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

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

Seventh Report to Congress

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

ADMINISTRATION FOR CHILDREN & FAMILIES

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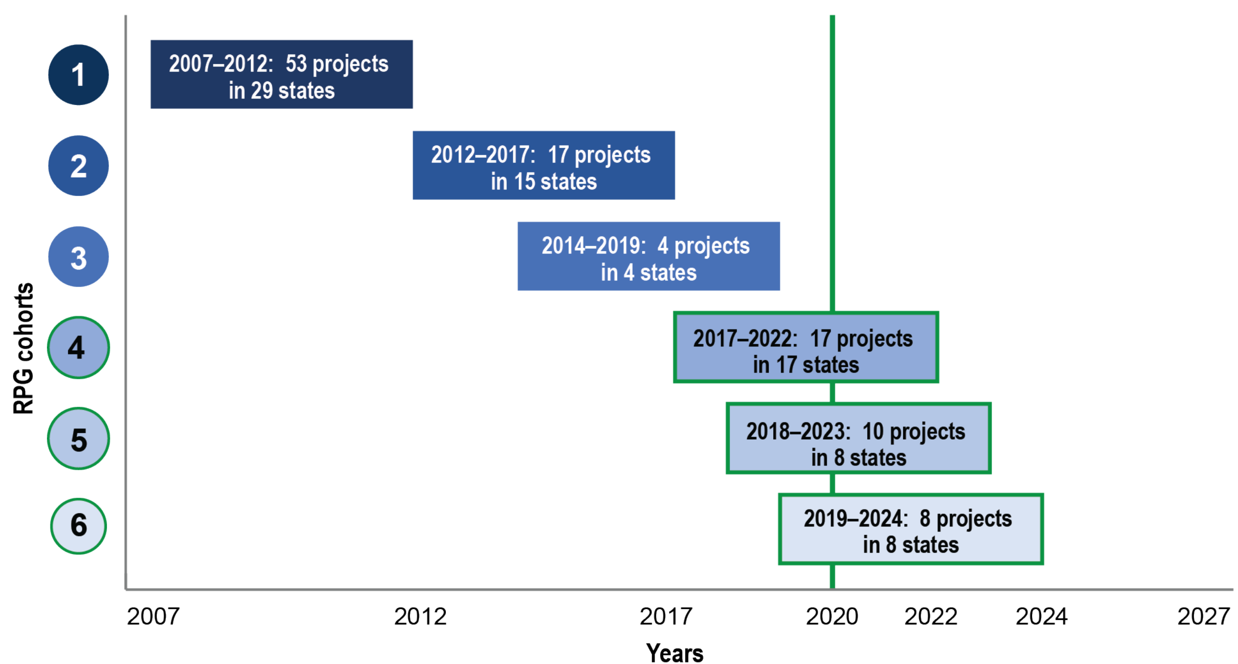
EXECUTIVE SUMMARY

Since 2007, Regional Partnership Grants (RPGs) have funded programs that are designed to help at-risk families stay safe, together, and well. The grants began after The Child and Family Services Improvement Act of 2006 (Pub. L. 109-288) amended section 437 of the Social Security Act (42 U.S.C. 629g[f]) to include the new RPG competitive grants program. Congress first authorized and later reauthorized RPGs because many families that are involved in the child welfare system include adults with potential or diagnosed substance use disorder (SUD) or substance misuse that has led to or might lead to removal of a child. These families often have trouble simultaneously navigating the child welfare and SUD treatment systems. In turn, providers in both systems face obstacles to coordinating their work. RPG was created to help these families and providers and their communities. The U.S. Department of Health and Human Services (HHS) has made these discretionary grants in six 2- to 5-year cohorts since 2007, as shown in Figure ES.1.

Figure ES.1. Timing and number of Regional Partnership Grants made from 2007 through 2019



Note: The vertical line at Year 2020 shows the cutoff point for cross-site evaluation data used in this report.

RPG is the only federal grant program designed to address the intersection of child maltreatment and adult SUD or misuse.[1] Because RPG is unique, HHS provides regular reports to inform Congress and the child welfare field about the status and accomplishments of the grants. Using data gathered as part of a national cross-site evaluation, the reports describe the partnerships

[1] As defined by the Surgeon General (HHS, 2016), substance use disorder (SUD) is a medical illness caused by repeated misuse of a substance, and 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.

HHS has funded, and assess whether RPG projects are reaching the families intended for services, what services they provide, and whether family outcomes improve after the families enter RPG. This report discusses the three cohorts of RPG projects (referred to as RPG4, RPG5, and RPG6) that were active as of July 2020. These three cohorts were each in different stages of implementation and encompassed 35 projects; 8 were in the planning phase only (RPG6), 10 in early implementation (RPG5), and the remaining 17 midway in their grants (RPG4). (Figure ES.1 shows all six of the RPG funding cycles through July 2020.) The purpose of the Seventh Report to Congress is threefold – (1) to introduce the RPG5 and RPG6 projects, which were funded in 2018 and 2019, respectively, and to describe their plans; (2) to describe the families enrolled in RPG4 and RPG5 and the services they have received; and (3) to discuss implementation progress and challenges for all three cohorts. (The RPG4 projects, funded in 2017, were introduced in the Sixth Report to Congress [HHS, forthcoming]).

Initial plans (RPG5 and RPG6 projects)

Target populations. Projects typically focus on serving subgroups in the RPG target population. Five of the 18 RPG5 and RPG6 projects planned to serve families with children from birth to age 1, 5, or 12, whereas the remaining 13 projects did not set age criteria. Ten projects included pregnant women and/or parents with newborn children in their target populations, and 4 other projects focused on enrolling American Indians and Alaska Natives (though not exclusively). In addition, projects specified the levels of child welfare involvement that they planned to address, such as before a child was reported to or involved with child welfare, once families had become involved with the child welfare system but before a child was removed, or after a child had been removed from the home.

Planned services and partners. Most of the 18 projects will provide services in at least two of the following five categories: (1) parenting or family strengthening (15 projects); (2) case management or service coordination (13 projects); (3) treatment for trauma symptoms or mental health (13 projects); (4) treatment for SUD (12 projects); and (5) peer coaching, mentoring, or support (10 projects). Projects expected to provide these services, conduct evaluations, and govern their work in collaboration with partners are from the following four main social service sectors: child welfare, behavioral health, courts, and child and family social service agencies.

Enrollment and services (RPG4 and RPG5 projects)

Enrollment. From March 1, 2019, through July 2, 2020, 27 partnerships from RPG4 and RPG5 enrolled 1,796 participants – 675 adults and 1,121 children in 554 cases. (Each RPG case includes the adults and children who enrolled together in RPG, but it might not include all family members.) Projects vary in their designs, including the number and types of expected sources of referrals to RPG. More than half of all enrollees were referred to RPG by *child welfare* (54 percent). *SUD providers and courts*, the next most common sources, referred 11 percent and 10 percent of families, respectively. *Hospitals or clinics* referred 56 percent of the enrollees in projects that served pregnant women and parents of newborns; SUD treatment agencies referred one-quarter of them (26 percent). In contrast, more than half of the enrollees in the four projects serving American Indians and Alaska Natives were *walk-ins or self-referrals*.

Family demographics. Most RPG-enrolled adults were women (82 percent of adults) and were non-Hispanic and White (64 percent of adults). Families ranged in size from 2 to 10 members.

The average number of people in a family was three, and the average family was composed of an adult and two children. Forty percent of children lived with one or both biological parents at the time they enrolled in RPG, and about one-third lived with other relatives or non-relative foster parents (23 and 15 percent, respectively). Six percent lived with a parent in an SUD treatment facility.

Employment and income. RPG is not targeted to low-income families, but it does serve many families that face economic challenges. For instance, at enrollment, only about one-third of the adult participants were employed either full time or part time (37 percent). About one-third reported that their largest income source was public assistance such as Temporary Assistance for Needy Families; the Women, Infants, and Children Nutrition Program; or Supplemental Security Income (31 percent). Fourteen percent had no income from any source.

Adult substance use. Based on data that projects collected on substance use in the past 30 days, 27 percent of adults were in the high-severity group for drugs, alcohol, or both when they enrolled in RPG. Drug use was more commonly reported than alcohol use, with three times as many adults having high severity drug use compared with high-severity alcohol use. For all adults, including those in the high-severity group, marijuana, amphetamines (which include methamphetamine), and opioids (including prescription opioids), in that order, were the most frequently used drugs.

Child safety and permanency. Nearly 40 percent of the children who were enrolled in RPG had been involved in the child welfare system the year before they entered RPG – 17 percent had a report of maltreatment, 18 percent had at least one report and one removal during the year, and 3 percent did not have a report but had been removed from their homes once or more during the year (most likely based on reports in an earlier period not covered by the data).

Adult and child well-being. Adults in RPG reported more symptoms of depression, and a greater proportion of them reported severe symptoms (36 percent compared to 11 percent), than a similar, nationally representative sample of parents. On average, emotional and behavioral problems were reportedly more common among children enrolled in RPG than they were in children in comparative national samples, but sensory processing problems, which can sometimes be caused by prenatal substance exposure, were less common for children in RPG than in national samples.

Types of services provided. Most projects offered *case management or service coordination*; three-quarters of families received this essential service. Consistent with the RPG mission, *therapy and counseling services* such as individual, group, couples, parent-child, or family therapy were the second most common service, received by about half of all families enrolled in RPG. Therapy sessions focused on SUD, mental or other behavioral health issues, trauma processing, or family strengthening. The third most common service was *screening and assessment*, typically done at enrollment to help develop a service plan for the family. About 36 percent of all RPG families received at least one screening or assessment.

Peer mentoring. Peer mentors have lived experiences that are similar to those of the families they support. Recovery support services offered by peer mentors are increasingly being employed in a range of settings to help people with SUD. In the 12 projects that used them and

provided data on this service, peer mentors worked with 80 percent or more of the enrolled families, and virtually all (98 percent) of the mentoring that families received came from these peers. However, mentors also provided other project services, such as case management, parent training or home visiting, or counseling.

Implementation challenges (all projects)

Like projects in past cohorts, all the RPG projects reported challenges in reaching their target population, enrolling the desired number of participants and retaining them in services, hiring and retaining staff, and collaborating smoothly with partners. An exploratory study the cross-site evaluation contractor conducted in September 2020 found that the public health emergency resulting from the severe acute respiratory syndrome coronavirus 2 (SARS-COVID-2) early in 2020 affected all of the current RPG projects, with challenges faced by the community, each service system (child welfare, SUD treatment, and the courts), project planning and operations, and the conducting of required evaluations.

- RPG system partners adapted their approaches to delivering services and meeting the amplified needs of participants. The child welfare, SUD treatment system, and courts had to decrease their activities; they shifted to virtual operations to the extent possible. RPG partners helped address participants' food insecurity and other basic needs, such as child care, transportation, and physical and mental health treatment.
- RPG project planning and operations continued, with some adaptations and challenges. All RPG projects that were interviewed had some or all staff working remotely. A few projects were confronted with staff turnover, hiring delays, furloughs, or other staffing challenges related to staff exposure to COVID-19. Some of the interviewed RPG projects saw a decrease in referrals and enrollments during this time, possibly related to disruptions in reporting and case processing within local child welfare offices and to state or local shutdowns, levels of illness in their communities, or other factors. Many of them shifted to virtual recruitment, referral, and enrollment processes, or planned to do so.
- Most RPG projects shifted to virtual service delivery, with little to no change in offerings. Some participants enrolled in RPG services lacked the connectivity, devices, or privacy they needed to participate virtually. Some program components, such as drug testing, could not be done virtually. However, virtual services also reduced some barriers to participation, so projects might keep some in place when in-person work resumes.
- Almost all of the RPG projects that were interviewed expected to shift to virtual consent and data collection processes, or had already done so. Some projects adapted their local evaluation designs in other ways, such as by reducing planned sample sizes. Grantees were concerned that participant outcomes might change for the worse because of factors external to their programs, highlighting the importance of maintaining rigorous evaluation designs with comparison groups to help control for these factors.

Going forward, the continuing effects of the evolving public health emergency must be kept in mind when interpreting grantees' performance and the findings of their evaluations.

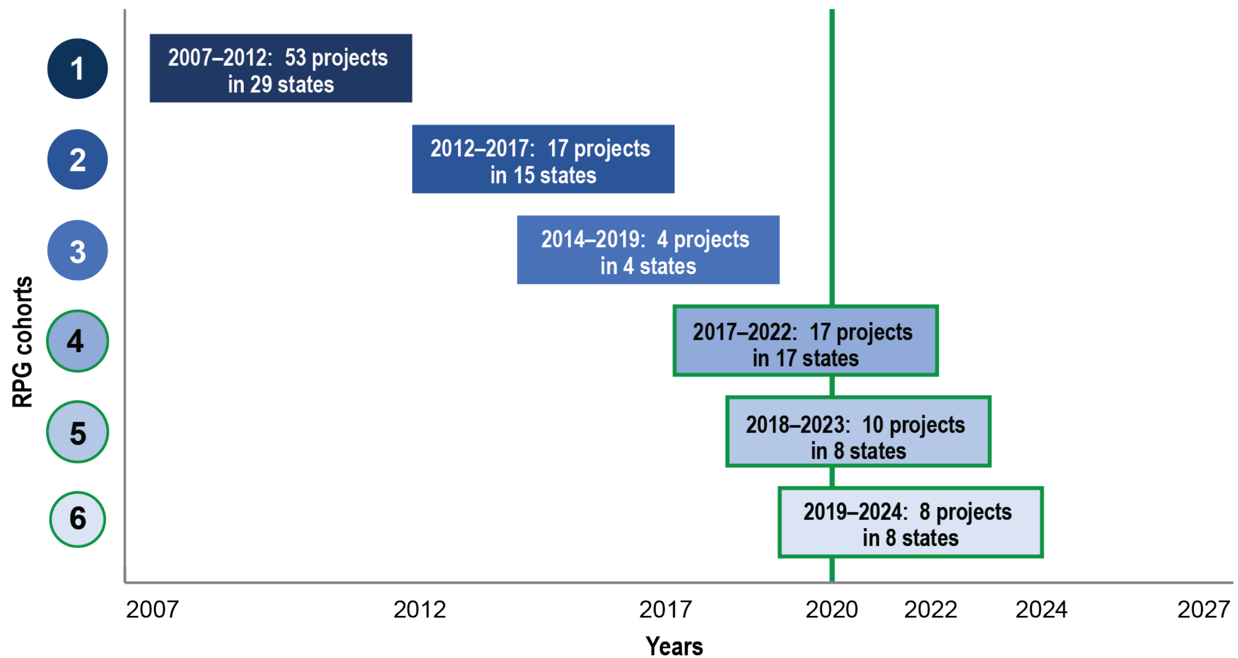
I. INTRODUCTION

Substance misuse has deep, lasting effects on families. Substance misuse contributes to high rates of child maltreatment, and child welfare cases involving substance misuse tend to involve a greater severity of maltreatment and lead to higher rates of foster care placement (Radel, Baldwin, Crouse, Ghertner, & Waters, 2018). In 2018, parental drug use was a factor in 36 percent of the cases that led to a child's removal from the home in the United States; parental alcohol use was a factor in 5 percent of such cases (Children's Bureau, 2019). Rates of physical, emotional, and sexual abuse of children are higher among parents who use substances (Smith et al., 2007; Staton-Tindall et al., 2013; Walsh et al., 2003). One study found a consensus among child welfare caseworkers that reunification was generally slower and more challenging in cases involving substance use than in cases without it (Jedwab et al., 2018). Children who experience maltreatment are also at greater risk of eventually using substances themselves, perpetuating a generational cycle of substance misuse and child maltreatment (Cicchetti & Handley, 2019).

The Child and Family Services Improvement Act of 2006 (Pub. L. 109-288) amended section 437 of the Social Security Act (42 U.S.C. 629g[f]) and authorized the U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF), Administration for Children, Youth and Families (ACYF), Children's Bureau, to fund discretionary grants to improve safety, well-being, and permanency outcomes for children at risk of or in out-of-home placement because of their caregiver's substance misuse. In response, HHS launched a competitive grants program called "Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine and Other Substance Abuse," which is also known as the Regional Partnership Grants (RPG) program.[2] Reauthorized in 2011 and again most recently by the Bipartisan Budget Act of 2018 (Pub. L. 115-123), these grants are designed to support partnerships between child welfare agencies, substance use disorder (SUD) treatment organizations, and other social services systems, and thereby improve the well-being, permanency, and safety outcomes of children and families. In 6 rounds of grants to 6 cohorts of grantees, beginning in 2007 (referred to in this report as RPG1–RPG6), HHS has awarded 109 RPGs. As Figure I.1 shows, RPG cohorts 4, 5, and 6 are the subject of this report, which uses data obtained through 2020 from projects in the 3 cohorts.

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

Figure I.1. Timing and number of Regional Partnership Grants made from 2007 through 2019



Note: The vertical line at Year 2020 shows the cutoff point for cross-site evaluation data used in this report.

Box I.I. RPG Legislative requirements

Authorization. The Child and Family Services Improvement Act of 2006 (Pub. L. 109-288) created the competitive RPG program. The legislation required HHS to select performance indicators; required grantees to report the indicators to HHS; and required HHS to report to Congress on (1) the services provided and activities conducted, (2) the progress made in addressing the needs of families with methamphetamine or other substance use disorders who come to the attention of the child welfare system, and (3) grantees' progress achieving the goals of child safety, permanence, and well-being.

The first reauthorization. The September 30, 2011, passage of the Child and Family Services Improvement and Innovation Act (Pub. L. 112-34) extended funding for the RPG program from federal fiscal year (FFY) 2012 to FFY 2016. The legislation removed the specific focus on methamphetamine use. It specified that grantees could apply for and be awarded multiple grants. In addition to the statutorily required reports for grantees and HHS, it required HHS to evaluate and report on the effectiveness of the grants by specified dates.

The second reauthorization. In 2018, the president signed the Bipartisan Budget Act of 2018 (Pub. L. 115-123) into law, reauthorizing the RPG program through FFY 2021 and adding a focus on opioid misuse. As part of the reauthorization, several changes were made to the RPG program, with the primary ones being a change in the required mandatory partners and a newly required planning phase that was not to exceed 2 years or a funding disbursement of $250,000.

To help assess whether the RPG program operates as intended and meets its desired goals, Congress requires HHS to define and collect performance measures data from the lead agency for each grant. To evaluate the overall program, and to satisfy the legislative mandate for

performance measurement, HHS has contracted with Mathematica and its partner, WRMA, Inc., to conduct a national cross-site evaluation of the program. As part of the evaluation, HHS has submitted six reports to Congress (Table I.1) that were prepared by the contractor. A description of RPG cohorts 4, 5, and 6 and their activities is the subject of this seventh RPG report to Congress.

Table I.1. Prior RPG reports to Congress

RPG cohort	Report title	Year submitted to Congress
RPG1	*Targeted grants to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse: First Annual Report to Congress.*	2012
RPG1	*Targeted grants to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse: Second Annual Report to Congress.*	2013
RPG1	*Targeted grants to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse: Third Annual Report to Congress.*	2014
RPG1	*Targeted grants to increase the well-being of, and to improve the permanency outcomes for, children affected by methamphetamine or other substance abuse: Fourth Annual Report to Congress.*	2017
RPG2	*2012 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: First Annual Report to Congress*	2014
RPG2	*2012 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: Second Annual Report to Congress*	2015
RPG2, RPG3	*2012 and 2014 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: Third Annual Report to Congress*	2016
RPG2, RPG3	*2012 and 2014 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: Fourth Annual Report to Congress*	2018
RPG2	*2012 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: Fifth Annual Report to Congress*	2020
RPG3, RPG4	*2014 and 2017 Regional Partnership Grants to increase the well-being of, and to improve the permanency outcomes for, children affected by substance abuse: Sixth Report to Congress*	Forthcoming

Note: RPG = Regional Partnership Grants.

This chapter introduces the report. Section A describes the 35 RPG projects in the RPG cohorts included in the report. Section B is an overview of the cross-site evaluation, including the data used in this report. It also describes the technical assistance (TA) that HHS gives RPG projects to support their implementation of the grants. Section C lays out the organization of the report.

A. Current RPG awardees

Since 2007, HHS has awarded 109 RPG grants in 38 states. HHS has provided 6 rounds of 2-, 3-, or 5-year grants to partnerships, 3 of which are currently operating and are the subject of this report. The RPG4 and RPG5 cohorts that were funded in 2017 and 2018, respectively, are actively enrolling and serving participants, conducting local evaluations, and submitting data to the cross-site evaluation. The most recent RPG6 cohort of projects, which were funded in September 2019, completed a required initial planning year and started enrolling participants in October 2020.

1. RPG4 cohort

In 2017, HHS funded 17 RPG projects, which are shown in Table I.2. Fifteen of the grants were awarded through the general RPG funding opportunity announcement (ACF, 2017a). Two grants, in Alaska and Kansas, were awarded through a funding opportunity announcement for organizations that offer RPG services to American Indian or Alaska Native (AI/AN) communities (ACF, 2017b). The grants are disbursed to and administered by lead agencies, which are also referred to as grantees. HHS allows current or former RPG grantees to apply for additional rounds of funding. As shown in Table I.2, some RPG4 grantees, such as those in Iowa and Oklahoma, also received funding during Rounds 1, 2, or 3. For both RPG4 funding opportunities, the annual grant award could range from $500,000 to $600,000 per year, or up to $3 million in total for 5 years, with the required percentage of grantee matching funds increasing over time. Twelve grantees received the maximum award amount. The grantees span the continental United States and Alaska, including both urban and rural areas.

Seven of the 17 grantees had participated in earlier RPG rounds. Experience with RPG can be useful for grantees because they are more likely to have established partnerships, developed systems for coordinating services and sharing data, recruited and served the RPG target population, and gained familiarity with the grant requirements.

