross-site impact analysis, but only one successfully completed its rigorous evaluation as planned. Despite their commitment to rigorous evaluation, three of the seven grantees experienced challenges to their initial evaluation plans during the second year of RPG and changed their evaluation designs in ways that eliminated them from participating in the impact study (Strong et al. 2015). Other projects encountered challenges during the third year of the grants.

RPG projects that offer several program models or services, as Florida, New York, and Oregon did, might enroll only some participants in each individual model or service (Table VII.1).[48] However, when only a subset of the RPG population is enrolled in each program model, it limits the evaluation's statistical power to detect impacts of an individual program model or service. Yet, the offer of a slate of services, not just a single program model, might be required to meet the goals of some RPG projects. If an RPG project offers several program models and/or services, and families receive different combinations of them, it becomes increasingly complex to produce an estimate of the impact of any one of them alone, with sample sizes too small to demonstrate meaningful contrasts. On the other hand, such a study could potentially measure the effect of several project elements in combination and indicate if they work best in combination.

[48] Of the 17 RPG2 projects, 14 offered RPG families several EBPs, and 3 offered only 1. Even though more than half of the projects used a service approach that included a package of EBPs targeted to all families, only about 30 percent of all families in the cross-site evaluation actually enrolled in more than one EBP (HHS 2020a).

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Appendix A

RPG Participant Outcomes

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Table A.1. The IMPACT Project (Florida): Changes in key outcomes from baseline to follow-up

Outcome	N	Mean (percentage in high-severity category)[a]		Change from entry to exit		*p*-value of change	Favorable (+), unfavorable (-), or no significant change (0)
		At program entry	At program exit	Raw units	Standardized effect size		
Adult Recovery							
Drug use (ASI-SR)	66	0.08 (24%)	0.03 (9%)	-0.05	-0.49	0.002	+
Alcohol use (ASI-SR)	64	0.04 (3%)	0.02 (0%)	-0.02	-0.27	0.129	0
Enrollment in SUD treatment	60	27%	80%	53%	1.25	< 0.0001	n.a.
Adult well-being and family functioning							
Trauma symptoms (TSC-40)	64	24.8	19.8	-4.9	-0.21	0.125	0
Parenting stress (PSI-SF)	64	70.3 (19%)	67.0 (17%)	-3.3	-0.13	0.327	0
Depressive symptoms (CES-D)	65	10.3 (31%)	7.7 (17%)	-2.7	-0.31	0.008	+
Inappropriate expectations for children (AAPI-2)	23	7.0 (43%)	6.4 (22%)	-0.6	-0.34	0.102	0
Lack of empathy for children (AAPI-2)	23	7.2 (48%)	7.0 (43%)	-0.2	-0.09	0.736	0
Values corporal punishment (AAPI-2)	23	6.2 (17%)	6.3 (22%)	0.2	0.10	0.622	0
Treats children like adult peers, not like children (AAPI-2)	23	6.7 (43%)	5.7 (17%)	-1.0	-0.49	0.012	+
Oppresses children's independence (AAPI-2)	23	7.7 (57%)	6.6 (35%)	-1.1	-0.57	0.031	+
Child safety and permanency							
Any maltreatment: Abuse, neglect, and other types	60	98%	2%	-97%	-7.49	< 0.0001	+
Removed from the home[b]	60	0%	8%	-8%	0.42	0.024	-
Child well-being							
Behavior problems (CBCL)	30	48.8 (17%)	42.6 (0%)	-6.1	-0.50	0.032	+
Socialization skills (Vineland-II)	32	99.2 (0%)	92.8 (6%)	-6.4	-0.39	0.012	-
Atypical sensory processing (ITSP)	34	50%	38%	-12%	-0.24	0.254	0
Executive functioning (BRIEF)	27	50.2 (11%)	50.2 (19%)	0.0	0.00	0.993	0

Table A.1 (*continued*)

Source: Grantees' administration of standardized instruments at baseline and exit, including data submitted to the cross-site evaluation through April 2019.