The type of organization that receives the grant can also shape the project's planned services, service area, target population, and choice of partners. A variety of organizations received a 2017 grant, though most were awarded to behavioral health services providers, with family support providers the second most common type of organization.

Table I.2. RPG4 grantees funded in 2017

State, grantee name, and city where located	Area served[a]	Congressional district(s)	Organization type	Previous RPG	Total program funding
Alaska: Cook Inlet Tribal Council, Inc. Anchorage	Anchorage	AK-1	Family support services provider (tribal organization)	RPG1	$3,000,000
Alabama: University of Alabama at Birmingham Birmingham	Jefferson County	AL-7	University hospital or clinic	No	$3,000,000
Delaware: Children & Families First Delaware Wilmington	Delaware	DE (at large)	Family support services provider	No	$2,930,850
Florida: Broward Behavioral Health Coalition, Inc.	Broward County	FL-20, 22–24	Contracted entity to oversee the network	No	$3,000,000

State, grantee name, and city where located	Area served[a]	Congressional district(s)	Organization type	Previous RPG	Total program funding
Ft. Lauderdale			of behavioral health services providers		
Illinois: Youth Network Council dba Illinois Collaboration on Youth Chicago	Boone, Kankakee, Will, and Winnebago counties	IL-1–3, 11, 14, 16–17	Youth advocacy organization	No	$2,954,115
Indiana: Volunteers of America Indiana (VOAIN) Indianapolis	Marion County	IN-7	SUD treatment provider	No	$3,000,000
Iowa: Northwest Iowa Mental Health dba Seasons Center Spencer	Calhoun, Carroll, Cherokee, Crawford, Ida, Monona, Plymouth, Pocahontas, Sac, and Woodbury counties	IA-5	Behavioral health services provider	RPG2	$3,000,000
Kansas: University of Kansas Center for Research, Inc. Lawrence	Johnson, Wyandotte, Douglas, and Shawnee counties; and the PBPN, Sac and Fox, and ITKN tribal sites	KS-2–3	University	RPG3	$2,986,808
Kentucky: Mountain Comprehensive Care Prestonburg	Johnson, Martin, and Floyd counties	KY-5	Behavioral health services provider	No	$3,000,000
Missouri: Preferred Family Healthcare, Inc. Springfield	Greene, Barry, Lawrence, Stone, Christian, and Taney counties	MO-7	Behavioral health services provider	RPG2	$2,988,170
Ohio: The Ohio State University Columbus	Fairfield and Pickaway counties	OH-3	University	No	$3,000,000
Oklahoma: Oklahoma Department of Mental Health and Substance Abuse Services Oklahoma City	Oklahoma and Tulsa counties	OK-5	State mental health and substance abuse services agency	RPG1 RPG2	$3,000,000
Tennessee: Helen Ross McNabb Center Knoxville	Knox County	TN-2	Behavioral health services provider	RPG1 RPG2	$3,000,000
Vermont: Lund Family Center, Inc. Burlington	Chittenden, Orleans, and Essex counties	VT (at large)	Family support services provider	RPG1	$3,000,000
Washington: Catholic Charities of Spokane Spokane	Spokane County; Spokane, Kalispel, and Colville tribal sites	WA-4–5	Family support services provider	No	$2,970,000
West Virginia: Prestera Center for Mental Health Huntington	Cabell, Lincoln, and Wayne counties	WV-3	Behavioral health services provider	No	$3,000,000
Wisconsin: Meta House, Inc. Milwaukee	Milwaukee County	WI-4	SUD treatment provider	No	$3,000,000

[a] Areas are cities unless otherwise indicated.

Note: dba = doing business as.

Source: Grantees' RPG applications.

2. RPG5 cohort

HHS funded 10 RPG projects in 2018 (Table I.3). Applicants could apply for up to $1.9 million for a single 3-year project and budget period (ACF, 2018). In total, HHS awarded $15,517,100 in amounts ranging from $745,143 to $1,900,000. Midway through the initial grant period, however, HHS offered 2-year extensions, with additional funds. As of August 2020, 9 of the 10 awardees had applied for and received this extension. (The amounts in the table include the original 3-year award plus the 2-year extension award, except for Illinois, which did not apply for the extension.) Half of the projects are led by a previous or current RPG grant recipient, including two that held ongoing RPG4 grants, enabling them to build on their partnerships and service delivery experiences. The projects are spread across the East Coast and the Midwest, in both urban and rural areas. Like the 2017 cohort, the 2018 grantees represent various types of organizations, but most of them are behavioral health service providers.

Table I.3. RPG5 grantees funded in 2018

State, grantee's name, and grantee's city	Area served[a]	Congressional district(s)	Organization type	Previous RPG	Federal award
Florida: Citrus Health Network dba Citrus Family Care Network, Miami	Miami-Dade County	FL-24	Entity contracted to oversee child welfare service providers	RPG3	$3,169,624
Florida: Family Support Services of North Florida, Jacksonville	Duval County	FL-4	Contracted entity to oversee child welfare service providers	No	$2,952,624
Illinois: Centerstone of Illinois, Inc. West Frankfort	Franklin, Jackson, Madison, Perry, Randolph, St. Clair, Washington, and Williamson counties	IL-12	Behavioral health services provider	No	$745,173
Iowa: Judiciary Courts for the State Des Moines	Eastern Region of Iowa	IA-02	Court/judicial agency	No	$3,069,624
Iowa: Northwest Iowa Mental Health Seasons Center Spencer	Buena Vista, Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Sioux, and Woodbury	IA-004	Behavioral health services provider	RPG4	$3,069,624
Massachusetts: Institute for Health and Recovery, Inc. Cambridge	Worcester County	MA-002	Behavioral health services provider	No	$2,943,997
Missouri: Preferred Family Healthcare, Inc. Jefferson City	Cole, Boone, and Callaway counties	MO-003	Behavioral health services provider	RPG4	$3,159,390
New York: Montefiore Medical Center Bronx	Bronx	NY-015	University hospital or clinic	RPG3	$3,169,623
Pennsylvania: Health Federation of Philadelphia Philadelphia	Philadelphia and Bucks counties	PA-001	Family support services provider	RPG2	$3,169,623
South Dakota: Volunteers of America, Dakotas Sioux Falls	Sioux Falls	SD-SDAL	SUD treatment provider	No	$2,918,656

[a] Areas are cities unless otherwise indicated.

Source: Grantees' RPG application; calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic TA providers that took place from October 2018 through August 2020; and summaries of projects provided by the National Center on Substance Abuse and Child Welfare.

3. RPG6 cohort

HHS funded 8 RPG6 projects in 2019 (Table I.4). The grants were awarded through the RPG funding opportunity announcement. Applicants could request up to $2,650,000 for a single 5-year project and budget period (ACF, 2019). Five of the eight RPG6 awardees had also received a grant in a previous year, including two that held RPG4 awards made in 2017, and one that had received awards in both 2017 and 2018. The projects are concentrated in the Midwest and East Coast, in both urban and rural areas. As was the case with the 2018 RPG5 cohort, behavioral health service providers were the single most common type of grantee agency.

Table I.4. RPG6 grantees funded in 2019

State, grantee's name, and grantee's city	Area served[a]	Congressional district(s)	Organization type	Previous RPG	Federal award
Colorado: Colorado Judicial Department; State Court Administrator's Office Denver	Arapahoe, Broomfield, Denver, El Paso, Garfield, Jefferson, and Huerfano counties (additional counties to be identified)	All	Court/judicial agency	No	$2,650,000
Georgia: Georgia State University Research Foundation, Inc. Atlanta	Hall, Dawson, Chatham, Clarke, Oconee, Baldwin, Jones, Putnam, Greene, Morgan, Wilkinson, Hancock, and Jasper counties	GA-005	University	RPG2	$2,640,931
Illinois: Youth Network Council dba Illinois Collaboration on Youth Chicago	Livingston, Ford, Iroquois, McLean, Dewitt, Macon, Shelby, Moultrie, Piatt, Champaign, Douglas, Coles, Cumberland, Vermilion, Edgar, and Clark counties	IL-13, 15, 16, & 18	Youth advocacy organization	RPG4	$2,650,000
Missouri: Preferred Family Healthcare, Inc. Kirksville	Miller, Moniteau, and Morgan counties	MO-003	Behavioral health services provider	RPG2 RPG4 RPG5	$2,496,632
New Hampshire: Mary Hitchcock Memorial Hospital, dba Dartmouth-Hitchcock Medical Center (DH) Lebanon	Sullivan and Grafton counties	NH-002	University hospital or clinic	No	$2,646,953
New Jersey: Acenda, Inc. Glassboro	Atlantic, Cape May, and Ocean counties	NJ-002	Behavioral health services provider	No	$2,612,500
Oklahoma: Oklahoma Department of Mental Health and Substance Abuse Services Oklahoma City	Oklahoma County	OK-005	State agency	RPG1 RPG2 RPG4	$2,650,000
West Virginia: Prestera Center for Mental Health Huntington	Boone, Kanawha, Raleigh, and Wyoming counties	WV-003	Behavioral health services provider	RPG4	$2,650,000

[a] Areas are cities unless otherwise indicated.

Notes: dba = doing business as; SUD = substance use disorder.

Source: Grantees' RPG applications; calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic TA providers that took place from October 2018 through August 2020; and summaries of projects provided by the National Center on Substance Abuse and Child Welfare.

B. The cross-site and local evaluations and data sources

The 2011 reauthorizing legislation for RPG (Pub. L. 112-34, as described in Box I.1) requires HHS to evaluate the services and activities that are provided with RPG funds. To address the legislation's goals and contribute knowledge to the fields of child welfare and SUD treatment programming, HHS requires and supports a cross-site evaluation. In collaboration with HHS, Mathematica designed the cross-site evaluation to answer key questions of interest to HHS and the broader field. Through the cross-site evaluation of all RPG projects, HHS seeks to better understand (1) the partnerships that form the basis of each project, (2) who was enrolled in RPG projects and what services they received, (3) their outcomes, and (4) the impacts of the projects (D'Angelo et al., 2019). This will be accomplished by relying on quantitative and qualitative data that Mathematica collects through document reviews, interviews, site visits, and surveys, or that the RPG projects provide. Each cohort participates in the evaluation.

Projects submit some data to the cross-site evaluation contractor, and the contractor also collects additional data from RPG grantee agencies and their partners. This report is based on data obtained through September 2020 from both sources. The next section describes the specific data from each source.

1. Data that grantees submit for the cross-site evaluation

Grantee agencies, or their partners or local evaluation contractors, provide the following three main types of data to the cross-site evaluation, as shown in Table I.5: progress reports, data on project enrollment and services, and data to measure child and family outcomes in five domains specified by HHS. The domains are child safety, permanency, and well-being; adult recovery; and family functioning.

Table I.5. Data RPG projects provide for the national cross-site evaluation

Data source (and content)	Submission period for data used in this report
Progress reports (narrative descriptions of partnerships and implementation progress, challenges, and successes for prior 6 months; plans for next 6 months)	Submitted to HHS October 2019 and April 2020
Enrollment and services data (dates of participant enrollment and exit, demographics, and RPG services received)	Entered into RPG-EDS daily from March 2019 through July 2020
Outcome data (measures of child safety, permanency, and well-being; family functioning; and adult recovery)	Uploaded to RPG-EDS from March 2019 through July 2020

Note: RPG-EDS = Regional Partnership Grants Enrollment and Services Data System.

- HHS requires RPG grantees to submit written progress reports twice a year. These semiannual progress reports (SAPRs) describe the partner agencies and their activities, project implementation, and successes and challenges experienced by the projects during each 6-month reporting period. This report uses information from progress reports that RPG4 and RPG5 grantees submitted in October 2019, and the progress reports that all three cohorts submitted in April 2020.

- Along with these reports, RPG grantees or their partner agencies that enroll or provide services to participants enrolled in RPG enter data on the people whom they have enrolled and the services that participants receive into a federally approved, secure data collection system built for the cross-site evaluation.[3] The system is known as the RPG cross-site evaluation data system (RPG-EDS). This report uses enrollment and services data that RPG projects provided from March 2019, after the cross-site evaluation received OMB clearance, to July 2020.

Box I.2. What are standardized instruments?

A standardized instrument or test 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. It is scored in a standard or consistent manner, which makes it possible to compare the relative performance of individuals or groups.

- Grantees and their evaluators also upload to RPG-EDS data on family and child outcome measures collected at enrollment (baseline) and program exit (follow-up). Projects collect outcome data by administering standardized data collection instruments (defined in Box I.2) to adults in families enrolled in the RPG cross-site evaluation, or by requesting administrative data (defined in Box I.3) on enrolled children or adults from the relevant child welfare and SUD treatment agencies in their states. Outcome data from March 2019 to July 2020 are used in this report.

Box I.3. What are administrative data?

Administrative data are the records that governments or other organizations collect as part of their operations. They are not collected for research purposes, but to help support and document the administration of programs.

2. Data obtained by the cross-site evaluation contractor

To more closely examine how the partnerships function, implement RPG, and plan to sustain themselves after RPG funding ends, Mathematica collects additional data for the cross-site evaluation. First, the evaluation team reviews the RPG grant applications and implementation plans, along with project summaries that the partnerships develop during the first year of each grant. These documents were available for all three cohorts. In addition, the team conducts interviews, site visits, and surveys. Data from interviews conducted in September 2020 are used in this report, whereas the other data sources will be used for later reports.

- Although projects do describe the successes and challenges they experienced as part of the SAPRs, HHS wanted more details on how RPG projects were affected by the COVID-19 public health emergency that began early in 2020. As discussed further in Chapter VII, in September 2020, Mathematica interviewed one key informant each from selected projects to explore the possible effects of the public health emergency.
- To better understand how partnerships operated and implemented RPG services, the cross-site evaluation conducts site visits to each project once during the grant period. Members of the cross-site evaluation team typically spend two days on-site. Using OMB-approved protocols to guide their discussions, team members meet one-on-one or in groups with

[3] The Office of the Chief Information Officer at HHS granted the system a conditional Authority to Operate (ATO) in 2019, and a full ATO in 2020.

leaders and staff members from the grantee agency and partner agencies. They talk with the people who provide RPG services, such as program managers, supervisors, and caseworkers or other staff who work directly with families. The team conducts qualitative analyses of their field notes and summaries from the visits.

- In contrast with interviews and site visits, surveys yield a common set of detailed information from multiple respondents. The RPG cross-site evaluation includes two surveys of representatives from RPG partner agencies. The partner survey asks for background on the partner agency, its role in RPG, its goals for the project, and its communications and coordination with other agencies in the partnership. An improvement and sustainability survey queries survey respondents about strategies for sustaining the collaboration after RPG ends, and whether funding or other resources will be available to support continuation of services after that time. Both surveys are administered once during the grant period. The cross-site evaluation team uses statistical methods to analyze the resulting data.

3. Local evaluations

To build evidence on the effectiveness of targeted approaches that improve outcomes for children and families affected by opioids and other substances, HHS requires each partnership to rigorously evaluate its RPG project, report on performance indicators, and participate in the national cross-site evaluation. HHS instructs grantees to spend a minimum of 20 percent of their grant funds on these evaluation elements. (See, for instance, HHS-2019-ACF-CU-1568, the funding opportunity announcement for RPG6.)

RPG projects often use some or all of the data elements they submit to the cross-site evaluation to conduct their own local outcome and process evaluations, but some projects collect other data instead of or in addition to those data. For example, some projects survey their participants, interview RPG program staff and/or participants, or conduct site visits to locations that provide their RPG project services.

Depending on the design of their local evaluations (so called to distinguish them from the cross-site evaluation), projects contribute data on the people in their RPG programs and those in comparison groups who receive different or business-as-usual services. Along with measuring participant outcomes, defined as the changes in outcome measures from baseline to follow-up, grantees use data from comparison groups to estimate the impacts of RPG. The term “impact evaluation” refers to evaluations that can not only detect changes in outcome measures, but can attribute outcomes to the program being tested. They do this by comparing the program outcomes to outcomes for similar families who are not receiving the services that are being studied. If enough projects successfully implement comparison groups and share comparison group data with the cross-site evaluation, then the cross-site evaluation will pool program and comparison data across sites and estimate the impacts of RPG. Chapters II and III have more information about local RPG evaluation designs.

C. Organization of this report

Chapters II and III introduce the 2 cohorts of partnerships, RPG5 and RPG6, that have been funded since the most recent report to Congress. That report (HHS, forthcoming) provided detailed information on the RPG4 awards made in September 2017. Chapter II, Introduction to

RPG Projects Funded in 2018 (RPG5) describes the 10 RPG5 projects funded in September of 2018, including their project and evaluation plans as articulated in their grant applications and early planning documents. Chapter III (Introduction to RPG Projects Funded in 2019 (RPG6) introduces the 8 RPG6 projects funded in September 2019, and describes their activities during the mandatory planning year and their local evaluation plans. Chapter IV, The RPG6 Planning Year, describes activities during the RPG6 planning year, and how HHS supported planning by the projects.

The three chapters that follow describe participants and the services they received in RPG4 and RPG5, which began implementation during the period this report covers. Chapter V, Characteristics of RPG Enrollees, describes the demographic and economic characteristics of the people who were enrolled in projects through July 2020 and the composition of RPG cases during the period. Chapter VI, Participant Outcomes at Enrollment, describes children and adults at the time they enrolled in RPG, using information from standardized instruments and administrative data that projects submitted to the cross-site evaluation through July 2020. Each RPG project offers a unique menu and sequence of services and supports, and Chapter VII, Services Received by Families, describes the services that families received.

Chapter VIII, Context and Challenges, turns to a discussion of implementation challenges RPG projects experienced from April 2019 through March 2020, as described in the semiannual progress reports they submitted in October 2019 and April 2020. The chapter then explores how the emergence of COVID-19 and the associated public health crisis affected RPG projects through September 2020.

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II. INTRODUCTION TO RPG PROJECTS FUNDED IN 2018 (RPG5)

In September 2018, HHS awarded a 5th round of 10 regional partnership grants (RPG5), authorized by the Child and Family Services Improvement and Innovation Act (Pub. L. 112-34). The grants were initially awarded for a 3-year period based on the funds available at that time. Midway through the grant period for RPG5, however, HHS was able to extend the grants for 2 years. It can be beneficial to fund projects for 5 years if possible, because studies have shown that it takes several years to cultivate partnerships, implement and refine programs, and establish effective data collection procedures (see, for example, the 5th report to Congress; HHS, 2020). To contribute to the knowledge base on how to serve the vulnerable families who will benefit from their programs, grantees are required to conduct an evaluation of their grant programs and to participate in the national cross-site evaluation.

This chapter introduces the grantees in the RPG5 cohort. It describes their target populations, planned services, partnerships, and initial plans for their local evaluations. Information in the chapter is drawn from the grant applications, notes from TA discussions held with each awardee from October 2018 through August 2020, and federally required SAPRs.

A. Target populations

RPG's broad focus is families with adults at risk of developing substance use disorders, and/or children at risk of maltreatment. Projects can work with families in which adults have a suspected or diagnosed SUD, or is at risk for substance misuse (Box II.1). Children might have substantiated reports of maltreatment, or they might already have been removed from their homes and placed in foster care, or they might not have experienced maltreatment but be at risk of it. Projects typically define the population they intend to serve more narrowly based on the needs of their communities and a consideration of who would benefit from their planned services. The RPG5 projects commonly narrowed their target populations by planning to serve families with children of specific ages and/or levels of involvement with the child welfare system. As shown in Table II.1, of the 10 projects, 1 is serving pregnant women, 2 seek to enroll families with a child from birth to age 5, and the remaining 7 are designed for families with children up to age 17 or 18.

> **Box II.1. Substance misuse**
>
> Substance misuse refers to the use of any substance in a manner, situation, amount, or frequency that can cause harm to the individual or to those around them. For some substances, any use would constitute misuse (such as underage drinking, or any use of illegal drugs). Prescription drug misuse refers to the use of a drug in any way a doctor did not direct an individual to use it. (Taken from *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, (2016), glossary, pp. 3–4., U.S. Department of Health and Human Services.)

Nearly all of the projects planned to enroll families with open child welfare cases in which a parent's substance use might cause a child's removal from the home, and the services are designed to avoid that outcome or to reunify families following a removal. Specifically, one project is focusing on preventing child removals (Florida: Family Support Services), one focuses on families in which a child has been removed from the home, and reunification is possible (Florida: Citrus), and four projects are focusing on both (Illinois; Iowa: Judiciary; Massachusetts; and Missouri). In contrast, one project (New York) planned to serve women who

could become involved in the child welfare system because of their prenatal substance use. The remaining three projects (Iowa (Seasons Center), Pennsylvania, and South Dakota) focus on families in all three of the following situations: before the child welfare agency is involved, once the child welfare agency is involved but before a child is removed from the home, and following a removal by the child welfare agency.

Table II.1. RPG5 target populations

		Status of child welfare system involvement at enrollment		
State and grantee	Age of child at enrollment	At risk of involvement with child welfare	Child welfare involvement, child at risk for removal from home	Child welfare involvement, child removed from the home
Florida: Family Support Services of North Florida	0–5		X	
Florida: Citrus Health Network dba Citrus Family Care Network	0–17			X
Illinois: Centerstone of Illinois, Inc.	0–18		X	X
Iowa: Judiciary Courts for the State	0–17		X	X
Iowa: Northwest Iowa Mental Health Seasons Center	0–17	X	X	X
Massachusetts: Institute for Health and Recovery	0–18		X	X
Missouri: Preferred Family Healthcare, Inc.	0–18		X	X
New York: Montefiore Medical Center	Prenatal	X		
Pennsylvania: Health Federation of Philadelphia	0–5	X	X	X
South Dakota: Volunteers of America – Dakotas	0–18	X	X	X

Note: The project in South Dakota serves tribal and non-tribal families.

Sources: Calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic TA providers that took place from December 2018 through August 2020; summaries of projects provided by the National Center on Substance Abuse and Child Welfare; and projects' SAPRs.

B. Services and service recipients

HHS requires applicants to propose specific, well-defined, and quality program services and activities that are evidence supported and/or evidence informed. However, there is no specified RPG program model that partnerships must implement. Instead, partners design their RPG projects to meet the needs of their states or communities and the populations that they plan to serve. They do this by offering a range of direct services, usually in one or more of the following categories: (1) parenting or family strengthening, such as a parenting curriculum or family problem-solving activities; (2) SUD treatment; (3) trauma or mental health treatment or counseling; (4) case management or service coordination; and (5) coaching or mentorship from a peer with lived experience in substance use recovery.

Table II.2 shows the type or types of services each RPG5 project provides. Six of the 10 projects offer services in 4 or all 5 of the service categories, and 4 offer services in 2 or 3 categories. Nearly all RPG5 projects offer SUD treatment services (9 projects), parenting or family strengthening services (8 projects), case management (8 projects), and trauma or mental health treatment or counseling (7 projects). Five projects employ peer mentors.

RPG projects provide services to the adult or adults in the family, to the family unit (such as a parent-child dyad), and/or directly to the child or children. All of the RPG5 projects are directly serving adults, such as with SUD treatment or peer support. Eight also have services for the family unit, typically a parenting intervention. Three projects serve all three groups (adults, the family unit, and children), by including, for example, trauma-focused therapies for the children (Table II.2). Regardless of the service type, grantees are expected to implement "specific, well-defined, and quality program services and activities that are evidence supported and/or evidence informed," according to the RPG funding opportunity announcement.

Table II.2. Services offered through RPG5 projects, and service recipients

		Types of RPG services provided				
State and lead organization	Targeted recipients of services	Parenting/ family strengthening	SUD treatment	Trauma or mental health treatment	Case management or service coordination	Peer coaching, mentoring, or support
Florida: Family Support Services of North Florida	Adult, family	X	X	X	X	X
Florida: Citrus Health Network dba Citrus Family Care Network	Adult				X	X
Illinois: Centerstone of Illinois, Inc.	Adult, family	X	X	X	X	X
Iowa: Judiciary Courts for the State	Adult, family		X		X	
Iowa: Northwest Iowa Mental Health Seasons Center	Adult, family, child	X	X	X	X	
Massachusetts: Institute for Health and Recovery	Adult, family, child	X	X	X		X
Missouri: Preferred Family Healthcare, Inc.	Adult, family	X	X	X	X	X
New York: Montefiore Medical Center	Adult	X	X		X	
Pennsylvania: Health Federation of Philadelphia	Adult, family	X	X	X		
South Dakota: Volunteers of America – Dakotas	Adult, family, child	X	X	X	X	

Notes: RPG = Regional Partnership Grants; dba = doing business as; SUD = substance use disorder.

Sources: RPG5 grant applications; calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic TA providers that took place from December 2019 through August 2020; and summaries of projects provided by the National Center on Substance Abuse and Child Welfare.

In their grant applications, the RPG5 projects named a total of 43 specific program models they planned to implement. They generally listed well-defined or manualized programs, curricula, or practices. Individual projects named between 2 and 14 program models to offer adults, families or children (Appendix Table A.1). Two projects, which are led by a behavioral health or SUD treatment provider, accounted for more than half of the named models. This is because treatment services are often comprehensive, incorporating several therapeutic approaches or tools as part of recovery, mental health, and parenting interventions. Overall, most of the models address trauma and behavioral health care (17 models), parent training or family strengthening (12 models), and SUD treatment (12 models). The model that the most projects planned to deliver is the Nurturing Parenting Program. It is a parenting course for families with a parent in recovery from SUD. Five of the 10 projects planned to offer it.

C. Partnerships

The service arrays described above are delivered by the partners that join together to form an RPG project. By working together, child welfare, SUD treatment, and other agencies can draw from a wider array of resources to meet families' needs. As expected of the RPG funding stream, all 10 of the partnerships included either a state or county child welfare agency, and an *SUD treatment and/or behavioral health treatment provider*, inclusive of the lead grantee (Table II.3). Most partnerships also included a *substance use or mental health system agency* (7 projects) that funds and/or oversees SUD and/or mental health treatment. It was also common for partnerships to include court or legal systems that are involved in dependency cases (6 projects), and child and family social services organizations (6 projects).

As of April 2020, the RPG5 cohort included 113 partner organizations across the projects, ranging from 4 to 27 per project, including the lead grantee agencies. The variation across projects is attributable to the variety of project designs, some of which call for a wider network of supports than others do; the strength of preexisting partnership structures; and the richness of services and supports that are available in a community.

Table II.3. Number and types of partner organizations involved in RPG5 projects

Type of partner organization	FL (North)	FL (Citrus)	IA (Judiciary Courts)	IA (Seasons)	IL	MA	MO	NY	PA	SD	Total: Organi-zations	Total: RPG5 projects
SUD and/or mental health treatment provider	1	1	2	1	3	2	4	1	3	3	22	10
Child welfare agency	2	5	1	1	2	1	4	2	1	1	20	10
Substance use or mental health system agency		1			2	1	2	2	1	2	11	7
Educational institution (including university-based local evaluators)	1	1	1		1		1	1		1	7	7
Child and family social services organization	4				1		8	1	2	5	21	6
Courts		2	1	1			2		1	2	9	6
Health care					2		2	2			6	3
Housing	1						1		1		3	3
Private sector evaluator (non-university)				1						1	2	2
Legal services agency		1							1		2	2
Domestic violence agency	1						1				2	2
Other types			1		2		2	1		2	8	5
Number of organizations	**11**	**11**	**6**	**4**	**13**	**4**	**27**	**10**	**10**	**17**	**113**	**-**

Note: "Other types" is used when there is only a single organization of a given type. Examples are an organization that sets professional standards for gynecologists and obstetricians, a church, and an employment support organization.

Sources: Notes from calls between cross-site evaluation TA liaisons and grantees held during winter 2020, and projects' SAPRs.

D. Local evaluations

HHS requires all RPG awardees to evaluate their own projects in addition to participating in the national cross-site evaluation. These project-specific evaluations are often referred to as local evaluations, to distinguish them from the national cross-site evaluation. HHS requires each project team to work with an evaluator (either internal or a third party) to conduct the local evaluation. RPG projects are also required to specify in their grant applications the number of families they plan to enroll in the study, and the data sources they plan to use. HHS strongly prefers that partnerships design a rigorous impact evaluation, using methods that can assess the effectiveness of RPG services on improving child safety, permanency, and well-being; adult recovery; and family functioning (ACF, 2017a, 2017b).[4]

For a study to be considered rigorous, it needs to include a program or treatment group that receives the RPG services of interest, and a comparison group that does not. By comparing outcomes for the two groups, an impact evaluation measures the effects that can be attributed to the RPG services. RPG projects form treatment groups using a random process for a randomized controlled trial (RCT) or a nonrandom process for a quasi-experimental design (QED). The comparison groups do receive services of some type, but they are not the same package of services the treatment group receives.

Evaluation designs. Table II.4 describes the impact evaluation designs that RPG5 projects planned, including the type of design (RCT or QED), the services that treatment and comparison group members were to receive, and the planned number of families in each group. Most of the RPG5 projects (six projects) are using an RCT design for their local impact evaluations, three are using a QED, and one is conducting both an RCT and a QED. The projects reported in their grant applications that they expected to enroll a combined total of between 104 to 804 families into their treatment and comparison study groups, depending on the project. Three projects planned to enroll 200 or fewer families, and the rest are expected to include more than 200. Generally, the more families enrolled in a study, the stronger the evaluation.

Services that are being tested. Generally, the local evaluations were designed to measure the impact of the new services that the projects added with RPG funds. A project that added, for example, a peer mentor or a parenting intervention to its usual offerings designed an evaluation to test the effectiveness of adding the peer or parenting intervention on top of the usual services. RPG5 projects that are implementing a combination of services, such as adding a parenting intervention plus case management or service coordination to usual care, are generally attempting to assess the impact of the combination of services.

[4] HHS also requires RPG partnerships to conduct a process evaluation, sometimes called an implementation evaluation, to understand how the project was implemented, how it operated, and how the partner organizations worked together. These studies generally document the services that were delivered, how projects were staffed, partners' collaboration, and successes and challenges. All 10 of the RPG5 projects have planned and are conducting a process evaluation.

Table II.4. Summary of RPG5 projects' planned local evaluations

State and lead organization	Local impact evaluation design		Services being tested		Planned evaluation enrollment goal (number of families)		
	RCT	QED	Treatment group	Comparison group	Treatment group	Comparison group	Total
Florida: Citrus Family Care Network	X		Usual child welfare case management services enhanced with a peer mentor who has lived experience with child welfare and substance use	Business-as-usual child welfare case management services	120	120	240
Florida: Family Support Services of North Florida	X	X	RCT: A voluntary, non-judicial diversion program (called Family Assessment Support Team, or FAST) enhanced with home visits from a parent educator/advocate and a health care coordinator; standard FAST includes child welfare case management, counseling, mental health services, SUD treatment services, and the Nurturing Parenting Program QED: Either standard FAST or enhanced FAST services	RCT: standard FAST QED: Business-as-usual dependency system services	RCT: 200 QED: 400	RCT: 200 QED: 400	RCT: 400 QED: 800
Iowa: Judiciary Courts for the State	X		Through Child and Family Assessment and Treatment Centers (CFATCs): assessments, treatment planning, and service coordination from a family navigator, including services for early intervention and children's education, SUD treatment and mental health, and a family strengthening and prevention program	Assessments and treatment planning through CFATCs and business-as-usual services in the community	125	125	250
Iowa: Northwest Iowa Mental Health Seasons Center		X	Seasons Center's usual behavioral health services enhanced with Seeking Safety home visiting and/or Child Adult Relationship Enhancement home visiting	Seasons Center's business-as-usual behavioral health services	170	85	255
Illinois: Centerstone of Illinois, Inc.	X		Centerstone's usual behavioral health services enhanced with the Strengthening Families program	Centerstone's business-as-usual behavioral health services plus Nurturing Parenting Program and trauma-focused cognitive behavioral therapy	52	52	104

State and lead organization	Local impact evaluation design		Services being tested		Planned evaluation enrollment goal (number of families)		
	RCT	QED	Treatment group	Comparison group	Treatment group	Comparison group	Total
Massachusetts: Institute for Health and Recovery		X	Institute for Health and Recovery's usual behavioral health services enhanced with home visits from a child-family clinician and recovery peer team, using Child-Parent Psychotherapy; Attachment, Self-Regulation and Competency; and/or Motivational Interviewing program models	Business-as-usual community behavioral health services	180	180	360
Missouri: Preferred Family Healthcare, Inc.	X		Two program groups: both receive Preferred Family Healthcare's usual behavioral health services enhanced with a family advocate for outreach/advocacy, individualized service planning, plus either the Helping Men Recover/Helping Women Recover trauma education program (Group 1) or the Living in Balance relapse prevention program (Group 2)	Preferred Family Healthcare's business-as-usual behavioral health services	Group 1: 60 Group 2: 60	60	Group 1: 120 Group 2: 120
New York: Montefiore Medical Center	X		Motivational Enhancement, group-based parenting skills classes, contingency management, and case management, plus usual community prenatal care and SUD treatment	Business-as-usual community prenatal care and SUD treatment services	210	210	420
Pennsylvania: Health Federation of Philadelphia	X		Child-parent psychotherapy integrated with Mothering from the Inside Out, plus usual residential or outpatient SUD treatment	Child-parent psychotherapy plus residential or outpatient SUD treatment	113	57	170
South Dakota: Volunteers of America – Dakotas		X	Volunteers of America's usual residential SUD treatment program for pregnant women or mothers (who can reside with their children up to age 8), enhanced with Nurturing Parenting Program, Integrated Dual Disorders Treatment Recovery life skills services, children's mental health treatment and play therapy, cultural activities, and after-care services	Similar residential SUD treatment program and after-care services at a separate, nearby facility but mothers do not reside with their children, and the facility is open to adult women and men	100	100	200

Notes: QED = quasi-experimental design; RCT = randomized controlled trial; SUD = substance use disorder.

Sources: Grantees' RPG application; notes from calls between cross-site evaluation TA liaisons and grantees, local evaluators, federal project officers, and programmatic TA liaisons, held October 2018 through August 2020; and project summaries provided by the National Center on Substance Abuse and Child Welfare.

Most of the RPG5 projects formed comparison groups that represent “business as usual,” or the usual standard care of care available through the lead organization or elsewhere in the community. This enables the project teams to estimate what might have happened in the absence of the RPG services. In contrast, some projects are adding an RPG service to the treatment group and a different RPG service to the comparison group to estimate how the different RPG services compare with one another. For example, one project team is comparing two program models against each other.

Evaluation progress. Two years into the RPG5 grant period, many of the projects were not reaching their enrollment targets for their programs, meaning they also were not reaching their target numbers for their impact evaluations. The challenges they faced included difficulty recruiting families into the project and finding out that there were fewer eligible candidates in the target population than they first estimated. Some projects were having difficulty locating families for follow-up assessments once they left the project, meaning fewer families than planned had complete data for the evaluation.

To support the projects, midway through the 3-year grant period, HHS announced that RPG5 partnerships could apply to receive additional funding to extend their 3-year grant period to 5 years. All but one RPG5 partnership applied for and received the funding and extension. Among other advantages, the extra 2 grant years will enable the project teams to serve more families than they could have reached in the shorter time frame, to come closer to meeting their intended enrollment goals, and, by virtue of enrolling more families, strengthen their local evaluations and the cross-site evaluation.

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III. INTRODUCTION TO RPG PROJECTS FUNDED IN 2019 (RPG6)

In 2018, the president signed the Bipartisan Budget Act of 2018 (Pub. L. 115-123) into law, reauthorizing the RPG program through 2021. As part of the reauthorization, several changes were made to the RPG program, primarily adding required mandatory partners and a newly required planning phase, not to exceed 2 years or a funding disbursement of $250,000.

This chapter introduces the eight 5-year RPG projects funded in September 2019 (the RPG6 cohort). It describes who the projects planned to serve, the services they planned to offer, the entities involved in the partnerships, and planned features of their required local evaluations. Information in this chapter reflects what was known at the end of the first year of the grant (August 2020), which was a planning period. At that time, several of the partnerships were still making final decisions about their planned services or their evaluation designs. Information for the chapter is drawn from the applications submitted by the RPG6 awardees; the first federally required SAPR that the grantees filed in April 2020; and notes from meetings with grantees, their local evaluators, federal staff, and TA liaisons, which were held on a regular schedule from October 2019 through August 2020.

A. Target populations

Like the RPG5 partnerships, RPG6 partnerships planned to serve families with children of specific ages and levels of involvement with the child welfare system. Among the eight RPG6 projects, one planned to focus on families with infants, one planned to focus on families with preadolescent children (ages from birth to 12), and the rest planned to include families with children up to age 18, as shown in Table III.1.

Most of the RPG6 cohort, like the RPG5 cohort, planned to enroll families with an active child welfare case, in which services could possibly either prevent a child from being removed from the home because of a parent's substance use, or reunify families after such a removal. Of the eight projects, one (Illinois) planned to focus only on preventing child removals among families engaged with the child welfare agency, and four (Colorado, Georgia, Missouri, and West Virginia) planned to enroll families in which either preventing a child removal or reunifying a family was possible. One project (Oklahoma), in contrast, planned to serve families who might come to the attention of the child welfare agency because of the mother's prenatal substance use. The remaining two projects (New Hampshire and New Jersey) intended to enroll families in all three of these categories.

Table III.1. RPG6 planned target populations

State and grantee	Age of child at enrollment	Status of child welfare system involvement: At risk of involvement with the child welfare system	Child welfare involvement, child at risk of removal from home	Child welfare involvement, child removed from the home
Colorado: Colorado Judicial Department, State Court Administrator's Office	0–18		X	X
Georgia: Georgia State University Research Foundation, Inc.	0–18		X	X
Illinois: Youth Network Council dba Illinois Collaboration on Youth	0–18		X	
Missouri: Preferred Family Healthcare, Inc.	0–18		X	X
New Hampshire: Mary Hitchcock Memorial Hospital, dba Dartmouth-Hitchcock Medical Center	0–18	X	X	X
New Jersey: Acenda, Inc., Glassboro	0–18	X	X	X
Oklahoma: Oklahoma Department of Mental Health and Substance Abuse Services	Prenatal and 0–1	X		
West Virginia: Prestera Center for Mental Health	0–12		X	X

Note: dba = doing business as.

Sources: Calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic TA providers, which took place from December 2019 through August 2020; summaries of projects provided by the National Center on Substance Abuse and Child Welfare; and projects' SAPRs.

B. Planned services and service recipients

Many of the families RPG is designed to serve have multifaceted health and social service needs, and partners must decide which ones to address through which services. Like partnerships in the RPG5 cohort, the RPG6 partnerships plan to offer services in the following five core categories: (1) parenting or family strengthening, such as a parenting curricula or family problem-solving activities; (2) SUD treatment; (3) trauma or mental health treatment or counseling; (4) case management or service coordination; and (5) coaching or mentorship from a peer with experience in recovering from SUD.

The RPG6 project teams plan to use the grant to offer families an array of services spanning 2 or more of these categories (Table III.2). Four of the projects plan to offer a wide service array, spanning four of the service categories. Seven of the eight RPG6 projects will offer parenting supports, and six projects will offer trauma or mental health treatment or counseling. Five projects also plan to offer case management services and a form of peer support. Three plan to directly offer SUD treatment. Most plan on directly serving the adult and the family unit (typically through a family-centered therapeutic intervention), and three projects will also directly serve children through, for example, case management.

Table III.2. Planned services and service recipients for RPG6 projects

Lead organization and state	Targeted recipients of services	Types of RPG services planned				
		Parenting/family strengthening	SUD treatment	Trauma or mental health treatment	Case management or service coordination	Peer coaching, mentoring, or support
Colorado: Colorado Judicial Department, State Court Administrator's Office	Adult	X				X
Georgia: Georgia State University Research Foundation, Inc.	Adult, family	X		X		
Illinois: Youth Network Council dba Illinois Collaboration on Youth[a]	Adult, family	X	X	X	X	
Missouri: Preferred Family Healthcare, Inc.[a]	Adult, family	X	X		X	X
New Hampshire: Mary Hitchcock Memorial Hospital, dba Dartmouth-Hitchcock Medical Center	Adult, family, child	X		X	X	X
New Jersey: Acenda, Inc., Glassboro	Adult, family	X		X	X	X
Oklahoma: Oklahoma Department of Mental Health and Substance Abuse Services[a]	Adult, family, child	X	X	X		
West Virginia: Prestera Center for Mental Health[a]	Adult, family, child			X	X	X

[a] The Illinois Collaboration on Youth, the Oklahoma Department of Mental Health and Substance Abuse Services, and Prestera Center for Mental Health also have RPG4 grants. Preferred Family Healthcare, Inc., also has grants under RPG4 and RPG5. In some cases, the partnerships and programs are the same in each funding cycle, but in others, some partnership members and some or all of the planned services are different for RPG6.

Notes: dba = doing business as; RPG = Regional Partnership Grant program; SUD = substance use disorder.

Sources: RPG6 grant applications; calls between cross-site evaluation TA liaisons and grantees, local evaluators, federal project officers, and programmatic TA liaisons that were held from December 2019 through August 2020; and summaries of projects provided by the National Center on Substance Abuse and Child Welfare.

Project teams typically implement well-defined and evidence-supported services, as expected under the grant. The 8 RPG6 projects named a total of 28 program models in their grant applications (encompassing programs, curricula, and practices), with individual projects naming between 2 and 12 models (Appendix Table B.2). The 3 grantee agencies that are behavioral health treatment providers account for more than half of the 28 program models, because they often combine multiple program models and multiple service domains into a comprehensive treatment approach. Consequently, 13 of the 28 named program models are SUD treatment interventions, and 6 are focused on trauma and behavioral health care. In contrast, three projects took a more targeted approach, naming four or fewer program models.

C. Partnerships

In RPG, services are typically planned and implemented through partnerships that include the lead grantee organization, other public agencies, and other community service providers. Collaboration is an inherent part of the RPG funding stream, and is often the means through which lead agencies gain community support and leadership, identify eligible families and offer them the variety of services outlined above. Mandatory partners now include the state child welfare agency that is responsible for the administration of the state plan under Title IV-B or Title IV-E of the Social Security Act, and the state agency responsible for administering the

substance use prevention and treatment block grant provided under Subpart II of Part B of Title XIX of the Public Health Service Act 42 U.S.C. 629(f)(2)(A). If the partnership will serve children in out-of-home placement, the collaboration must include the Juvenile Court or Administrative Office of the Courts that oversees the administration of court programs that address the population of families who come to the attention of the court due to child abuse or neglect.

As expected, all RPG6 projects as proposed included a state or county child welfare agency, and all but one named a substance use and/or mental health system agency as a partner (Table III.3). Social service organizations and court or judicial systems involved in child welfare dependency cases were often included as partners, too. In their April 2020 progress reports, grantees said that the number of partners they were working with ranged from 6 to 9 organizations, for a total of 55 entities, including the lead grantee organizations, involved in the RPG6 cohort.

Table III.3. Type and numbers of organizations involved in RPG6 projects

									Total	
Type of organization	CO	GA	IL	MO	NH	NJ	OK	WV	Organizations	RPG6 projects
Child welfare system agency	1	1	1	1	1	1	1	1	8	8
Substance use or mental health system agency	1		1	1	1	1	1	2	8	7
Courts	1	3		1	1	1	1		8	6
SUD and/or mental health treatment provider			1	2		3	1	3	10	5
Child and family social services organization	2		4		1	1			8	4
University (including university-based local evaluators)		2			1		1		4	3
Private evaluator (non-university)		1	1					1	3	3
Healthcare					1	1	1		3	3
Other types	1		1	1					3	3
Number of organizations	**6**	**7**	**9**	**6**	**6**	**8**	**6**	**7**	**55**	**-**

Notes: "Other types" is used when there is only a single organization of a given type. Examples include an organization that supports victims of domestic violence and a youth advocacy organization.