Administrative records in the years before and after RPG enrollment from state or county child welfare agencies and SUD treatment agencies, obtained by grantees and submitted to the cross-site evaluation through April 2019.

[a] Definitions of the high-severity categories appear in Appendix B.

[b] As discussed in Chapter IV, Section D, given that the rate of removals at baseline was zero, there was no room for this measure to improve; therefore, the negative result for this measure should not be interpreted as a failure of the project.

ASI-SR = Addiction Severity Index, Self-Report Form; SUD = substance use disorder; TSC-40 = Trauma Symptoms Checklist; PSI-SF = Parenting Stress Index-Short Form; CES-D = Center for Epidemiologic Studies Depression Scale-Short Form; AAPI-2 = Adult-Adolescent Parenting Inventory-2; CBCL = Child Behavior Checklist; Vineland-II = Vineland Adaptive Behavior Scales; ITSP = Infant-Toddler Sensory Profile; BRIEF = Behavior Rating of Executive Function. n.a. = not applicable (enrollment in SUD treatment could be favorable or unfavorable depending on the circumstances).

Table A.2. KSSAF (KANSAS): Changes in key outcomes from baseline to follow-up

Outcome	N	Mean (percentage in high-severity category)[a]		Change from entry to exit		p-value of change	Favorable (+), unfavorable (-), or no significant change (0)
		At program entry	At program exit	Raw units	Standardized effect size		
Adult recovery							
Drug use (ASI-SR)	190	0.04 (13%)	0.04 (12%)	0.00	-0.05	0.443	0
Alcohol use (ASI-SR)	201	0.02 (1%)	0.02 (1%)	0.00	-0.05	0.519	0
Enrollment in SUD treatment	231	26%	17%	-9%	-0.21	0.015	n.a.
Adult well-being and family functioning							
Trauma symptoms (TSC-40)	201	24.3	20.7	-3.6	-0.18	0.001	+
Depressive symptoms (CES-D)	206	10.0 (26%)	9.0 (25%)	-1.1	-0.02	0.740	0
Inappropriate expectations for children (AAPI-2)	219	6.1 (18%)	6.0 (16%)	-0.1	-0.06	0.423	0
Lack of empathy for children (AAPI-2)	219	6.3 (28%)	5.5 (21%)	-0.7	-0.32	< 0.0001	+
Values corporal punishment (AAPI-2)	219	5.1 (11%)	5.2 (7%)	0.0	0.02	0.789	0
Treats children like adult peers, not like children (AAPI-2)	219	5.8 (20%)	5.3 (16%)	-0.6	-0.26	< 0.0001	+
Oppresses children's independence (AAPI-2)	219	6.0 (30%)	5.7 (24%)	-0.3	-0.12	0.126	0
Child safety and permanency							
Any maltreatment: Abuse, neglect, and other types[b]	231	7%	13%	7%	0.22	0.016	-
Removed from the home	231	94%	3%	91%	-4.49	< 0.0001	+

ASI-SR = Addiction Severity Index, Self-Report Form; SUD = substance use disorder; TSC-40 = Trauma Symptoms Checklist; CES-D = Center for Epidemiologic Studies Depression Scale-Short Form; AAPI-2 = Adult-Adolescent Parenting Inventory-2; n.a. = not applicable (enrollment in SUD treatment could be favorable or unfavorable depending on the circumstances).