Sources: Projects' semiannual progress reports.

D. Local evaluations

HHS requires projects to conduct local evaluations to learn about the implementation and outcomes of their unique set of services. RPG6 project teams proposed local impact and process evaluations as part of their grant applications, and during the planning year, they worked to refine and finalize their plans. Plans for the local impact evaluations are described in Table III.4.

Evaluation designs. HHS asked the projects to propose impact evaluation designs that featured comparison groups. Table III.4 shows that in their grant applications, all the projects proposed such designs. Half of the RPG6 projects planned to use a QED for their local impact evaluation (four projects), and three proposed an RCT; one team proposed to conduct both an RCT and a

QED. The projects anticipated enrolling between 216 and 2,100 families into their evaluation (across RPG program and comparison groups), as reported in their grant applications. Three of the projects hoped to enroll between 100 and 200 families, and 5 hoped to enroll more than 200 families.

Services that are being tested. Like those of the RPG5 projects, the RPG6 local evaluations were generally designed to measure the impact of the new services that projects added through RPG funds. Projects that added, for example, an intensive case management process to business-as-usual offerings designed evaluations to assess the effectiveness of the new case management piece. RPG6 projects implementing a combination of services planned to assess the impact of the combination. All eight projects planned to test their RPG services by comparing a treatment group, which was offered the usual standard of care plus the new RPG services, to a comparison group of similar families who only had access to the usual standard of care available through the lead organization or elsewhere in the state or community.

Progress on evaluation designs. As of August 2020, the RPG6 partnerships had made considerable progress on refining and finalizing their evaluation plans so that they could launch their evaluations right after the 1-year planning period, when they would start enrolling people into their programs. As they discussed in the implementation plans that they submitted to their federal project officers at the close of the first grant year, the project teams used the planning year to finalize their evaluation designs (with most of them maintaining the impact study designs proposed in their grant applications), develop plans for collecting the data (such as identifying which team members would collect data with clients), and hire key staff members to carry out the evaluations. Three projects were still in the process of solidifying plans for their comparison groups, such as identifying the sites that would refer families to the comparison group. In their first year, projects also took steps toward obtaining Institutional Review Board (IRB) approval from their local administrative authority, which HHS requires before teams can begin enrolling families into their evaluations. As of August 2020, one project had secured IRB approval, and the others had their requests under review or had not yet submitted them.

Table III.4. Summary of RPG6 projects' planned local evaluations

State and grantee	Local impact evaluation design		Services tested		Enrollment goal for impact evaluation (number of families)		
	RCT	QED	Treatment group	Comparison group	Treatment	Comparison	Total
Colorado: Colorado Judicial Department, State Court Administrator's Office	X		Circle of Parents in Recovery, a peer-run support group for parents in a family drug treatment court program called the Dependency and Neglect System Reform Program	Business-as-usual services from Dependency and Neglect System Reform Program	125	125	250
Georgia: Georgia State University Research Foundation, Inc.		X	Family treatment court's usual behavioral health services enhanced with a parenting skills intervention	Business-as-usual family treatment court services	90	90	180
Illinois: Youth Network Council dba Illinois Collaboration on Youth		X	Child welfare's Intact Family Services (IFS) program, enhanced with a recovery coordinator for specialized case management and extended for an extra 6 months; the recovery coordinator, staffed by an SUD treatment partner, conducts case planning with the IFS caseworker	Business-as-usual Intact Family Services	240	240	480
Missouri: Preferred Family Healthcare, Inc.	X		Two program groups: both receive Preferred Family Healthcare's usual behavioral health services enhanced with a family advocate for outreach/advocacy, service planning, and either the Helping Men Recover/Helping Women Recover trauma education program (Group 1) or the Living in Balance relapse prevention program (Group 2)	Preferred Family Healthcare's business-as-usual behavioral health services	Group 1: 72 Group 2: 72	72	Group 1: 144 Group 2: 144
New Hampshire: Mary Hitchcock Memorial Hospital, dba Dartmouth-Hitchcock Medical Center	X		A wraparound coordinator for care coordination and referrals, plus expanded access to child-parent psychotherapy and Sober Parenting Journey	Business-as-usual community services	80	80	160
New Jersey: Acenda, Inc., Glassboro		X	SUD assessment and case planning, an in-home therapist for parenting/family functioning interventions, and a peer recovery coach	Business-as-usual community services	535	450	985

State and grantee	Local impact evaluation design		Services tested		Enrollment goal for impact evaluation (number of families)		
	RCT	QED	Treatment group	Comparison group	Treatment	Comparison	Total
Oklahoma: Oklahoma Department of Mental Health and Substance Abuse Services	X	X	RCT: Modified Attachment Biobehavioral Catchup (mABC) home visiting program model, plus prenatal and SUD treatment services through a Substance Use Treatment and Access to Resources and Supports (STARS) clinic QED: SUD treatment and prenatal care through STARS clinic, plus mABC for half the group	RCT: STARS clinic services only QED: Business-as-usual obstetric and community SUD treatment services	RCT: 42 QED: 84	RCT: 42 QED: 42	RCT: 84 QED: 126
West Virginia: Prestera Center for Mental Health		X	Wraparound intensive care coordination services from a care coordinator, peer recovery coach, and/or a family therapist	Business-as-usual child welfare case management	260	Not reported	Not reported

Notes: dba = doing business as; QED = quasi-experimental design; RCT = randomized controlled trial; SUD = substance use disorder.

Sources: Grantees' RPG applications; calls between Mathematica and grantees, local evaluators, federal project officers, and programmatic TA providers, which took place from October 2019 through August 2020; and the National Center on Substance Abuse and Child Welfare grantee profiles.

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IV. THE RPG6 PLANNING YEAR

The Bipartisan Budget Act of 2018 (Pub. L. 115-123) required a planning period of up to 2 years for all RPG projects. Before that act was passed, HHS had encouraged RPG partnerships in earlier cohorts to use the first 6 to 12 months of their grants for planning. Grantees and their partners could use this time to finalize their services and evaluation designs, obtain IRB clearance, and execute agreements with state agencies to obtain administrative data. In practice, though, partnerships were usually eager to get implementation started, and sometimes they did not set aside enough planning time to complete these milestones. Consequently, their implementation did not always proceed as smoothly as it might have.

In the funding opportunity announcement for RPG6, HHS formalized this planning time by requiring grantees to commit to a 1-year planning phase.[5] Grantees were expected to complete intentional work to prepare for implementation and the evaluation. The expected activities included (1) finalizing governance, data sharing, or other agreements with partners; (2) refining the target population and eligibility criteria, and the referral and recruitment processes; (3) assessing the appropriateness of the project's intervention for the target population and making changes to the program model if necessary (and with approval from HHS); (4) building capacity and readiness for implementation and evaluation among the lead agency and key partners; (5) obtaining IRB approval; and (6) completing data sharing agreements to obtain administrative data on child welfare and SUD treatment from state agencies to support the cross-site evaluation.

The planning period also included time to refine and strengthen local evaluation designs. The partners used this time to make any necessary changes to their evaluation in response to the refinements that they were making to their project design, partnerships, and target populations, and making sure that they were meeting the cross-site evaluation requirements, such as using specified instruments to collect data on child well-being. HHS expected partners to make changes to their programs and local evaluations during the planning year. To formalize their final plans and ensure HHS approval, the planning period culminated in a project implementation and evaluation plan, produced by each grantee on behalf of the partnership, and submitted to their federal project officer for review. Once the project officer approved the plan, projects could begin enrollment and services. Details from the grant applications and approved plans for each RPG6 project are in Chapter III.

This chapter describes grantees' activities in the planning year. As projects begin implementation, HHS can examine how the new planning requirement affected the implementation experiences of RPG6 projects, and consider whether or how to modify its approach to the new requirement by considering whether one year was long enough, or whether future cohorts should have a second planning year.[6]

[5] The funding opportunity announcement stated that HHS could approve grantees to begin implementation earlier than 12 months, if they did not require a full year of planning. No RPG6 projects moved to the implementation phase until at least 12 months after award.

[6] For example, during a second year the projects could pilot test their services, and refine them if needed.

HHS supported project teams' efforts throughout the planning year through project meetings and TA, described in Section A. Section B describes the types of group-based TA HHS provided during the planning period. Section C describes the individual TA RPG6 grantees and evaluators received during the planning period. Finally, Section D describes the activities partnerships undertook during the period, and briefly summarizes the progress made to develop their implementation and evaluation plans.

A. HHS approach to federal TA

RPG funds partnerships, and the funds come with significant responsibilities for programming and evaluation. For this reason, HHS contracts with outside entities to provide TA through group and one-on-one activities. The contractors provide group TA by making presentations at orientations and annual meetings and webinars. They support individual grantees with regular conference calls and site visits. Contractors also provide written materials and resources to support successful cross-system partnerships. Examples of those materials are available at https://ncsacw.samhsa.gov/collaborative/default.aspx. The materials also give guidance on evaluation (such as Avellar et al., 2017, for tips or planning impact evaluations; or D'Angelo et al., 2016, for guidance on whether and how to provide data collection incentives to adults with substance use issues).

HHS contracted with two entities to provide TA to all RPG grantees. HHS contracted with Mathematica to integrate the RPG6 cohort into the ongoing national cross-site evaluation. As part of the contract, Mathematica also provides TA to support grantees' submission of common data elements to the cross-site evaluation and to help grantees design and conduct their own required local evaluations. As part of its contract to manage the National Center for Substance Abuse and Child Welfare (NCSACW), supported through an intra-agency agreement between SAMHSA and ACF, the Center for Children and Family Futures provides program-related TA to the grantees. The federal TA team working with each project includes the project's federal project officer, a programmatic TA provider known as a change liaison, and an evaluation TA provider known as a cross-site evaluation liaison.

The members of each team collaborate with projects. They iteratively assess projects' TA needs and use, and present possible options for further action or to resolve problems. The team members aim to make decisions collaboratively with each partnership; the partnership is represented by the RPG project director who is employed by each grantee agency, and the lead evaluator who is retained by the grantee on behalf of the partnership. Sections B and C below describe the TA activities during the planning year.

B. HHS group-based supports for all RPG6 projects during planning year

The main way HHS directly supported the new projects as a group during the planning year was by holding three events: an orientation webinar, an in-person meeting, and an annual in-person conference for all active RPG projects. These events were intended to provide opportunities for the RPG project leaders to connect and collaborate with each other, their TA providers, and federal staff.

First, HHS held a 90-minute orientation webinar with the eight RPG6 projects in November 2020, shortly after grants were awarded. The call introduced the projects to one another, and

gave an overview of the role of the Children's Bureau, which administers RPG, and the RPG funding stream. For example, Children's Bureau staff described the Bureau's structure and purpose; the history of the RPG program, including its authorizing legislation and the location of projects from earlier rounds of funding, the cooperative agreement structure of RPG projects, the goals and activities for the planning phase; and the design of the cross-site evaluation and how projects participate in it. To help project teams get a sense of what their peers in the RPG6 cohort were doing, HHS shared an overview of the eight projects, including the organizations involved, the people whom they expected to serve, and the approaches that they expected to use. Staff from each RPG6 grantee also briefly presented their project and evaluation designs. Finally, the call explained HHS' approach to providing TA to the projects (as described in Section A).

Soon after the orientation webinar, HHS convened all RPG6 project teams, TA providers, and federal staff for an in-person kickoff meeting in Washington, DC. HHS asked each RPG project to invite its key program and evaluation staff, along with representatives of its key partners, to the kickoff meeting. Taking place over 3 days in December 2019, this meeting helped to cement projects' understanding of the grant expectations and to assist in their planning efforts. It was also an opportunity for these RPG stakeholders to get better acquainted and start developing positive working relationships.

The meeting included presentations by the Children's Bureau, NCSACW, and Mathematica. HHS staff introduced the meeting's objectives and offered reflections after each day's sessions. In addition, HHS leaders also outlined their vision and priorities for RPG. The TA providers shared information on team building, creating successful collaborative partnerships, and planning for implementation, along with evaluation-related topics such as data-informed decision making, designing rigorous local evaluations, and requirements for the cross-site evaluation. The TA providers also facilitated interactive breakout sessions so project teams could work together on their implementation plans. In some cases, these conversations were some of the first opportunities that partner and lead agency staff had for in-depth planning since they wrote their grant applications. Staff from HHS and the TA providers circulated and joined conversations throughout the sessions.

Each project also had time to present details on its planned program and evaluation, with time for discussion after each presentation. This allowed each project to learn what other teams were working on, enabling peers with similar plans to connect with each other. For instance, staff from two projects shared that they planned to use a wraparound service model. Later in the meeting, they exchanged contact information so that they could connect with each other after the kickoff meeting. Because grantee agencies from five of the eight RPG6 projects had received funding in earlier rounds of RPG, teams from the three projects new to RPG used the opportunity to network and learn from the seasoned projects. Each project team left the meeting with an action plan it had developed during the kickoff.

Finally, all projects attended the RPG annual grantee meeting, which HHS held over 2.5 days in March 2020 in Washington, DC. This meeting included teams from all three of the active RPG cohorts (RPG4, RPG5, and RPG6). As it had in the kickoff meeting, HHS asked projects to invite their primary program staff, lead evaluation staff, and key partners, such as representatives of state or local child welfare agencies supporting some of the projects. Staff and representatives

from the Children's Bureau also attended, along with the change liaisons and cross-site liaisons from NCSACW and Mathematica, respectively, and leadership from both entities.

Like the kickoff meeting, the grantee meeting included a variety of sessions. During the meeting, HHS and the TA providers made presentations on topics such as mapping community resources, planning for sustainability, and presenting the findings from the RPG3 impact evaluation. In addition, the meeting included time for breakout sessions to discuss specific topics in smaller groups, or for project teams to meet with each other for action planning. TA providers circulated during the breakout sessions to listen and offer suggestions or to make note of potential needs for additional or future TA. Although most of the sessions covered topics relevant for all grant rounds, a few breakout sessions were specifically for RPG6 projects, such as ones that reiterated the requirements of the cross-site evaluations. As they did in the kickoff meeting, projects had an opportunity to connect with their peers. For instance, people representing one RPG6 project connected with people representing an RPG4 project because they were both serving expectant mothers. They discussed recruiting and collecting cross-site and local evaluation data for this population.

Outside of these meetings, the TA team also presented webinars and facilitated virtual spaces for grantees to share their experiences. The programmatic TA provider facilitated meetings, called communities of practice, for the active RPG4, RPG5, and RPG6 projects. These small group meetings, which were held by teleconference, convened projects with similar target populations or service delivery methods to discuss common issues or opportunities. For example, there were community of practice meetings for projects serving American Indian and Alaska Native families, and also for projects that planned to provide peer supports as part of their RPG services.[7] Within communities of practice, the TA provider and project teams discussed strategies for addressing common challenges that arise when serving similar families or delivering similar services. Key project staff also learned from the experiences of their peers, including those from RPG4 and RPG5 projects with lessons to share.

Similarly, Mathematica's cross-site evaluation team, including the CSLs, held trainings and peer learning calls relevant to the cross-site evaluation and to help build local evaluation capacity. For example, the cross-site evaluation team held an interactive peer learning call specifically to discuss the challenges and opportunities involved in requesting and obtaining administrative data from state agencies, and for projects to share successful strategies that they had used in the past for securing data sharing agreements and obtaining data from agencies once the agreements were in place.

In addition, to help prepare program and evaluation staff for the data collection and submission requirements of the cross-site evaluation, Mathematica released several prerecorded trainings that RPG project leaders and their staff could listen to when their schedules allowed. For each recorded training, Mathematica held a live question-and-answer session so RPG project leaders and staff could ask questions. Topics included administering standardized instruments to the adults in RPG families, entering data on enrollment and services into the RPG-EDS system, and

[7] Recovery peers are people with lived experience similar to that of people participating in SUD treatment. The peers can support and mentor adults or families during treatment, and especially during continued recovery after treatment ends.

preparing and uploading standardized instrument and administrative data into the secure data system.

C. TA provided to individual grantees during planning year

In addition to group-based activities, the TA teams provided focused one-on-one TA to each RPG6 grantee and the grantee's local evaluators. The grantee-specific TA included monthly calls, site visits, and additional supports as needed. Through the individual TA activities, the evaluation TA liaisons collected information for an assessment of the rigor of each local evaluation and to find areas for potential improvement.

1. Monthly TA phone calls

Throughout the planning period (a full year for RPG6), the federal TA teams held monthly one-hour calls with selected members of each RPG6 project. This practice was also used for earlier RPG cohorts. The calls typically covered updates, questions, and concerns about the program and the evaluation. Teams spent about 30 minutes each on the program and the evaluation, although some calls focused on one topic more than the other, depending on the grantee's needs for the month. For instance, calls focused longer on the evaluation if the project was working through the details of its research design or data collection plans. Conversely, calls spent more time on programmatic issues if the TA team was helping the project staff work through issues with hiring facilitators to implement the program or was answering a question about the role of a particular partner. The exact attendees varied by project, but typically included at least project leaders, the lead evaluator and other key evaluation staff, staff from partner agencies, the federal project office, evaluation TA liaison, and program TA liaison.

2. TA site visits

From April through August 2020, the federal TA teams, including the change liaison and cross-site evaluation liaison, organized a site visit with each project. The purpose of the visit was to offer in-depth TA as grantees finalized their implementation and evaluation plans. A second purpose was to meet with, and provide an orientation for, representatives of all members of the RPG partnerships for each project. These visits were meant to take place in person over two days at the grantee organization's site. However, HHS shifted to virtual video visits in response to travel restrictions, stay-at-home orders, or recommendations, and to ensure safety during the COVID-19 public health emergency in 2020 (discussed at length in Chapter VII).

The federal TA team worked with the project teams to generate an agenda and schedule tailored to the needs of each project. Most of the site visits included discussions that covered an overview of RPG, the importance of collaboration between partners, and the program evaluation requirements. Each partnership gave the federal TA team a presentation describing their planned programs and evaluations in more detail than they could convey in their grant applications or in the ongoing monthly calls. The change liaisons and cross-site liaisons led discussions of program- and evaluation-related issues, respectively, which were tailored to the specific needs of each project. Common topics were how participants would flow through the program services from enrollment through completion, and what the local evaluation design and planned data collection procedures were. Based on the specific needs of the project, there were other sessions at some sites, such as a steering committee meeting, provider and stakeholder meetings, and in-depth discussion of the program model(s) that the project planned to implement.

3. Additional TA

To provide extra support during the planning year, the change liaisons and cross-site evaluation each supplemented the monthly calls and site visits with additional forms of support tailored to the needs of each project. For one project, the change liaison held supplemental monthly calls to address programmatic issues in more depth. In particular, the change liaison met with the project director to talk through changes needed in the planned program based on feedback the grantee had received from its state child welfare partners. These changes were relatively extensive, so having separate calls allowed more time for nuanced, detailed conversations than they had in the regular monthly calls, which were usually just an hour long. The project modified the intervention (1) to add a motivational interviewing component, which was designed to encourage parents to enter SUD treatment, and (2) to refine the planned components to include in-home therapy for families after parents' treatment for substance use ended.

4. Assessment of local evaluation plans

To support learning among RPG stakeholders, the broader child welfare field, and related fields, HHS requires each project to conduct a local evaluation in addition to providing data for the cross-site evaluation. To assess each project's capacity for this, at the end of the planning year the cross-site liaisons gave written, detailed feedback about the strengths and weaknesses of each project's local evaluation plans to the federal project officer for each of the eight RPG6 projects.

These evaluability assessments were based on all the information the cross-site liaison had collected in one-on-one TA, the site visits, and the project team's grant applications. The assessments described the target population and the expected size of the evaluation sample; the plan for recruiting and enrolling people into the study; the services planned for the RPG and comparison groups; the research design; and the timing and procedures for data collection. Each assessment succinctly described the evaluation plan as it stood at the end of the planning period, and rated the rigor of the evaluation design.[8] The evaluation TA liaison also described how likely each evaluation was, as designed, to produce credible evidence on program impacts if projects implemented their plans successfully. Further, the liaison catalogued specific concerns about the design, if any, and recommended improvements to it.

D. Partnerships' planning activities

Outside of their work with the federal TA team, RPG partnerships undertook planning activities throughout the year and refined the plans outlined in their grant applications as needed. For example, they convened steering committee meetings. The meetings could include key stakeholders such as leaders of state or local child welfare and SUD treatment agencies, plus staff from other partner organizations such as those identified in Chapter III.

Steering committee meetings typically addressed topics such as identifying the purpose of the committee and its role throughout the RPG project or completing community mapping to identify existing services and gaps in community services. The committees also developed plans

[8] Evaluation rigor refers to the ability of the evaluation to identify outcomes that can be attributed to the program being evaluated, and not to differences between the people who enrolled in RPG and those who did not. Examples are an increased readiness for change or less severe substance use issues among people who were in the program.

for recruiting and getting people referred to the RPG project, and they often gave input on potential revisions to the program or evaluation outlined in the grant application.

Other activities conducted by the partnerships in the planning year commonly included:

- Establishing lines of communication between the project and evaluation teams, and specifying roles for all team members.
- Outlining recruitment and enrollment procedures and protocols with referral partners.
- Creating databases and processes for securely collecting and storing participant data for local use.
- Working to secure data sharing agreements with the state, as well as securing IRB approvals.
- Hiring project staff for implementation.

All teams refined their project and evaluation plans over the course of the planning and TA activities and the meetings of the steering committee or other committees. Some projects substantially changed their original plans. For example, two projects modified their local evaluation to be more rigorous and align more closely to the cross-site evaluation by, for example, replacing data collection instruments that they had initially selected with the instruments that were recommended for the cross-site evaluation. Instead of creating a comparison group from administrative data and not collecting any primary data from comparison group members, as originally planned, both projects also decided to conduct an RCT. This change will allow for a more rigorous assessment of the impacts of the RPG project and contribute more data to the cross-site evaluation.

At the end of the planning year, RPG projects submitted an implementation and evaluation plan to HHS to provide details of those plans set forth in their RPG grant applications, and to summarize how their plans had evolved. Each project's federal project officer solicited reviews of the plans from the change liaison and cross-site liaison for each site, and then prepared letters of approval to begin implementation. Based on these plans, six of the RPG6 projects expected to begin enrollment after the required 1-year planning period ended in September 2020. The other two grantees were still working out final planning with their partners and the state agencies that they were requesting data from. One of these grantees expects to finalize its plans in fall 2020 and start enrolling people by January 2021. The second grantee expects to start enrolling people by March 2021 after completing its planning in winter 2021.

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V. CHARACTERISTICS OF RPG ENROLLEES

RPG partnerships define the part of the overall RPG target population that they wish to serve. For example, some projects decide to enroll families based on how old the children are and/or whether they are involved with the child welfare system. One project might focus on children who have already been removed from the home by child protective services (CPS), another on children who are still in the home but have come to the attention of CPS, and a third on children who are at risk based on a parent's substance use. Some projects serve families in which a parent has been diagnosed with or is in treatment for SUD, which is a clinical diagnosis, has screened positive for a potential SUD, or misuses some type of substance.[9] Depending on how successful projects are at recruiting and enrolling families in their target populations, the characteristics of people who are enrolled in RPG, such as the ages of children, will reflect those target populations.

The demographics of people who are enrolled in RPG also reflect the demographics of the communities or regions where projects operate, and reflect any other ways that partnerships target their RPG services; for example, by providing residential SUD treatment services versus outpatient services. For the cross-site evaluation, RPG4 and RPG5 projects provide information on the characteristics of both adults and children who enroll in RPG.[10] The diversity of the RPG4 and RPG5 participant population can be revealed by examining that information.

This chapter summarizes the demographic characteristics and economic situations of the people who enrolled in RPG4 and RPG5 between March 1, 2019, and July 2, 2020,[11] resulting in a snapshot of the people who are enrolled in the projects. Section A gives a broad perspective of the characteristics of participants across all the RPG4 and RPG5 projects. This masks some diversity that is revealed by looking at projects with specific target populations, such as those shown in Table V.1. For example, one subset of the RPG4 and RPG5 projects (10 projects) includes pregnant women and parents with newborn children in their target population. Another subset of projects specifically serve American Indians/Alaska Natives (4 projects). The other RPG4 and RPG5 projects have other target populations, such as families with children up to age 18, not just newborns or young children, and do not focus on serving a specific racial or ethnic community. Sections B and C, respectively, capture the diversity of the population enrolled in RPG4 and RPG5 by summarizing the characteristics of participants in the projects designed for pregnant women and parents of young children and the projects designed to include American Indians/Alaska Natives.

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

[10] RPG6 projects will also submit the same information once they begin implementation.

[11] March 1, 2019, is when grantees completed cross-site data collection training related to collecting information on enrollment, services, and outcomes. July 2, 2020, is the last date on which grantees uploaded outcomes data before data analysis for this report began. These inclusive dates for data were used to align the data sample across the chapters on enrollment, services, and outcomes.

One limitation of the data in this chapter, however, is that they are a snapshot of just the early enrollment profile for the RPG4 and RPG5 projects. When the projects end, further analysis will fully portray the people whom all the projects enrolled across their entire grant periods.

Another limitation of the data is that the projects aim to serve different numbers of families, and they enroll families at different rates. Consequently, projects that plan to serve more families or that enroll families faster will have more participants represented in these enrollment data. Thus, the aggregate demographic and economic characteristics in this chapter could be skewed by the larger projects or by those projects implementing their services faster.

Table V.1. Target populations served by the RPG4 and RPG5 projects

		Target populations		
State	Grantee	Pregnant women and parents of newborns	American Indians/Alaska Natives	Other target populations
RPG4 projects				
Alaska	Cook Inlet Tribal Council, Inc.		X	
Alabama	University of Alabama at Birmingham	X		
Delaware	Children & Families First Delaware	X		
Florida	Broward Behavioral Health Coalition, Inc.			X
Illinois	Youth Network Council dba Illinois Collaboration on Youth			X
Indiana	Volunteers of America Indiana	X		
Iowa	Northwest Iowa Mental Health dba Seasons Center			X
Kansas	University of Kansas Center for Research, Inc.		X	
Kentucky	Mountain Comprehensive Care	X		
Missouri	Preferred Family Healthcare, Inc.			X
Ohio	The Ohio State University			X
Oklahoma	Oklahoma Department of Mental Health and Substance Abuse Services	X		
Tennessee	Helen Ross McNabb Center	X		
Vermont	Lund Family Center, Inc.	X		
Washington	Catholic Charities of Spokane		X	
West Virginia	Prestera Center for Mental Health			
Wisconsin	Meta House, Inc.			X
RPG5 projects				
Florida	Citrus Health Network dba Citrus Family Care Network			X
Florida	Family Support Services of North Florida	X		
Illinois	Centerstone of Illinois, Inc.			X
Iowa	Judiciary Courts for the State			X
Iowa	Northwest Iowa Mental Health Seasons Center			X
Massachusetts	Institute for Health and Recovery, Inc.			X
Missouri	Preferred Family Healthcare, Inc.			X

State	Grantee	Target populations		
		Pregnant women and parents of newborns	American Indians/Alaska Natives	Other target populations
New York	Montefiore Medical Center	X		
Pennsylvania	Health Federation of Philadelphia	X		
South Dakota	Volunteers of America, Dakotas		X	

Source: RPG grant applications.

A. Characteristics of the people enrolled in RPG

From March 1, 2019, through July 2, 2020, the RPG4 and RPG5 projects enrolled 554 cases. RPG defines a case as the group of people who enroll together in RPG services. The cases included in this report have a total of 1,796 participants; 675 are adults and 1,121 are children, including 53 unborn children who were enrolled in the case when a pregnant women enrolled for RPG services. As described below, members of cases have biological or other relationships to each other—they are members of nuclear, extended, or joint families, although the case might not include all family members.

Table V.2 shows the composition of the families who enrolled in RPG. At a minimum each family consists of one adult and one child, even if projects plan to provide services only to the adult or only to the child. This is because the goal of RPG is to improve family outcomes in the domains of adult recovery and child safety, permanency, and well-being, so each case must include at least one adult and child for whom these outcomes can be measured. However, there is no upper limit to the number of people who can enroll in RPG together; the projects serve both small and large families. The average size of families enrolled in RPG4 and RPG5 is three.

Table V.2. Composition of families enrolled in the RPG4 and RPG5 projects

	Total
Families (n)	554
Individuals (n)	1,796
Average number of people in a family	3
Range in family size	2 to 10 people
Adults	675
Children	
All children	1,121
Unborn children only	53

Source: RPG-EDS data, March 1, 2019, through July 2, 2020.

Table V.3 shows the percentage of families who came to the RPG4 and RPG5 projects from various referral sources. Child welfare agencies were the most common referral source, with 56 percent of all families referred by agencies. SUD providers and courts, the next most common sources, referred 11 percent and 10 percent of families, respectively, across all projects. The table also shows referral sources for two subgroups of participants – those specifically designed to serve pregnant women and parents of newborns and those serving American Indians and Alaska Natives. (The tables in the rest of this chapter also show information for these two

subgroups. Chapters VI and VII provide more information about participant outcomes and services received, respectively, in projects serving pregnant women and parents of newborns.)

Table V.3. Referral sources for families enrolled in the RPG4 and RPG5 projects

	Families enrolled across all RPG4/5 projects		Families enrolled in RPG4/5 projects for pregnant women and parents of newborns		Families enrolled in RPG4/5 projects for American Indians and Alaska Natives	
	Percent	n	Percent	n	Percent	n
Child welfare agency (public or private)	56	312	3	3	28	11
SUD treatment provider	11	59	26	27	3	1
Mental or behavioral health provider	7	40	2	2	8	3
Hospital or clinic	0	1	56	58	0	0
Family support service agency	2	12	0	0	8	3
Indian/Native American Tribally Designated Organization	2	13	5	5	0	0
Self-referral/walk-in	5	29	8	8	54	21
Court	10	55	0	0	0	0
Other	1	7	0	0	0	0
Unknown	5	26	0	0	0	0

Source: RPG-EDS data, March 1, 2019, through July 2, 2020.

Across all the projects, most adult participants were females[12] (82 percent), and most were non-Hispanic and White (64 percent), as shown in Table V.4. The majority (52 percent) were ages 25 to 34. Most of the adults enrolled in RPG did not have college degrees; 65 percent of them completed some high school or had a high school diploma. Additionally, most of the adult participants faced economic challenges. Just over one-third of the adult participants (37 percent) were employed, either full time or part time. About one-third reported that their largest income source was public assistance such as Temporary Assistance for Needy Families; the Women, Infants, and Children Nutrition Program; and Supplemental Security Income (SSI) (31 percent). Fourteen percent said that they received most of their income from other people and the same proportion (14 percent) had no income from any source.[13] (The cross-site evaluation only collected demographic and economic data on income for adults enrolled in the RPG case; there is no information on the income of people who live in the same household, but did not enroll in RPG.)

[12] Gender is a required field at enrollment, and there are only two responses available, male or female.

[13] If one of the prespecified income sources did not apply to a participant, projects could select "other," and specify the income source. Across the projects, only 2 percent of adults had "other" selected as their largest income source.

Table V.4. Characteristics of adults enrolled in the RPG4 and RPG5 projects

	Families enrolled across all RPG4/5 projects		Families enrolled in RPG4/5 projects for pregnant women and parents of newborns		Families enrolled in RPG4/5 projects for American Indians and Alaska Natives	
	Percent	n	Percent	n	Percent	n
Gender						
Male	18	181	16	54	11	19
Female	82	829	84	281	89	157
Age						
Younger than 18	0	0	0	0	0	0
18 to 24	16	161	20	67	17	30
25 to 34	52	521	53	177	57	100
35 to 44	25	255	22	73	20	35
45 to 54	5	52	5	15	3	6
55 to 64	1	13	1	2	2	4
65 or older	1	7	0	1	1	1
Mean	33		31		32	
Race and ethnicity						
White, non-Hispanic	64	596	63	196	28	45
Black or African American, non-Hispanic	13	122	20	61	1	2
American Indian or Alaska Native, non-Hispanic	11	99	0	1	59	96
Asian, non-Hispanic	0	2	1	2	0	0
Native Hawaiian or Other Pacific Islander, non-Hispanic	0	0	0	0	0	0
More than one race, non-Hispanic	3	23	2	6	4	6
Hispanic or Latino (any race)	10	94	16	50	9	14
Primary language[a]						
English only	99	951	99	320	100	165
Spanish only	1	9	1	2	0	0
Other	0	1	0	0	0	0
Highest education level						
8th grade or less	2	21	2	6	1	1
Some high school	24	210	26	68	31	49
High school diploma/GED	41	360	36	95	38	60
Some vocational/technical education	4	32	2	5	6	9
Vocational/technical diploma	2	14	2	4	2	3
Some college	20	179	24	62	21	33
Associate’s degree	3	24	2	5	1	2
Bachelor’s degree	3	30	4	11	1	1
Graduate-level schooling or degree	1	9	2	5	1	2
Employment status						
Full-time employment	22	198	19	55	11	18
Part-time employment	15	130	10	29	12	20
Self-employed	2	20	1	4	1	2

	Families enrolled across all RPG4/5 projects		Families enrolled in RPG4/5 projects for pregnant women and parents of newborns		Families enrolled in RPG4/5 projects for American Indians and Alaska Natives	
	Percent	n	Percent	n	Percent	n
Not employed but looking for work	28	247	17	51	53	86
Not employed and not looking for work, or unable to work	34	301	53	158	22	35
Relationship/marital status						
Never married	63	581	71	220	64	105
Married	19	173	17	53	12	20
Divorced/widowed/separated	19	172	12	38	24	40
Largest income source						
Wages/salary	36	316	29	78	17	28
Public assistance (TANF, WIC, Food stamps/SNAP)	23	201	31	84	23	38
Retirement/pension/spousal survivor's benefits	1	8	0	1	1	1
Disability/SSI	7	61	7	19	5	8
Unemployment benefits	2	13	1	2	0	0
Child support	1	11	1	2	1	2
Support from other individuals	14	125	16	43	7	11
Child's benefits (SSI, survivor's benefits)	1	8	2	5	0	0
Other	2	15	0	1	6	9
None	14	122	12	33	41	66

[a] RPG-EDS captures one primary language option from these three: “English only,” “Spanish only,” or “Other.” No specified response is requested for “Other.”

Notes: TANF = Temporary Assistance for Needy Families; SNAP = Supplemental Nutrition Assistance Program; SSI = Supplemental Security Income; WIC = Women, Infants, and Children Nutrition Program.

Source: RPG-EDS data, March 1, 2019, through July 2, 2020.

The population of children was slightly more racially and ethnically diverse than the adult population in RPG4 and RPG5. Just over half of the children enrolled were non-Hispanic and White (51 percent). These and other demographic characteristics, along with the economic circumstances of children enrolled in RPG4 and RPG5, are in Table V.5. There were almost equal numbers of male and female children, and about half the children were age 4 or younger. At enrollment, most of the children were living in a private residence (86 percent). Most of them were living in private residences, and, as noted, were living with at least one biological parent. Three in four children enrolled in RPG4 and RPG5 were on Medicaid, which is the nation’s public health insurance program for people with low incomes, including adults, children, and pregnant women (Centers for Medicare and Medicaid Services, n.d; Rudowitz et al., 2019).[14]

[14] States can also choose to provide Medicare to other groups, such as children in foster care who are not eligible otherwise.

Table V.5. Characteristics of children enrolled in the RPG4 and RPG5 projects

	Families enrolled across all RPG4/5 projects		Families enrolled in RPG4/5 projects for pregnant women and parents of newborns		Families enrolled in RPG4/5 projects for American Indians and Alaska Natives	
	Percent	n	Percent	n	Percent	n
Gender						
Male	52	719	53	171	50	149
Female	48	674	47	154	50	149
Age						
Younger than 1	19	269	31	102	17	50
1 to 4	32	449	33	107	39	115
5 to 8	24	328	15	50	31	92
9 or older	25	347	20	66	14	41
Mean	6		4.6		5	
Race and ethnicity						
White, non-Hispanic	51	637	45	132	24	66
Black or African American, non-Hispanic	1	194	18	54	1	2
American Indian or Alaska Native, non-Hispanic	10	124	1	3	44	120
Asian, non-Hispanic	0	0	0	0	0	0
Native Hawaiian or Other Pacific Islander, non-Hispanic	0	1	0	0	0	0
More than one race, non-Hispanic	10	121	13	38	14	39
Hispanic or Latino (any race)	14	173	23	69	17	46
Primary language[b]						
English only	99	1283	100	311	100	278
Spanish only	1	10	0	0	0	0
Other	0	0	0	0	0	0
Medicaid status						
Receiving Medicaid	75	1046	64	207	61	182
Not receiving Medicaid	4	57	6	19	5	14
Status unknown	21	290	31	99	34	102
Primary type of residence at enrollment						
Private residence	86	1192	86	278	64	190
Treatment facility	6	84	12	38	7	21
Correctional facility/prison	0	0	0	0	0	0
Homeless/shelter	2	33	2	6	7	22
Group home	1	14	1	2	1	4
Other	0	0	0	0	0	0
Unknown	5	70	0	1	20	61
Primary adults in household at enrollment						
Biological mother only	24	332	30	97	22	64
Biological father only	6	78	2	6	9	28

	Families enrolled across all RPG4/5 projects		Families enrolled in RPG4/5 projects for pregnant women and parents of newborns		Families enrolled in RPG4/5 projects for American Indians and Alaska Natives	
	Percent	n	Percent	n	Percent	n
Both biological mother and father	10	143	20	64	1	4
Other relative or adult only[a]	23	326	9	30	30	90
Any biological parent and a relative/other adult	17	231	35	114	5	15
Non-relative foster parent only	15	203	3	9	14	42
Other	0	0	0	0	0	0
Unknown	6	79	2	5	19	55

[a] "Other relative or adult only" includes situations in which children are living with foster parents who are their relatives.

[b] RPG-EDS captures one primary language option from these three: "English only," "Spanish only," or "Other." No specific response is requested for "Other."

Source: RPG-EDS data, March 1, 2019, through July 2, 2020.

The most common family makeup is 1 adult and 1 child (46 percent). Just over half of the children lived with at least one biological parent: 40 percent of children lived with one or both biological parents, and 13 percent lived with at least one biological parent and another relative. However, more than one-third of the children enrolled in RPG4 and RPG5 (38 percent) did not live with any biological parents, including 23 percent of children who were living only with other relatives, and 15 percent of children who were living with a non-relative foster parent. Almost all (98 percent) of the children were biologically related (including half-siblings) to at least some of the other children in their family who enrolled together with them in RPG4 and RPG5 (not shown). Only 11 percent of families included children who were not biologically related to any of the other children in the family.

B. Participant characteristics: projects serving pregnant women and parents of newborns

Ten of the 27 RPG4 and RPG5 projects are designed to serve pregnant women or parents of newborn children. Specifically, they aim to serve pregnant women who are in SUD treatment or women who give birth to newborns who test positive for illegal substances. Across these 10 projects, the characteristics of the participants differ from the characteristics of participants in the overall RPG4 and RPG5 caseload in several ways. They enter the projects from different referral sources; they are younger and more racially and ethnically diverse; and a higher percentage of them face economic challenges.

Participants in projects serving pregnant women and parents of newborns typically enter RPG services because they received referrals from hospitals and SUD treatment providers, with 83 percent of the families entering services through referrals from these two sources (Table V.4). These two referral sources align with the criteria for the target population: pregnant women who are in SUD treatment or have given birth to children who test positive for illegal substances. In

contrast, the main referral source for all the RPG4 and RPG5 projects combined is child welfare agencies (Table V.3).

The enrollees of projects serving pregnant women and parents with newborns are younger and more racially and ethnically diverse than the combined pool of all RPG4 and RPG5 participants is. Tables V.4 and V.5 summarize the demographic and economic characteristics of adults and children in RPG projects for pregnant women and parents of newborns. These projects had a higher proportion of participants identifying as Hispanic/Latino (among both adults and children), and a larger proportion of adults from these projects identify as Black or African American compared to the overall service population of the RPG4 and RPG5 projects.

Economic challenges are more prevalent among those enrolled in the projects serving pregnant women and parents of newborns than they are in the RPG4 and RPG5 projects in general. For example, unemployment was higher, as one might anticipate in a group of expectant or new mothers: 70 percent said they were not employed. Compared with unemployed adults enrolled in RPG4 and RPG5 as a whole, a higher proportion were not looking for work or reported that they were unable to work.

About one-third of adults enrolled through projects designed for pregnant women or parents of newborns identified their largest source of income as public assistance. In contrast, the adults who enrolled through other programs were much more likely to identify their largest source of income as wages or a salary. Additionally, fewer children enrolled through projects that focused on serving pregnant women or parents of newborns were reported as receiving Medicaid. However, this might reflect an undercount, because these projects reported that the Medicaid status was unknown for a higher percentage of children at enrollment than other projects. (The Medicaid status for the children can be updated, if it is known, when these families exit RPG services.)

Children enrolled in the projects for pregnant women or parents with newborns were living in treatment facilities at higher rates than all children enrolled in RPG4 and RPG5 were, at least in part because some of these projects seek to enroll women who are currently in SUD treatment. However, a private residence was still the most common living circumstance for these children. The families enrolled in these projects tended to be small; 63 percent of the families were made up of one adult and one child (not shown). Children were also more likely to live with at least one biological parent, including 30 percent who lived with their biological mother only and 20 percent who lived with both their biological mother and biological father.

C. Participant characteristics for projects serving American Indians and Alaska Natives

In addition to RPG's overall target population, for the RPG4 cohort HHS offered a separate funding stream for projects that were designed to serve American Indians and Alaska Natives specifically (but not exclusively). Four of the 27 RPG4 and RPG5 projects (two of them funded under this targeted funding stream) are serving American Indians or Alaska Natives (though not exclusively). These include one project in which the tribal organization is the grantee organization, one project that features a partnership with a tribal organization, and two projects that are specifically enrolling members of the American Indian/Alaska Native communities, but

the organization that is providing services is not a tribal organization and is not partnering with a tribal community. The participants in these four projects also differ from the participants in the RPG4 and RPG5 projects overall in their demographic characteristics and economic situations.

As expected, these projects are serving a large share of adults who identify themselves and their children as American Indians or Alaska Natives (59 percent of adults and 44 percent of children), though not serving these groups exclusively. The differences, however, extend beyond racial and ethnic identity. Tables V.4 and V.5 show the demographic characteristics and economic situation of the adults and children in the four projects designed specifically for American Indians and Alaska Natives. In contrast with the wider group of RPG4 and RPG5 projects, a slightly higher proportion of the adults in these projects were female (89 percent compared to 82 percent).

The families that these projects serve were somewhat larger than families served by other projects. Two-thirds of the families had two or more children (see Table V.2). In comparison, less than half of families in all RPG4 and RPG5 projects had two or more children. This composition of families in RPG projects that enroll American Indians and Alaska Natives is largely consistent with statistics on the American Indian and Alaska Native population that show families in these communities tend to be larger than the average American family (Administration for Native Americans, 2014).