Table A.3. Enhanced FT/R (New York): Changes in key outcomes from baseline to follow-up

Outcome	N	Mean (percentage in high-severity category)[a]		Change from entry to exit		*p*-value of change	Favorable (+), unfavorable (-), or no significant change (0)
		At program entry	At program exit	Raw units	Standardized effect size		
Adult recovery							
Drug use (ASI-SR)	44	0.08 (23%)	0.06 (16%)	-0.02	-0.23	0.232	0
Alcohol use (ASI-SR)	44	0.03 (0%)	0.03 (5%)	0.00	0.02	0.902	0
Adult well-being and family functioning							
Trauma symptoms (TSC-40)	44	23.8	19.1	-4.6	-0.24	0.079	0
Parenting stress (PSI-SF)	43	74.7 (23%)	73.9 (26%)	-0.8	-0.03	0.828	0
Depressive symptoms (CES-D)	44	10.6 (32%)	9.2 (25%)	-1.4	-0.16	0.339	0
Inappropriate expectations for children (AAPI-2)	44	7.0 (36%)	6.8 (32%)	-0.3	-0.15	0.425	0
Lack of empathy for children (AAPI-2)	44	7.2 (45%)	6.6 (41%)	-0.6	-0.27	0.095	0
Values corporal punishment (AAPI-2)	44	6.2 (18%)	6.3 (23%)	0.1	0.04	0.787	0
Treats children like adult peers, not like children (AAPI-2)	44	7.0 (45%)	6.5 (39%)	-0.5	-0.23	0.129	0
Oppresses children's independence (AAPI-2)	44	6.8 (43%)	6.3 (27%)	-0.5	-0.23	0.172	0
Child safety and permanency							
Any maltreatment: Abuse, neglect, and other types	55	69	36	-33	-0.69	< 0.001	+
Removed from the home[b]	55	1%	9%	9%	0.44	0.024	-
Child well-being							
Behavior problems (CBCL)	40	54.6 (30%)	51.2 (13%)	-3.4	-0.28	0.086	0
Socialization skills (Vineland-II)	34	112.8 (3%)	108.0 (9%)	-4.8	-0.20	0.312	0
Executive functioning (BRIEF)	38	53.3 (21%)	49.0 (5%)	-4.3	-0.37	0.047	+

Table A.3 (*continued*)

Source: Grantees' administration of standardized instruments at baseline and exit, including data submitted to the cross-site evaluation through April 2019.

Administrative records in the years before and after RPG enrollment from state or county child welfare agencies and SUD treatment agencies, obtained by grantees and submitted to the cross-site evaluation through April 2019.

[a] Definitions of the high-severity categories appear in Appendix B.

[b] As discussed in Chapter IV, Section D, given that the rate of removals at baseline was just 1 percent, there was no room for this measure to improve; therefore, the negative result for this measure should not be interpreted as a failure of the project.

ASI-SR = Addiction Severity Index, Self-Report Form; SUD = substance use disorder; TSC-40 = Trauma Symptoms Checklist; PSI-SF = Parenting Stress Index-Short Form; CES-D = Center for Epidemiologic Studies Depression Scale-Short Form; AAPI-2 = Adult-Adolescent Parenting Inventory-2; CBCL = Child Behavior Checklist; Vineland-II = Vineland Adaptive Behavior Scales; BRIEF = Behavior Rating of Executive Function.

Table A.4. FRS (Oregon): Changes in key outcomes from baseline to follow-up

Outcome	N	Mean (percentage in high-severity category)[a]		Change from entry to exit		p-value of change	Favorable (+), unfavorable (-), or no significant change (0)
		At program entry	At program exit	Raw units	Standardized effect size		
Adult recovery							
Drug use (ASI-SR)	75	0.09	0.08	-0.01	-0.08	0.467	0
Alcohol use (ASI-SR)	76	0.07	0.08	0.01	0.05	0.692	0
Enrollment in SUD treatment	83	49	22	-28	-0.60	< 0.001	n.a.
Adult well-being and family functioning							
Trauma symptoms (TSC-40)	75	28.6	21.8	-6.8	-0.40	< 0.0001	+
Parenting stress (PSI-SF)	52	71.0	70.5	-0.5	-0.02	0.827	0
Child safety and permanency							
Any maltreatment: Abuse, neglect, and other types	83	39	11	-28	-0.67	< 0.0001	+
Removed from the home	83	34	2	-31	-0.89	< 0.0001	+
Child well-being							
Socialization skills (Vineland-II)	68	102.5	101.9	-0.6	-0.04	0.729	0
Trauma symptoms (TSCYC)	40	58.4	53.5	-5.0	-0.35	0.031	+

Source: Grantees' administration of standardized instruments at baseline and exit, including data submitted to the cross-site evaluation through April 2019.