The families enrolled in projects specifically serving American Indians and Alaska Natives were grappling with more challenging economic situations. This is also consistent with statistics showing that American Indian and Alaska Natives have higher-than-average rates of unemployment and poverty, particularly if they live on reservations or tribal lands (Administration for Native Americans, 2014). For instance, 75 percent of adults in this subset of projects reported being unemployed, a rate higher than the rate for adults in all RPG4 and RPG5 projects combined. Furthermore, these adults identified their largest income sources as child support, children's SSI benefits, and support from other individuals. The proportion reporting wages or salary as their largest source of income was also lower (17 percent) than the proportion of adults enrolled throughout the RPG4 and RPG5 projects generally (40 percent). In addition, a higher proportion of children enrolled through projects serving American Indians and Alaska Natives lived in homeless shelters (9 percent versus 3 percent for the larger population of children enrolled in all RPG4 and RPG5 projects).

VI. PARTICIPANT OUTCOMES AT ENROLLMENT

The Institute of Medicine identifies a parent's SUD as a known risk factor for maltreating children and becoming involved with the child welfare system (Institute of Medicine & National Research Council, 2013). Moreover, adult SUD often co-occurs with poor mental health, poor parenting skills and attitudes, and symptoms of trauma. These traits negatively reinforce each other, with consequences for both the adults who suffer from them and their children. Children's experiences of maltreatment, in turn, have been found to be associated with a variety of adverse outcomes, such as diminished academic and cognitive performance (Crozier & Barth, 2005; Jaffee & Maikoich-Fong, 2011; Mills et al., 2011), poor social-emotional and behavioral adjustment (Font & Berger, 2015), and a higher likelihood of risky behaviors and depression compared with other children (Arata et al., 2005).

A central objective of the RPG national cross-site evaluation is to report the prevalence and/or severity levels of adults' substance use, trauma, and potential for depression at enrollment; to assess their children's well-being and their history of being maltreated and removed from the home; and to measure how these outcomes change after the family has been in the RPG program. This chapter describes where these outcomes stood when families enrolled in the RPG project, providing a snapshot of cross-site evaluation outcome measures at RPG enrollment (also called program entry) for children and adults enrolled in RPG4 or RPG5 between March 1, 2019, and July 2, 2020. A later report will examine change from program entry to program exit, comparing the same outcomes after families leave RPG.[15]

Section A describes adults' outcomes in the recovery and family functioning domains at the time they enrolled. These include the type and severity of recent substance use by adults enrolled in RPG through July 2, 2020; their participation in SUD treatment in the year before they enrolled in the RPG program; and symptoms of trauma and depression. Section B reports children's involvement with the child welfare system in the year before they enrolled in the RPG program, including reports of maltreatment, removal from the home, and permanency outcomes (if achieved) after a removal. Section C discusses children's well-being.

The following two main limitations affect the findings: (1) some data that were used in this report were incomplete and (2) projects will continue to enroll participants for several years. First, fewer than half of the 27 RPG4 and RPG5 projects were able to complete data sharing agreements with state child welfare and/or SUD agencies in time to obtain and submit administrative data on child welfare and adult SUD treatment for this report. Thus, the findings in this report do not represent all families enrolled in RPG during the analysis period. Second, the findings reported here are based on interim data collected through July 2, 2020. Results on some or all of the measures reported as of enrollment, such as average scores or the proportion of adults or children in high-risk categories, might change when the data for all children and adults

[15] Some projects whose services are intended to last for a long time (such as a year or more) collect the follow-up data at the end of a defined interval after enrollment, such as 6 months.

who enroll in the RPG4 and RPG5 cohorts are available at the end of the cross-site data collection period.[16]

A. Adult recovery and family functioning at or before enrollment

RPG projects seek to enroll families in which adults have or had substance use issues, based on various assessments or on current or past participation in SUD treatment. A major goal of most RPG projects is to help adults recover. Recovery from substance use is a process of change that helps individuals make healthy choices and improve the quality of their lives (Substance Abuse and Mental Health Services Administration, 2012).

To study adult recovery, the cross-site evaluation uses the following three sources of data to examine adult substance use issues at program entry and exit: (1) the Addiction Severity Index, Self-Report Form (ASI-SR), which measures the extent and severity of substance use (McLellan et al.,1992); (2) administrative data obtained from state SUD treatment agencies, which reveal whether enrolled adults had received publicly funded SUD treatment; and (3) the Trauma Symptoms Checklist-40 (TSC-40; described in detail in Appendix B), which measures trauma symptoms reported by adults (Briere & Runtz, 1989).

These data show that, on average, adults' reported recent drug use at RPG enrollment was similar to the levels of use by individuals who were enrolled in substance use disorder (SUD) treatment settings nationally, but that alcohol use was less prevalent.[17] A subset of these adults had been enrolled in publicly funded SUD treatment settings before.[18] Many adults also reported they experienced some trauma symptoms before they entered RPG.

1. Adult substance use

At the time they enrolled in RPG, 27 percent of adults who completed the ASI-SR drug use scale and alcohol use scale[19] were in the high-severity group for drugs, alcohol, or both, according to the benchmarks that were used in the cross-site evaluation (Table VI.1).[20] Drug use was more

[16] RPG4 projects will submit their final data to the cross-site evaluation by April 2022. RPG5 projects will submit their final data by April 2023.

[17] Grantees collect and submit recovery domain data on the adult in each RPG case who is at risk of developing a substance use issue (such as substance misuse or an SUD), has an active substance use issue, or is in recovery from a substance use issue. If no such adult is part of the case, then the data are obtained from the focal child's biological or adoptive parent, or the adult who has a goal of reunification with the focal child.

[18] State laws require SUD treatment programs to report their publicly funded admissions to the state. Publicly funded treatment programs have traditionally relied on three funding streams: federal substance abuse block grants, Medicaid reimbursement, and state general funds (Substance Abuse and Mental Health Services Administration, 2000).

[19] An adult completed the ASI-SR in about two-thirds (66 percent) of the families enrolled in RPG. This instrument does not screen for or diagnose SUD.

[20] The cross-site evaluation categorizes adults enrolled in RPG as high-severity drug or alcohol users if their mean scores on the ASI-SR for drugs or alcohol are above the average for individuals in a national sample of adults in SUD treatment settings, as reported by McLellan and colleagues (McLellan et al., 2006). The scales used for this classification measure the frequency of use, the number of days intoxicated, and the number of days bothered by use of the substance, for example.

common than alcohol use. As shown in Table VI.1, the proportion of adults with drug use profiles that were classified as high in severity was 3 times greater than the proportion of adults with high-severity alcohol use. The average drug use score on the ASI-SR was similar to the average score observed in a nationwide sample of individuals who were in SUD substance use disorder treatment settings (McLellan et al., 2006). This national sample might be considered comparable to the target population for the RPG program based on substance use criteria for the target population. The RPG mean score for alcohol use, however, was lower than the mean for the national sample.

Table VI.1. Substance use in the 30 days before RPG enrollment

Baseline scale[a]	RPG sample size[b]	RPG sample mean score (SD)	National sample mean score (SD)[c]	Percentage of adults in RPG in high severity category[d]
Drug use	530	0.09 (0.14)	0.10 (0.13)	24
Alcohol use	533	0.05 (0.10)	0.22 (0.25)	7
Any drug or alcohol use	522	n.a.	n.a.	27

[a] Measure is based on adult self-report.

[b] Sample sizes vary by measure because of item nonresponse.

[c] As reported in McLellan et al. (2006), which focused on a nationwide sample of individuals in treatment settings for substance use disorder. Higher scores on the Addiction Severity Index, Self-Report Form (ASI-SR) scales represent higher severity ratings.

[d] High-severity drug or alcohol use was defined for the cross-site evaluation as a scale score on the ASI-SR for drug or alcohol use that was above the national mean. Calculation of the percentage of adults in the high-severity category is relative to the number with complete data for a given type of substance use.

Notes: About two-thirds (66 percent) of families enrolled in RPG had an adult complete the ASI-SR (N = 549). The sample sizes range from 522 to 533 because of item nonresponse. n.a. = not applicable; SD = standard deviation.

Source: Administration of the ASI-SR at RPG enrollment, including data submitted to the cross-site evaluation through July 2, 2020.

Of the drugs adults enrolled in RPG reported using in the past month, marijuana was the one used by the most adults, followed by amphetamines (Table VI.2). About 9 percent of adults enrolled in RPG4 and RPG5 used opioids, including heroin, methadone,[21] and/or prescription opioids, in the 30 days before program entry. Cocaine and sedatives were less commonly used, and hallucinogens and barbiturates were the least used drugs.

Compared with the entire group of adults enrolled in RPG who completed the instrument, a larger proportion of adults classified in the high-severity users group reported recent use of each of the drugs asked about in the ASI-SR, as shown in Table VI.2. Cannabis, amphetamines, and opioids were the drugs that were most frequently mentioned by adults in the high severity users group and the overall sample. However, the frequency of use for these and other drugs (not

[21] Methadone is a synthetic opioid primarily used in the treatment and maintenance of patients with opioid use disorder—particularly heroin (Anderson & Kearney, 2000). It may also be prescribed to treat pain. Methadone diversion is primarily associated with methadone prescribed for the treatment of pain and not for the treatment of opioid use disorders (National Institute on Drug Abuse, 2018). The data collection instrument used for the cross-site evaluation did not have a question to respondents who reported using methadone about whether it was being used as part of treatment.

shown) was higher in among those in the high-severity group than it was in the overall sample that completed the ASI-SR.

Table VI.2. Drugs adults used within 30 days before RPG enrollment, among those who completed the ASI-SR

Type of drug	Percentage of all adults reporting use of drug within the past 30 days	Percentage of adults in high severity category reporting use of drug within the past 30 days
Cannabis[a]	22	63
Amphetamines[b]	12	45
Opioids	9	31
Heroin	5	19
Methadone	5	18
Other opioids/analgesics[c]	5	17
Cocaine[d]	5	20
Sedatives/hypnotics/tranquilizers[e]	5	21
Hallucinogens[f]	3	10
Barbiturates[g]	2	8
Sample size	**540–548[h]**	**125**

[a] Cannabis includes marijuana, hashish, and pot.

[b] Amphetamines include monster, crank, Benzedrine, Dexedrine, Ritalin, Preludin, methamphetamine, speed, ice, and crystal.

[c] Other opioids/analgesics include morphine; Dilaudid; Demerol; Percocet; Darvon; Talwin; codeine; Tylenol 2,3,4; cough syrups; Robitussin; and fentanyl.

[d] Cocaine includes cocaine crystal, free-base cocaine, or “crack,” or “rock.”

[e] Sedatives/hypnotics/tranquilizers include Valium, Xanax, Librium, Ativan, Serax, Quaaludes, Tranxene, Dalmane, Halcion, and Miltown.

[f] Hallucinogens include LSD [acid], mescaline, mushrooms [psilocybin], peyote, green, PCP [phencyclidine], angel dust, and ecstasy.

[g] Barbiturates include Nembutal, Seconol, Tuinol, Amytal, Pentobarbital, Secobarbital, phenobarbital, and Fiorinol.

[h] Sample sizes range from 540–548 because of item nonresponse.

Note: ASI-SR = Addiction Severity Index, Self-Report Form.

Source: Administration of the ASI-SR at RPG enrollment.

2. Participation in treatment

An indicator of past or current SUD is participation in SUD treatment. About 20 percent of adults had been in publicly funded SUD treatment in the year before they enrolled in RPG. However, this result is based on data from only 9 out of 27 grantees that submitted recovery data. The other grantees were unable to obtain recovery data from the state SUD treatment agencies in time for the data to be used in this report.

Completing treatment is a positive accomplishment that can aid in recovery from SUD. Of the 88 adults who participated in treatment before RPG enrollment, 16 percent completed at least 1 treatment program in the year before they enrolled in RPG. More of these adults may have completed treatment after they enrolled in RPG.

3. Differences across RPG projects in adult substance use

Substance use and participation in treatment varied depending on the RPG projects that adults were enrolled in. Among the 19 projects that had ASI data for at least 10 adults, 2 projects had no adults characterized as high-severity users. Six projects had 40 to 50 percent of adults characterized as high-severity users. The percentage of adults in the high-severity users group in the remaining 11 projects ranged from 2 to 36 percent. Nine projects submitted data on SUD treatment. The rate of participation in pre-RPG SUD treatment ranged from 5 to 29 percent across these projects. For projects primarily serving pregnant women and families with young children, 14 percent of adults had at least 1 treatment episode before they entered RPG, compared with 20 percent in all projects combined.

4. Trauma symptoms

Experiences of trauma are strongly predictive of later substance misuse (National Child Traumatic Stress Network, 2008). People with trauma symptoms can also have mental and physical health conditions. Adults' trauma, substance use, and poor mental or physical health can all in turn affect their children. For the health and well-being of parents or caregivers and their children, RPG emphasizes using trauma-informed approaches (ACF, 2019). Moreover, many RPG projects implement program models that are designed to ease adult trauma symptoms (Burwick et al., 2017). The adults included in the sample reported they experienced some symptoms of trauma in the past 2 months, as assessed at RPG enrollment by the TSC-40, but they reported fewer symptoms than adults in an earlier study of 240 adults enrolled in SUD treatment (Tracy et al., 2012). The average scores in that study were nearly twice the average scores of adults enrolled in RPG.

5. Family functioning

Family functioning refers to the social and structural properties of the family environment (Alderfer et al., 2008). It includes interactions and relationships within the family, particularly levels of conflict and cohesion, adaptability, organization, and quality of communication. Two of the factors that can affect family functioning are parents' mental health and parenting attitudes. The cross-site evaluation therefore collects data on adult mental health and parenting attitudes for the family functioning outcome domain. Findings on parenting attitudes are not presented here because of data quality issues that are still under investigation, but findings will be included in a future report. The cross-site evaluation also measures depressive symptoms with the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). A detailed description of the CES-D is in Appendix B.

At RPG entry, adults had a higher mean score for depressive symptoms (12.0) than the mean score of 5.7 in a representative sample of parents of children in Head Start in the 2014 cohort of the Family and Child Experiences Survey (FACES) (Aikens et al., 2017). Both the Head Start program and the RPG program serve disadvantaged low-income families with young children. (Although RPG does not specifically focus on serving low-income families, a large proportion of families who enroll do face economic challenges, as described in Chapter V.) The percentage of adults enrolled in RPG who reported severe depressive symptoms, as measured by the CES-D (mean score of 15.0 and above), was also higher than the percentage reported in FACES (36 percent and 11 percent, respectively).

B. Child safety and permanency at or before enrollment

The intention behind RPG is to serve families with children who are in or at risk of out-of-home placements, but different partnerships intervene with those families at different points. Chapter II, for example, discusses how some RPG5 projects planned to enroll children who had already been removed from the home or were at risk of removal for reasons including having an open child welfare case. Others focused on families with children who were at risk of becoming involved with the child welfare system, such as children for whom there was a report of possible maltreatment (Table II.1). RPG projects ask states for data on maltreatment, and on removals and reunifications. The projects then submit these data to the cross-site evaluation for use in the safety and permanency outcome domains. Ten RPG4 and RPG5 projects (out of 27) submitted safety data and 9 projects submitted permanency data on 1 child for each case. The remaining projects were unable to obtain data from the state child welfare agencies in time to be included in this report, including the four designed for AI/AN families.

Measures of child safety and permanency. Data on safety reveal how many of the focal children who were enrolled in RPG projects had a report of maltreatment that (1) was investigated and determined to be in one of the following categories: substantiated, unsubstantiated, indicated (could not be substantiated, but there is reason to suspect that the child was maltreated or is at risk of being maltreated), or other resolution (such as closed with no finding or no alleged maltreatment for children in the same household as the child who is the subject of the report); and (2) for some states only, was categorized as alternative response (meaning the report was not investigated, but assigned to an alternative track for Child Protective Services). A report of maltreatment is substantiated when an investigation by a Child Protective Services agency concludes that the report was supported or founded as defined by state law or policy (HHS, 2020a). The cross-site evaluation categorizes the reported maltreatment as either substantiated or not substantiated. The category of "not substantiated" includes all responses other than substantiated, including unsubstantiated, indicated, other, or alternative response.

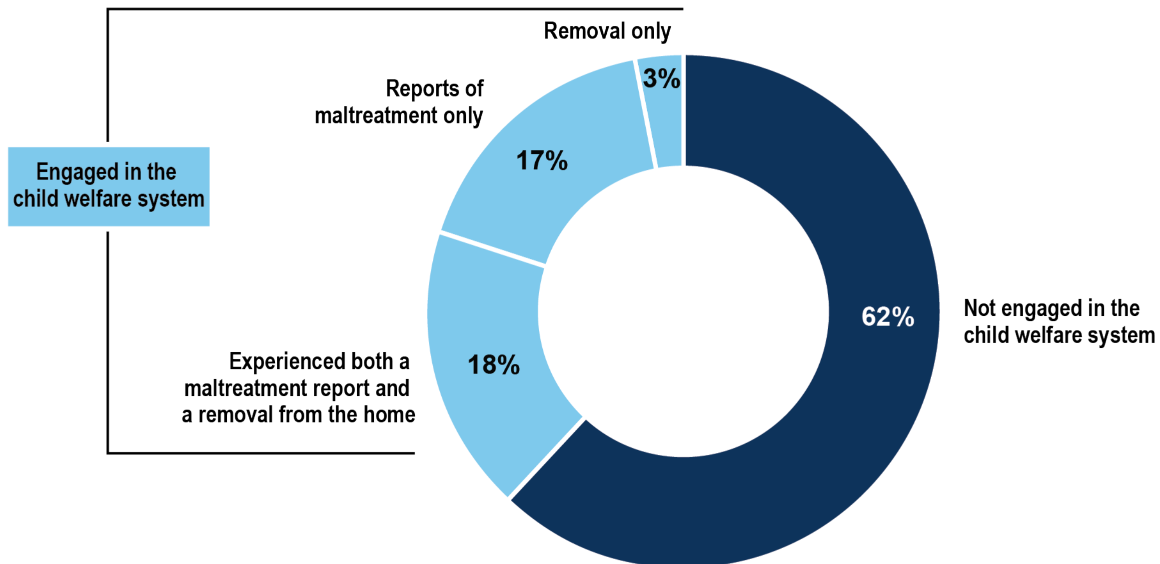
Data on permanency reveal how many children have been removed from their homes in a given time period (12 months before RPG enrollment, in data used for this report), and, if the children were placed in the foster care system during that time period, permanency data also reveal where they were placed. For children who exited the foster care system during the period, the data show whether they were reunified with their parents or were in another permanent living situation, such as an adoptive family.

About 40 percent of the children who were enrolled in RPG had been involved in the child welfare system the year before they entered RPG,[22] including about 20 percent of children who had been removed from their homes (Figure VI.1). The figure shows the overall picture of involvement in the child welfare system. It is based on focal children for whom grantees submitted both safety and permanency data. In the year before RPG enrollment, 17 percent of children had a report of child maltreatment only (including both reports that were substantiated

[22] The cross-site evaluation uses language from the Child Welfare Information Gateway (2013) to define involvement in the child welfare system. A report of suspected abuse, child abuse, or neglect is described as the main way that most families become involved in the local child welfare system. This would include both reports of child maltreatment and children's experiences in foster care when they are removed from the home.

and those that were not substantiated); 18 percent of children had a report and were removed from their home; and 3 percent of children were removed from their home, but did not have a report during the 1-year period before they enrolled in RPG (their report happened before the 1-year period).

Figure VI.1. Children with reports of child maltreatment and/or removals from home in the year before RPG enrollment



Note: Statistics are based on 537 children in 9 projects that submitted both safety and permanency data.

Source: Administrative records from state or county child welfare agencies, obtained by grantees and submitted to the cross-site evaluation through July 2, 2020.

The rest of this section examines maltreatment and out-of-home placement in detail, and notes the differences between projects in serving children with these experiences.

1. Maltreatment of children

Along with keeping at-risk children safe and out of the child welfare system, the RPG projects work to ensure the safety of children who are already involved in the child welfare system. At RPG entry, nearly one-third of the enrolled children had at least 1 report of maltreatment in the previous year.[23] Twenty-one percent of children had reports that were not substantiated, and 15 percent had substantiated reports (Table VI.3). The rate of maltreatment reports was 31 percent for children enrolled in RPG, which was higher than the national incidence (3.3 percent) of maltreatment reports (HHS, 2020a).

[23] The percentage is slightly different from the ones in Figure VI.1, because that figure is based on 537 children for whom grantees submitted both safety and permanency data.

Table VI.3. Reports of maltreatment for children one year before enrollment in RPG

Type of maltreatment	Percentage of children with reports[c]	Number of children with reports
Reports of any maltreatment (abuse, neglect, or other)	31	230
Reports of maltreatment that were substantiated	15	108
Reports of maltreatment that were not substantiated	21	156
Reports of abuse[a]	12	88
Reports of abuse that were substantiated	4	26
Reports of abuse that were not substantiated	9	68
Reports of neglect[b]	19	140
Reports of neglect that were substantiated	10	74
Reports of neglect that were not substantiated	9	67
Reports of other maltreatment	17	124
Reports of other maltreatment that were substantiated	5	37
Reports of other maltreatment that were not substantiated	12	88

[a] Includes physical, sexual, psychological, and emotional abuse.

[b] Failure to provide needed, age-appropriate care; includes medical neglect.

[c] Children may have had more than one report of maltreatment. Therefore, the same child could be included in more than one row in this table.

Notes: Sample sizes are based on the subset of 10 projects that submitted these data. The percentages are based on 734 children who had enrolled in these projects by July 2, 2020. Reports that were not substantiated include those that were unsubstantiated, indicated, or had other or alternative responses.

Source: Administrative records from state or county child welfare agencies, obtained by grantees and submitted to the cross-site evaluation through July 2, 2020.

There are two primary categories of child maltreatment – abuse and neglect. In addition, a variety of types of maltreatment are in the category of "other maltreatment." This report focuses on these three categories, although there could have been more than one type of maltreatment included in a report that falls within one of these categories (for example, both physical and sexual abuse could be in one report). Box V1.1 defines these maltreatment categories.

Box VI.1. Categories of child maltreatment

Abuse is defined as any recent act that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or that presents an imminent risk of serious harm to the child.

Neglect is defined as any recent failure to act on the part of a parent or caretaker that may result in any of the same types of harm or that presents an imminent risk of serious harm to the child.

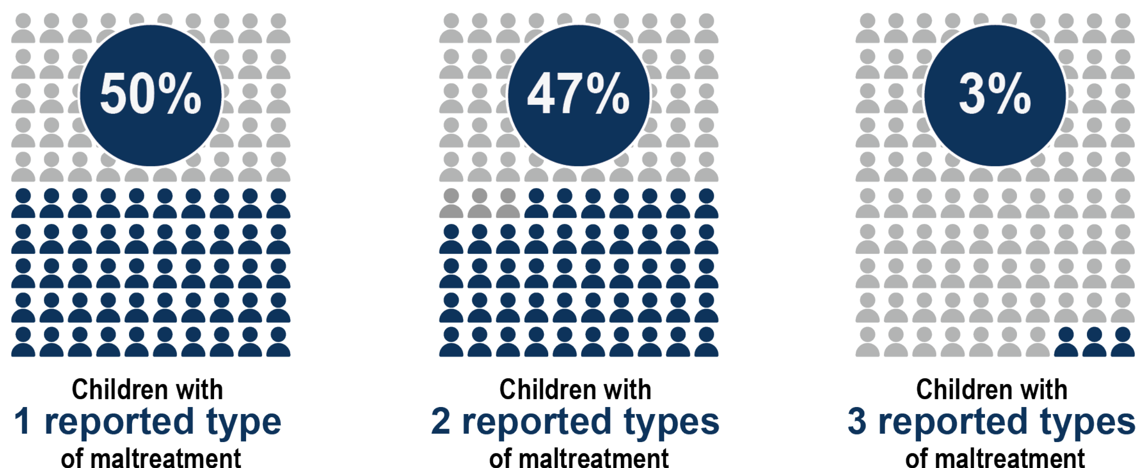
Other maltreatment is defined as instances of maltreatment that are not easily categorized as abuse or neglect. Examples vary by state and include threats of abuse or neglect rather than actual abuse or neglect, abandonment, the presence of illegal drugs in a child's body, or sex trafficking (HHS, 2020a).

For the children enrolled in RPG, neglect was the most commonly reported category (19 percent), but almost as many reports were for other maltreatment (17 percent). Abuse was the least commonly reported category (Table VI.3). More of the children with reports of abuse and other maltreatment had reports that were not substantiated rather than substantiated. For reports of neglect, however, the percentages of children with reports that were substantiated or not substantiated were about the same.

Many children enrolled in RPG had reports in more than 1 of these 3 categories of maltreatment. Among children with reports of maltreatment in the year before they enrolled in RPG, about half

had 1 category of maltreatment reported; and the other half had reports of multiple maltreatment categories: 29 percent had reports in 2 categories, and 22 percent had reports in all 3 categories (Figure VI.2).

Figure VI.2. Categories of maltreatment in reports for children in RPG



Notes: Statistics are based on 230 children who had maltreatment reports in the year before they enrolled in RPG. Maltreatment categories are abuse, neglect, and other.

Source: Administrative records from state or county child welfare agencies, obtained by grantees and submitted to the cross-site evaluation through July 2, 2020.

2. Out-of-home placements and permanency outcomes

About 20 percent of children had been removed from their home in the year before they enrolled in RPG (Table VI.4).[24]

Children are placed in out-of-home settings after they are removed from the home and placed elsewhere. On average, children had two such placements in the year before they enrolled in RPG. Forty-one percent had 1 placement; 28 percent had 2 placements; and 31 percent had 3 or more placements.

Foster care is not intended to be a permanent solution for a child; the goal is to find a permanent, stable, and safe home by, for example, reunifying the family or having the child adopted. A permanency outcome is defined as reunification, adoption, or guardianship. A small proportion of children who had been removed from their home in the year before they enrolled in RPG had achieved permanency (all through reunification) during the same period (Table VI.4).

[24] This number does not include children who were already living outside the home before the 1-year period before enrollment. Some children were already living outside the home before that period. These children have placement dates during the year, but no removal dates, which indicates that they were removed before the 1-year period. In addition, some children may have been removed before the 1-year period and not placed during the period.

Table VI.4. Out-of-home placements of children in the year before enrollment in RPG

Out-of-home placement and permanency	Sample size	Mean (SD)	Percentage of children
Removed from home	537	n.a.	21
Number of placements[a]	115	2 (1.5)	n.a.
One placement		--	41
Two placements		--	28
Three or more placements		--	31
Achieved permanency[b]	115	n.a.	9
Reunified with family[c]	115	n.a.	9

[a] Among children who were removed from the home and placed at least once during the year before they enrolled in RPG.

[b] Percentage of children who were removed from the home in the year before they enrolled in RPG and who achieved permanency during the period.

[c] Percentage of children who were removed from the home and then reunified with their families during the year before they enrolled in RPG.

Source: Administrative records from state or county child welfare agencies, obtained by grantees and submitted to the cross-site evaluation through July 2, 2020.

Notes: Sample sizes are based on the subset of 9 grantees who submitted these data elements. All children in the sample who achieved permanency did so by being reunified with their families. Projects did not seek to enroll adoptive families or families of children who had been placed in guardianship. n.a. = not applicable; SD = standard deviation.

3. Differences across RPG projects in serving children with maltreatment reports or out-of-home placement

Rates of maltreatment varied from one RPG project to another. In projects that had submitted safety data, families had rates of 14 to 50 percent of reported maltreatment in the year before program entry.[25] Two projects that aimed to serve open child welfare cases had markedly different rates. In one, 50 percent of children had maltreatment reports before enrollment; in the other, 16 percent of children had maltreatment reports. Projects that primarily served pregnant women or families with newborn children had a higher rate of prior maltreatment reports (44 percent, with unborn children excluded from the calculation) than all projects combined (32 percent).

In projects that submitted permanency data, 1 to 60 percent of children had been removed from the home in the year before they enrolled in RPG. Of the two projects that served families with open child welfare cases, 60 percent of enrolled children in one had been removed from the home, and in the other, only 1 percent of the enrolled children had been removed from the home. All of the other projects had rates of removal lower than 20 percent. Projects that primarily served pregnant women or families with newborns had a lower rate of removal than the rate across all projects (4 percent, with unborn children excluded from the calculation, versus 21 percent).

[25] Excluding 2 projects that had fewer than 10 children enrolled by July 2, 2020.

C. Child well-being at enrollment

It is well established that the experience of maltreatment has comprehensive and lasting implications for children (Institute of Medicine & National Research Council of the National Academies, 2013). The RPG program not only aims to maintain or increase children's safety and permanency, but also to improve their well-being. Therefore, RPG projects collect data on child well-being for the cross-site evaluation. To avoid overburdening projects and families, the cross-site evaluation requests such data on only the focal child in each family. Data submitted by the projects show that, on average, emotional and behavioral problems were more common among RPG focal children than they were for children in national samples, but sensory processing problems were less common.

Box VI.2. How did projects assess children's well-being?

The cross-site evaluation does not collect data from the children in RPG. Instead, it relies on reports of caregiver most familiar with the child. Projects assessed children's well-being by administering several standardized instruments to an adult in each family. Appendix B defines and describes those instruments in detail.

1. Emotional and behavioral problems

Children's emotional and behavioral problems might be associated with their caregiver's substance use (Behnke et al., 2013), caregiver well-being, and parenting skills (Neece et al., 2012). Compared with a national sample of children, adult caregivers reported children in RPG had more problems in total, and more emotional and behavioral problems specifically. (Total problems are a combination of emotional and behavioral problems and other problems). The mean scores of emotional, behavioral, and total problems (53.9, 55.9, and 55.8, respectively) for focal children at RPG entry were higher than the national mean of 50 (Table VI.5). The percentage of children in RPG who were categorized as being at high risk for these problems (30, 27, and 30 percent for emotional, behavioral, and total problems, respectively) were also higher than the 10 percent in the national sample.

Table VI.5. Child well-being at RPG enrollment

Aspect of child well-being	RPG sample size[a]	RPG sample mean score (SD)	National sample mean score (SD)	Percentage of children in RPG in high-risk category	Percentage of children in high-risk category in the national sample
Sensory processing[b]	144	n.a.	n.a.	22	32
Emotional, behavioral, and other problems					
Emotional problems	210	53.9 (14.1)	50 (10)	30	10
Behavioral problems	210	55.9 (13.2)	50 (10)	27	10
Total problems	210	55.8 (14.5)	50 (10)	30	10

[a] The sample sizes vary by measure because caregivers reported on different subsets of children depending on the child's age. For example, the Infant-Toddler Sensory Profile has a narrow age range (birth to 36 months), so a small number of children were analyzed for that measure.

[b] The RPG sample and national sample mean and SD for sensory processing are not reported in the table because they are not easily to interpret. Scores with either low or high values indicate undersensitivity or oversensitivity, both of which are problems.

Notes: Sensory processing was assessed using the Infant-Toddler Sensory Profile; emotional and behavioral problems were assessed using the Child Behavior Checklist (CBCL). Higher scores on the CBCL represent more problems. SD = standard deviation; n.a. = not applicable.

Source: Administration of standardized instruments at RPG enrollment, including data submitted to the cross-site evaluation through July 2, 2020.

2. Sensory processing

Prenatal substance exposure poses serious risks for early development and can have adverse long-term effects on a range of outcomes into adulthood (Behnke et al., 2013). Sensory processing has been shown to be affected by prenatal substance exposure (Chasnoff et al., 2010).

At the time they enrolled in RPG, adult caregivers reported better scores for the focal children on sensory processing, on average, than a national sample of children. The Infant-Toddler Sensory Profile (ITSP) identifies children who were over- or under-responsive to stimuli. The percentage of focal children in RPG who were in the high-risk category for sensory processing at RPG entry was lower than the 32 percent in the national sample (Table VI.5).[26]

[26] The numbers of children with sensory processing data were small for most of the RPG projects: 17 out of 21 projects had data on fewer than 10 children. Of the 8 projects that had no children characterized as high risk, 7 had data on fewer than 5 children. The small overall sample size and the small sample sizes from some projects (fewer than 5 children for some) in the current data might affect the reliability of the results for sensory processing.

VII. SERVICES RECEIVED BY FAMILIES

Chapter V profiled the adults and children enrolled in RPG4 and RPG5 by examining their demographic characteristics and economic situations. It discussed how these profiles differed for projects serving pregnant women and families with newborns, and those serving AI/AN families. Chapter VI considered families' needs and situations when they entered RPG, as indicated by data in five outcome domains tracked by the cross-site evaluation. It showed that:

- About 40 percent of the children who enrolled in RPG had been involved in the child welfare system in the year before they enrolled as measured by reports of maltreatment, and about 20 percent of children had been removed from the home during that time, some of whom had been reunified with their families.
- About 27 percent of adults enrolled in RPG were high severity users of drugs or alcohol or both. Though marijuana was the most commonly used drug, about 12 percent had used amphetamines (which include methamphetamine) and 9 percent of adults had used opioids. Nearly 20 percent of adults had enrolled in SUD treatment during the year before they enrolled in RPG.
- Adults enrolled in RPG reported more symptoms of depression than a nationally representative sample of similar parents of young children.
- Emotional and behavioral problems were more common among children enrolled in RPG than among a nationally representative sample.

RPG projects select a diverse set of services to address the needs such as these of the families they plan to enroll, but until data from RPG4 and RPG5 became available, little was known about the full range of services that families received. The cross-site evaluation for RPG2 and RPG3 projects collected data on evidence-based programs and practices (EBPs) offered by projects, but did not simultaneously collect data on the broader set of services that projects were providing, either instead of or along with the EBPs (Strong et al., 2014). The current cross-site evaluation fills that gap by studying a broad range of services offered by grantees and their partners (D'Angelo et al., 2019). It collects data from RPG projects on (1) services that are funded by the grants, and (2) services that are considered fundamental to the success of families' outcomes but are not funded directly by the grants. Grantees collect and submit data on most project services, including structured curricula or program models and other services, such as peer mentoring and financial or material supports.

This chapter describes the services that families in RPG4 and RPG5 received (RPG6 projects had not yet enrolled families). It is based on data submitted to the cross-site evaluation between March 1, 2019, (once clearance for data collection was received by the Office of Management and Budget), and July 2, 2020. Twenty-four of the 27 RPG4 and RPG5 projects contributed data on the services they provided. This produced information on almost 14,000 service encounters with 660 families. Section A is an overview of the services, including common service types and program models. Section B focuses on projects' use of peer recovery mentors, who are of high interest to HHS for use in recovery and reunification interventions (HHS, 2019). Section C highlights the services offered by projects working with pregnant women and parents of young

children, a target population described in Chapter V as a focus of 10 of the RPG4 and RPG5 projects.

The data that the findings here are based on are limited in two ways. First, most families enrolled in RPG receive some services that the cross-site evaluation cannot track. RPG projects typically refer families to services that the project does not fund, and that projects do not identify as part of their core services. For example, projects might refer families to programs or agencies outside the RPG project and partnership for needs such as employment assistance, health care, or housing. Thus, this report cannot give the full picture of every service received by RPG families that might support adult or child outcomes. Second, of the 17 RPG4 and 10 RPG5 projects, 3 were unable to submit service data for any of their cases, and several projects submitted only partial data.

Table VII.1 shows how many projects planned to submit data on each of the 17 different types of services that the cross-site evaluation tracks, and how many reported that participants had used each. There are no data on some services because no families needed them during the reporting period, or because families did not take up some services offered to them. Additionally, some projects submitted no or only partial data by July 2020.[27]

Table VII.1. Number of projects offering services and reporting their use, by service type

Service type	Number of projects planning to offer service type	Number of projects reporting use of service type	Percentage of projects reporting use of service type
Primary services			
Case management or service coordination	25	22	88
Therapy or counseling	19	14	74
Parenting training or home visiting program	19	11	58
Mentoring	14	10	71
Support group or workshop	9	7	78
Supportive services			
Screening or assessment	21	16	76
Transportation	10	10	100
Housing	7	3	43
Employment training	6	4	67
Medical care or appointment	7	4	57
Medication-assisted treatment	7	4	57
Child care	5	2	40
Financial or material supports	6	2	33
Court or legal	5	3	60
Academic education (child or adult)	1	0	0
Other services[a]	10	1	10

[a] Other services include family activities, psychiatrist sessions, drug testing, family crisis response, and domestic violence support.

[27] Some projects, for example, keep records on paper forms, and might not have given the forms to staff who enter their data in time for inclusion in this report.

Note: Service types are mutually exclusive.

Source: RPG-EDS data, March 1, 2019, through July 2, 2020.

A. Overview of services

RPG allows each partnership to design its project to fulfill the needs of its community and target population. Therefore, the focus of each RPG project and the number and types of services and programs it offers can vary. For example, some projects offer a few services to all participants, whereas others offer an array of services individually tailored to each participant. Some grantees design their projects around a structured curriculum or program model, and others use less structured approaches.

In total, across the 27 RPG4 and RPG5 projects, grantees identified more than 150 distinct services and supports that they planned to offer, alone or in different combinations, to some or all of the families who enrolled in their projects. The cross-site evaluation reviewed all of the proposed services and grouped them into 16 specific categories or types, and 1 "other" category. All of the RPG4 and RPG5 projects planned to offer a service in at least 1 of the 16 categories.

Box VII.1. Services and service types

Service. Any form of assistance that is offered to RPG families. The cross-site evaluation reports on services that are either funded by RPG (in whole or in part) or that are considered fundamental to the project.

Service type. The service types (Table VII.2) can be divided into two groups: primary services and supportive services. *Primary services* deliver the main content of the RPG project to the families, and include case management, therapy or counseling, support groups, parenting training or home visiting programs, and mentoring. *Supportive services* are ancillary services such as financial or material supports, transportation, or child care. These services are usually offered only briefly.

Across all projects combined, the data show that during the period covered in this report, families in RPG4 and RPG5 received, on average, 3 different types of services, and that case management was typically 1 of those 3. To receive their services, the average family met one on one with a service provider 13 times for an hour at a time, received all of its services from a single provider, and engaged in those services for 14 weeks. Next, this section describes variations in how people enrolled in services and in how the services were provided.

After families enroll in RPG, not all of them take up the services (which are defined in Box VII.1). Some families face challenges that keep them from engaging in services, or from starting them immediately after they enroll. Challenges might be logistical, such as a lack of transportation or time, or substantive, such as relapse, incarceration, or a change in the status of a child welfare case (for example, reunification or termination of parental rights). In the time period examined for this report, nearly 79 percent of all families enrolled in RPG projects had received at least one service. Six projects reported that they had provided services for all enrolled cases. Most other projects (16) had each provided services to more than 60 percent of their enrolled families. Two projects reported providing services for one-third or fewer of their enrolled families.

Box VI.2. Service encounter

A specific interaction between a service provider and the family enrolled in the RPG service, such as a group session; meeting with a therapist, counselor, or case manager; or brief consultation. Projects report details about the interaction that include location, duration, attendance, and the topics that were covered.

Two types of services were used by the most projects and families: case management or service coordination, and therapy or counseling. Both are primary services (defined in Box VII.1). Table VII.2 shows the percentage of RPG cases that received each type of service and the total number of service encounters (defined in Box VII.2) that were reported by all projects.

Table VII.2. Number of primary and supportive service encounters and percentage of cases receiving services, by service type

Service type	Number of projects reporting data on service (out of 24 that submitted data)	Number of service encounters	Number of cases with at least one member who received service type	Percentage of cases with at least one member who received service type
Primary services				
Case management or service coordination	23	4,274	507	77
Therapy or counseling	15	4,385	349	53
Parenting training/home visiting program	10	1,701	206	31
Mentoring	10	1,119	170	26
Support group or workshop	8	1,233	163	25
Supportive services				
Screening or assessment	16	385	235	36
Transportation	9	401	77	12
Housing[a]	3	n.a.	19	3
Employment training	4	14	8	1
Medical care or appointment	4	211	61	9
Medication-assisted treatment	4	93	29	4
Child care	2	61	8	1
Financial or material supports	2	45	20	3
Court or legal	2	15	10	1
Academic education (child or adult)	0	0	0	0
Other services	1	1	1	<1

[a] Housing includes providing a residence to families, including residential treatment facilities and supportive housing. These services are typically provided for the duration of a family's enrollment in RPG services. Because families are in housing every day for that time, grantees do not report on the number of service encounters for this type of service.

Notes: Service types are mutually exclusive. n.a. = not applicable.

Source: RPG-EDS data, March 1, 2019, through July 2, 2020.

Case management and service coordination were the two most common service types that were provided by RPG. Nearly all projects (22 of 24 that submitted data) provided these services to families enrolled in their RPG project. In total, three-quarters of all RPG families received some case management or service coordination by project staff. Within RPG projects, case management typically includes organizing the services a family needs by, for example, developing a service plan, communicating with other agencies or organizations, helping the family navigate social services and comply with any requirements from child welfare, and

referring families to other services that RPG does not directly provide. Consequently, it is essential to manage projects with multiple services and service providers, regardless of the target population or service mix. Also, during many of these encounters, service providers and participants covered topics related to life skills development and the adult's SUD.

Therapy and counseling services were the second most common type of service. They encompass a wide variety of activities, including individual, group, couples, parent-child, and family therapy sessions. These services focus on SUD, mental health or other behavioral health topics, and trauma processing or family strengthening. About half of all families enrolled in RPG projects received therapy or counseling. Fifteen projects reported providing these services.

Sixteen projects offered screening and assessment, which is categorized as a supportive service. Projects that offer this service usually conduct the screenings or assessments when a family first enrolls in the RPG project. These typically are needs assessments to help guide the development of a service plan for the family. Children in the family might also receive developmental screenings. In total, about 36 percent of all RPG families received at least one screening or assessment.

1. Use of program models

To provide services, projects at times use program models to guide the content or structure of the service. These models are often EBPs that use established methods to achieve desired outcomes. Projects use program models most often with primary services, rather than supportive services. Among primary services, program models are most often used in parenting training and home visiting services (92 percent of these service encounters used at least one model, such as Strengthening Parenting or Healthy Families), and with therapy and counseling (84 percent of these encounters used at least one model, such as Living in Balance or Seeking Safety). Table VII.3 shows the percentage of service encounters that used program models for each service type.

Box VI.2. Program models

Projects use curricula, strategies, and approaches to deliver some services, which the cross-site evaluation refers to as program models. Models can have specific guidelines for administration (such as weekly, 1-hour sessions with prescribed content for each session offered for 16 weeks). Some instead feature strategies or practices that can be incorporated into a therapy session or any interaction (such as techniques to motivate an individual to make behavior changes). Examples of the former are the Strengthening Families Program and Nurturing Parenting Programs. Examples of the latter are Motivational Interviewing and Cognitive Behavioral Therapy. RPG4 and RPG5 projects are using 74 different models.

Although program models are commonly used to provide services to RPG families, the specific models that programs use vary. Only a few models are offered by more than one or two projects. Two models, however, are offered and used by several projects: Nurturing Parenting Program and Motivational Interviewing.[28] In fact, each model was received by one-quarter of all families, and 15 percent of the families received both.