Administrative records in the years before and after RPG enrollment from state or county child welfare agencies and SUD treatment agencies obtained by grantees and submitted to the cross-site evaluation through April 2019.

[a] Definitions of the high severity-categories appear in Appendix B.

ASI-SR = Addiction Severity Index, Self-Report Form; SUD = substance use disorder; TSC-40 = Trauma Symptoms Checklist; PSI-SF = Parenting Stress Index-Short Form; Vineland-II = Vineland Adaptive Behavior Scales; TSCYC = Trauma Symptoms Checklist for Young Children. n.a. = not applicable (enrollment in SUD treatment could be favorable or unfavorable depending on the circumstances).

Appendix B

Risk Indicators

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Table B.1. Adult substance use and trauma experience risk indicators

Construct	Risk indicator	Instrument	Description	Criterion for risk category
Substance use severity	High level of alcohol use	Addiction Severity Index (ASI), Self-Report Form (McLellan et al. 1992)	This is an indicator of whether an adult has excessive alcohol use and intoxication frequency and of severity of problems caused by alcohol use, drawn from the alcohol use score.	Alcohol use score is above the national average of people in substance use disorder treatment settings described in McClellan et al. (2006). Specifically, we used an alcohol use score of 0.22 and 0.20 for males and females, respectively, as the threshold.
Substance use severity	High level of drug use	ASI	This is an indicator of whether an adult has excessive drug use and severity of problems caused by drug use, drawn from the drug use score.	Drug use score is above the national average of people in substance use disorder treatment settings described in McClellan et al. (2006). Specifically, we used a drug use score of 0.10 and 0.15 for males and females, respectively, as the threshold.

Table B.2. Caregiver well-being and parenting risk indicators

Construct	Risk indicator	Instrument	Description	Criterion for risk category
Parenting stress	Elevated level of parenting stress	Parental Stress Index–Short Form (PSI-SF) (Abidin 1995)	This is an indicator of whether a caregiver has a clinically significant level of stress, based on the PSI total score. The score is a summary of the overall level of parenting stress, drawing on information from the parental distress, parent-child dysfunctional interaction, and difficult child scales.	PSI-SF total score in the “clinically significant” range described in the PSI-SF test manual
Depressive symptoms	Symptoms of severe depression	Center for Epidemiologic Studies Depression Scale (CES-D), 12-Item Short Form (Radloff 1977)	This is an indicator of whether an adult demonstrates severe depression symptoms, based on the CES-D total score.	CES-D total score in the “severely depressed” range described in the CES-D test manual
Parenting attitudes	Inappropriate expectations for children	Adult-Adolescent Parenting Inventory (AAPI-2; Bavolek and Keene1999)	This is an indicator of whether a caregiver has inappropriate or unrealistic expectations for a child's development, based on the AAPI-2 expectations score.	AAPI-2 expectations score in the “high risk for child maltreatment” range described in the AAPI-2 test manual
Parenting attitudes	Lack of empathy for children	AAPI-2	This is an indicator of whether a caregiver has low levels of empathy/nurturing for their child, based on the AAPI-2 empathy score.	AAPI-2 empathy score in the “high risk for child maltreatment” range described in the AAPI-2 test manual
Parenting attitudes	Values corporal punishment	AAPI-2	This is an indicator of whether a caregiver is overly reliant on corporal punishment as a means of discipline, based on the AAPI-2 corporal punishment score.	AAPI-2 corporal punishment score in the “high risk for child maltreatment” range described in the AAPI-2 test manual
Parenting attitudes	Treats children like adult peers, not as children	AAPI-2	This is an indicator of whether a caregiver perceives a child as a means to meet self-needs (i.e., an object for adult gratification), based on the AAPI-2 family roles score.	AAPI-2 family roles score in the “high risk for child maltreatment” range described in the AAPI-2 test manual
Parenting attitudes	Oppresses children’s independence	AAPI-2	This is an indicator of whether a caregiver has an inappropriate understanding of child independence (i.e., interprets independence as a threat or as disrespect to the caregiver), based on the AAPI-2 power/independence score.	AAPI-2 power/independence score in the “high risk for child maltreatment” range described in the AAPI-2 test manual

Table B.3. Child well-being risk indicators

Child well-being aspect	Risk indicator	Instrument	Description	Criterion for risk category
Executive functioning	Impairments in executive functioning	Behavior Rating of Executive Function–Preschool (BRIEF-P; Gioia et al. 2000)	This is an indicator of clinically significant impairments in global executive functioning, drawn from the global executive composite summary score. The score captures information on all the instrument's clinical scales, including scores on the (1) inhibit, (2) shift, (3) emotional control, (4) working memory, and (5) plan/organize scales.	Global composite summary score exceeded the clinically significant threshold described in the BRIEF-P test manual.
Executive functioning	Impairments in executive functioning	Behavior Rating of Executive Function (BRIEF; Gioia et al. 2000)	This is an indicator of clinically significant impairments in global executive functioning, drawn from the global executive composite summary score. The score captures information by using the same clinical scales as the BRIEF-P, with the addition of the (1) initiate, (2) organization of materials, and (3) monitor scales.	Global composite summary score exceeded the clinically significant threshold described in the BRIEF test manual.
Sensory processing	Atypical sensory-processing ability	Infant-Toddler Sensory Profile (ITSP; Dunn 2002)	This is an indicator of whether a child has scores suggesting sensory-processing difficulties, drawn from the low-threshold score, a composite of the low-sensory sensitivity and sensation- avoiding scales.	Low-threshold scores fell outside the typical range described in the ITSP test manual, perhaps reflecting either under-responsiveness or over-responsiveness to stimuli.
Child emotional and behavioral problems	Emotional, behavioral, and other problems	Child Behavior Checklist-Preschool	This is an indicator of problematic levels of general behavior and emotional and social functioning, drawn from the total problems score. The composite score is made up of the scales in both the internalizing and externalizing behavior scale scores, combined with two additional scales: sleep problems and other problems.	Total problems scale score exceeded the clinically significant threshold described in the CBCL-PS test manual.
Child emotional and behavioral problems	Emotional, behavioral, and other problems	CBCL-School Age	This is an indicator of problematic levels of general behavior and emotional and social functioning, drawn from the total problems score. The composite score is made up of the scales in both the internalizing and externalizing behavior scale scores, combined with four additional scales: social problems, thought problems, attention problems, and other problems.	Total problems scale score exceeded the clinically significant threshold described in the CBCL-SA test manual.

Child well-being aspect	Risk indicator	Instrument	Description	Criterion for risk category
Social and adaptive behavior	Poor social skills	Socialization Subscale, Vineland Adaptive Behavior Scales, Second Edition, Parent-Caregiver Rating Form (Vineland II; Sparrow et al. 2005)	This is an indicator of whether a child has scores suggesting problematic levels of social skills, drawn from the socialization domain score. The score is a summary of information in the interpersonal relationships, play and leisure time, and coping skills subdomains.	The socialization score placed respondent in the lowest of five adaptive behavior levels as described in the Vineland II test manual.
Trauma symptoms	Post-traumatic stress disorder (PTSD) symptoms	Trauma Symptom Checklist for Young Children (TSCYC; Briere et al. 2001)	This is an indicator of whether a child has exhibited PTSD symptoms, drawn from the TSCYC total score. The score captures information from the following scales: (1) post-traumatic stress–intrusion, (2) post-traumatic stress–avoidance, and (3) post-traumatic stress–arousal.	Post-traumatic stress–total score exceeded PTSD symptom threshold described in TSCYC manual.

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