[28] Two Nurturing Parenting Program curricula have been reviewed by the Title IV-E Prevention Services Clearinghouse: NPP for Parents & Their Infants, Toddlers, & Preschoolers, and NPP for Parents & Their School Age Children 5 to 11 Years. Neither curriculum met the evidence review's criteria to achieve a rating of well-

Table VII.3. Percentage of service encounters using a program model, by service type

Service type	Percentage of service encounters using one or more program models	Percentage of service encounters using no program model
Primary services		
Case management or service coordination	48	52
Therapy or counseling	84	16
Parenting training/home visiting program	92	8
Mentoring	28	72
Support group or workshop	21	79
Supportive services		
Screening or assessment	36	64
Transportation	21	79
Housing	n.a.	n.a.
Employment training	36	64
Medical care or appointment	81	19
Medication-assisted treatment	3	97
Child care	5	95
Financial or material supports	2	98
Court or legal	13	87
Academic education (child or adult)	0	0
Other services	0	100

Note: Service types are mutually exclusive. n.a. = not applicable.

Source: RPG-EDS data, March 1, 2019, through July 2, 2020.

Thirteen projects offered Nurturing Parenting Programs, and reported that 8 families had received the program as of the time of data collection. The Nurturing Parenting Programs are family-based interventions and include about 30 different curricula designed to improve parenting skills. Each curriculum focuses on a specific target population defined by the age of the child, cultural and language contexts, or other needs, such as families with SUD.[29] The programs are designed to be adapted to different program structures, giving facilitators enough flexibility to ensure that the specific needs of families are met. RPG projects most commonly used Nurturing Parenting as part of a parenting training or home visiting program. About two-thirds of all families who were receiving this type of service received a Nurturing Parenting Program, and nearly 37 percent of service encounters of that type featured the model.

Although Nurturing Parenting is a structured program model with a specific content focus, Motivational Interviewing is a set of strategies that can be easily incorporated into a variety of

supported, supported, or promising. Motivational Interviewing received a rating of well-supported by the clearinghouse, having demonstrated favorable effects for parent/caregiver SUD-related outcomes.

[29] For more information on the Nurturing Parenting Program, see the website at https://www.nurturingparenting.com/.

services. Motivational Interviewing is designed to develop a person's internal motivation to change behavior that the individual considers unproductive or unhelpful (Rollnick & Miller, 1995).[30] It is built on four foundational values of quality, openness, generosity, and respect. Seven projects planned to offer Motivational Interviewing, and reported that five families had received it as of the time data were collected. Because of the model's flexibility, projects incorporated it into several different types of services. Among primary services, about 19 percent of cases that were receiving therapy or counseling services, and 43 percent of cases that were receiving parenting training and home visiting services, were exposed to Motivational Interviewing techniques. Projects also used Motivational Interviewing in providing case management or service coordination, with about 20 percent of cases receiving those services.

B. Projects using peer recovery mentors

Existing health care and treatment models for SUD are often not structured in ways that make it easy to engage participants in treatment and link them to services that can support recovery (Eddie et al., 2019). For this and other reasons, peer recovery support services, offered by peer mentors, are increasingly being employed in a range of settings to help individuals with SUD. Peers can keep people engaged, facilitating referrals to other services, and providing other supports. Peer recovery support services can be offered as a supplement to other services or as a stand-alone service (SAMHSA, 2017). Typically, peers offer mentorship to others in SUD treatment, helping them to develop strategies that support their recovery. A developing body of evidence suggests that peer support services in SUD recovery can lead to reductions in substance use or to other positive recovery-related outcomes (SAMHSA, 2017; Chapman et al., 2018; Mowbray et al., 2020; Tracy & Wallace, 2016). Use of peer recovery mentors has increased since RPG began. Several projects employ peer recovery mentors as part of their RPG project staff. In RPG, a peer recovery mentor (also known as a peer recovery specialist or coach) is someone who has lived through the same kinds of experiences that the RPG families are living through, typically involving SUD or other challenges, such as trauma.

Fifteen of the 27 RPG4 and RPG5 projects planned to use a peer recovery mentor to provide services to their families. In addition to mentoring, these projects intended to have peers facilitate referrals to other needed services, provide transportation or accompany people to their appointments, or help facilitate support group services. Twelve of these projects provided data documenting how peers work with RPG families.

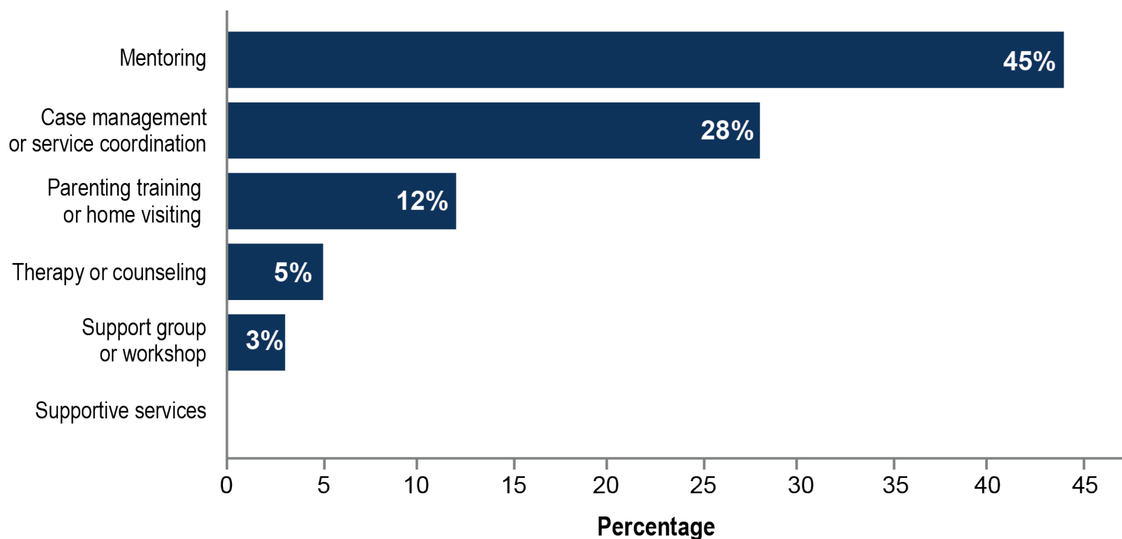
Most of the 12 projects assigned peers to work with the majority (80 percent or more) of the families they enrolled. Overall, peers provided about one-third of the services that RPG-enrolled families received. In one project, peers provided all of the services participants received. Most projects, however, used peers in combination with other service staff, such as clinicians, therapists, nurses, counselors, and case managers. These projects used peers to provide between 14 percent and 58 percent of all services.

Typically, peers provided mentoring to RPG families. In fact, they provided 98 percent of the mentoring services delivered by these projects. Mentoring represented about 15 percent of all the services that RPG projects provided. Most of these mentoring encounters focused on

[30] For more information on Motivational Interviewing, see the website at https://motivationalinterviewing.org.

developing personal life skills and addressing substance use. However, peers also provided about 22 percent of the case management services offered by the 12 projects that submitted data. Case management was, as noted, the most common type of service for these projects (41 percent of all service encounters). Like the mentoring sessions, case management typically focused on topics related to substance use and personal development of life skills. Figure VII.1 gives the percentage of service encounters involving peers that addressed each service type.

Figure VII.1. Percentage of service encounters involving peers, by type of service peers provided



Note: The figure shows all primary services individually, and combines all supportive services into one group.

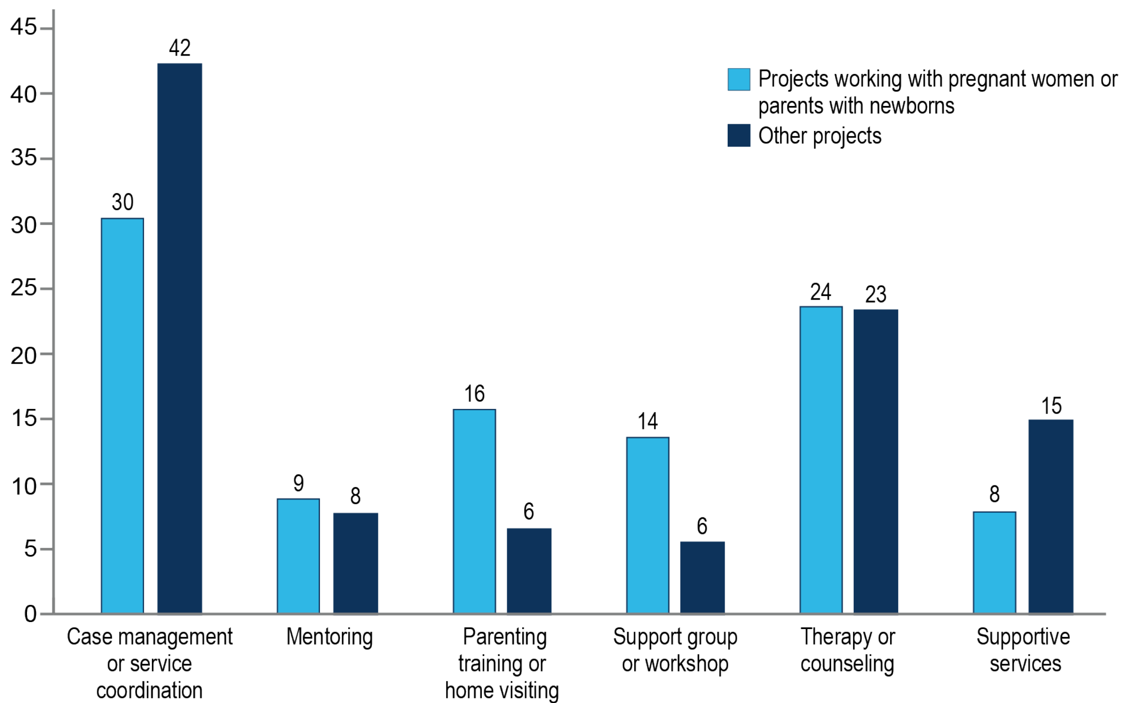
Source: RPG-EDS data.

C. Projects serving pregnant women and parents of newborns

As discussed in Chapter V, 10 projects direct their RPG services to pregnant women or parents of newborns. These projects can generally be categorized into 2 groups: residential treatment programs that allow women to reside in the facility with their young children (or enroll women while they are still pregnant) or family-strengthening programs. Of the 10 projects serving this target population, 9 have provided data on the services these families received.

Although these projects provide all of the primary service types, projects serving pregnant women and parents of newborns tend to offer parenting training or home visiting services to more families. Figure VII.2 shows the mix of services received by an average family enrolled in each group of projects. Families in these projects also participated in relatively more support groups or workshop services. However, fewer families in these projects received case management or service coordination and supportive services.

Figure VII.2. Proportion of cases receiving service types, by target population



Notes: Because each case can receive one or more different types of services, the calculation is done at the case level. For each case, the percentage of encounters of each service type is calculated. These percentages are then averaged across all cases within each group of projects. The figure presents all primary services individually, and combines all supportive services into one group.

Source: RPG-EDS data, March 1, 2019, through July 2, 2020.

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VIII. CONTEXT AND CHALLENGES

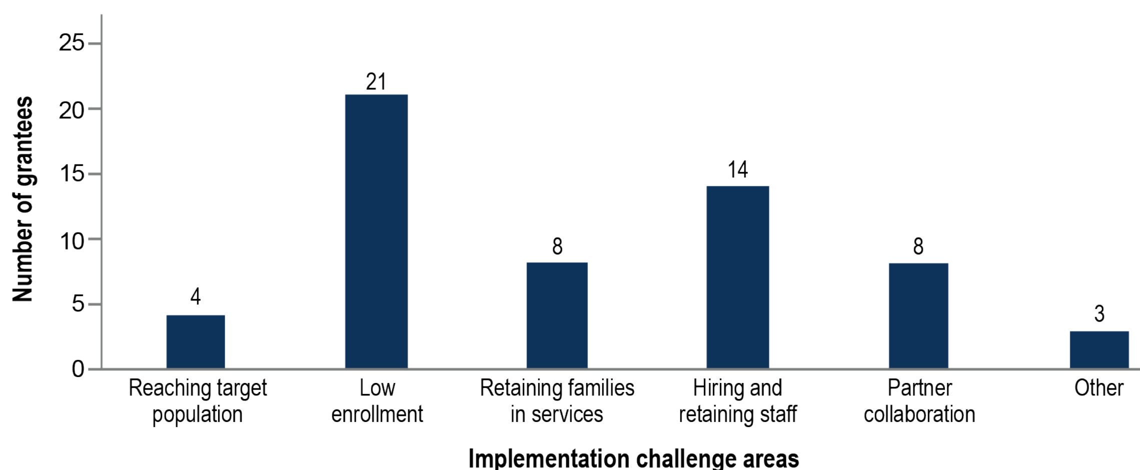
HHS has made notable progress since the last report to Congress (HHS, forthcoming). It funded 3 new cohorts of RPG partnerships, for a total of 35. It supported planning and implementation for all 3 cohorts, released final evaluation findings from a completed, earlier round of grants (HHS, 2020b) and is finalizing reports on the RPG3 cohort (Strong et al., forthcoming). The 35 RPG4, RPG5, and RPG6 partnerships discussed in this report have also made progress since they received their funding in 2017, 2018, and 2019, respectively. All of them completed their initial planning periods, and RPG4 and RPG5 partnerships began implementing their projects: enrolling participants, providing services, collecting data, and submitting data to the cross-site evaluation. Like past cohorts of partnerships, however, they have faced challenges along the way. A review of those challenges provides a context for understanding the findings of future evaluations, and helps HHS tailor future TA and other activities that support its grantees, such as those described in Chapter IV and elsewhere.

This chapter describes the challenges that RPG4, RPG5, and RPG6 grantees reported in the SAPRs they submitted in October 2019 and April 2020, and in telephone interviews conducted in September 2020. Section A describes the project implementation challenges that were brought up in SAPRs. Section B covers the effects of the public health emergency resulting from the severe acute respiratory syndrome coronavirus 2 (SARS-COVID-2) early in 2020 on projects in all three cohorts. Section C concludes with the emergency's implications for future reports to Congress.

A. Implementation challenges

Project implementation rarely unfolds in exactly the way it was intended. During their first few years of operations, RPG projects faced some challenges that could affect their ability to execute their projects as planned at each step, such as recruiting and enrolling their target populations, retaining them in services, and managing staff and partnerships (Figure VIII.1). Those challenges are described in this section, unless they were related directly to the public health emergency, which is discussed later in the chapter.

Figure VIII.1. Grantee-reported areas of challenge



Source: SAPRs filed by RPG4 and RPG5 grantees, October 2019 and April 2020.

1. Target population

As part of its application and planning, each grantee identifies a target population for its services. Four grantees faced challenges enrolling their target population. For example, one grantee enrolled more families with just one child than it had expected to, and consequently served fewer children than it had planned to. Another had planned to serve families before a child was placed outside of the home, but found that at the time of enrollment into RPG, many children were already in out-of-home placements. Discrepancies like this can make it difficult for a project to be completely faithful to its plans.

2. Enrollment

Twenty-one grantees said that they had difficulty enrolling enough families, making it the most common challenge faced by projects. Grantees had a variety of explanations for why enrollment was a problem, with some giving more than one reason. For three grantees, the issue was related to the intended target population. For example, one project that had planned to serve families dealing with heroin use discovered that people in the community had become more likely to use methamphetamines instead. Most grantees whose projects faced an enrollment challenge said that staff capacity or issues with partnerships were responsible. Ten attributed low enrollment to staff turnover or the fact that existing staff were already carrying their maximum caseloads. Eight grantees reported that they received fewer referrals from partners than they planned to.

3. Retention

Keeping families engaged in services is a common challenge in RPG; for example, Strong et al. (forthcoming) describes the work that RPG3 projects did to keep participants engaged. Eight current grantees talked about the difficulty of keeping participants in the project. The most common barriers to retention were participants' incarceration; their lack of a permanent address, phone number, or transportation; or the fact that they were not recognizing their need for behavioral health services. For example, one grantee noted that physiological changes from methamphetamine use made it difficult for participants to "find and feel a strong motivation to change until the brain begins to heal." Two grantees blamed programmatic issues such as staff turnover and long wait times for services to start because enrollment progress was slow.

4. Staff

Staffing issues were reported by 14 grantees, making them the next most common challenge after enrollment. Seven grantees had trouble hiring staff. Five had difficulties finding qualified candidates in their geographic area (especially peer recovery specialists) or could not attract applicants when other openings in the community offered similar wages with less stress. Five grantees reported that staff turnover was an issue for them. According to one grantee, "During this [6-month] reporting period, we have had over 21 transitions of new staff leaving or entering the program, or staff turnover, at all different levels from senior management, supervisors, to direct live staff at all the partner organizations." Grantees said that these staffing problems limited their ability to enroll and serve families.

5. Partners

Partnering is integral to RPG, but 10 grantees found collaboration challenging. Five had problems coordinating services; for example, their SUD treatment partner was not accepting

referrals from the RPG project. Four grantees faced challenges sharing data with partners; 1 of them was also having problems coordinating service provision. Two grantees said that problems at the partner agency created difficulties for them. For example, one grantee reported, “We are attempting to support our clients with connecting [them] to [recovery support] services, but clients are reporting calling the intake line multiple times with no return calls.”

6. Other challenges

Three grantees mentioned other issues affecting their RPG projects that were not in any of the categories discussed above. Two grantees explained that it was difficult to find the services that their participants needed. One said that there were not enough SUD treatment options in the geographic region to meet the needs of women and children, including those in RPG. Another reported difficulty finding housing for participants who were ready to leave residential treatment. This same grantee said that although its residential campus was tobacco-free, program participants were using tobacco or nicotine on campus, which required the project to remove participants from the program for noncompliance. A third grantee mentioned delays in collecting data for performance and evaluation because of issues with the relevant IRB for the local evaluation, and the difficulty of securing data sharing agreements with state agencies.

B. Influence of the public health emergency on RPG projects

Along with the implementation and collaboration challenges grantees described in their SAPRs, an unprecedented challenge that faced the United States and the world affected many of the communities, participants, and agencies involved in RPG. The first American case of the coronavirus[31] was reported on January 20, 2020, and the president declared the U.S. outbreak a public health emergency on January 31. On March 13, the president declared a national emergency. By mid-April, cases had been confirmed in all 50 U.S. states, the District of Columbia, and all inhabited U.S. territories. State and local responses to the outbreak have included prohibitions and cancellation of large-scale gatherings (including festivals and sporting events), stay-at-home orders, and school closures.

The 35 active RPG projects were located in states that had varying rates of COVID-19 infection.[32] Many RPG grantees and their partners were confronted with staffing challenges, reduced referrals, and temporary stoppages or adaptations to service delivery. The public health emergency also led to changes in RPG projects’ plans and operations. For example, many RPG grantees had to quickly adapt to provide services virtually, or develop an alternative to in-person recruitment. Furthermore, RPG grantees and their partners faced competing demands with public health priorities and helping participants meet basic needs. The necessary adaptive responses by RPG grantees to the public health emergency could affect their delivery of services to their target populations, limit their ability to achieve their project objectives, and ultimately influence their evaluation results.

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[31] The name of the coronavirus disease is abbreviated as COVID-19. “CO” stands for “corona,” “VI” for “virus,” and “D” for “disease” (CDC, n.d.).

[32] During the first several months of the public health crisis, specifically from March 1 through October 29, 2020, the estimated average monthly rates for COVID-19 in states with RPG projects ranged from 340 to 4,748 cases per 100,000 people, according to https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#states.

To learn about the different ways that RPG projects experienced and responded to the public health emergency, the cross-site evaluation team conducted an exploratory study of 16 RPG projects.[33] In September 2020, the team interviewed the director of each project or another knowledgeable staff member designated by that person.

1. RPG system partners

The public health emergency influenced the operations of many key system partners of RPG grantees and affected the grantees' ability to meet the needs of RPG target populations.

Child welfare system. Respondents noted that partner agencies from their state or local child welfare system were affected by several key changes as a result of the public health emergency. Staff from most of the RPG grantee agencies included in the study said that there were fewer reports of child maltreatment. They cited school closings as a primary reason, because school-based mandated reporters were not in a position to make as many reports. Respondents also said that the child welfare system had to quickly adapt its procedures for in-person parent-child visitations, which were suspended or moved to virtual platforms to ensure safety during the public health emergency. Almost all respondents to our study reported that child welfare visits in their communities transitioned to virtual formats. By September 2020, when the study was conducted, half of the respondents reported that in-person child welfare visits had started to resume, with safety precautions in place such as social distancing, mask wearing, and meeting in outdoor locations.[34] In addition, some respondents said that the public health emergency prompted them to rethink some of their approaches to child welfare, including ways to shorten case timelines for reunification and the use of out-of-home care. For example, respondents mentioned that there was an emphasis on considering ways to allow children to quarantine with their families or to expedite reunification and thereby potentially reduce exposure to COVID-19.

SUD treatment system. All of the respondents said that they adapted their SUD treatment services for participants enrolled in RPG to offer them virtually or through telehealth, with minimal disruption to SUD treatment services for most grantees. However, a few respondents said that clients lacked access to technology, were unable to access virtual services because of confidentiality concerns at home, or were uncomfortable using virtual services instead of meeting in person. Although therapy and group services could be moved onto virtual platforms, it was more difficult to shift substance use testing from in-person formats. For example, one respondent reported specific challenges with the urinalysis component of substance use testing, which led courts and SUD treatment providers to allow for more flexibility on testing locations, home visits, and self-testing. For residential SUD treatment facilities, the response to the public health emergency was varied, with service delays, temporary stoppages, adjusted admission policies, and/or restrictions for new clients all in play. Medication-assisted treatment, or MAT, had fewer service disruptions than other SUD treatment services. MAT treatment providers were able to limit the frequency of medication pickups (by allowing patients to pick up more than a single dose each day) and to institute COVID-19 symptom checks to maintain services. Some of

[33] The projects were selected for their variety, and not to be representative of all 35 active RPG projects.

[34] Precautions for in-person visits may have shifted after the study was conducted as rates of COVID-19 subsequently increased in many areas. Source: https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html#states.

the respondents described challenges specifically for women with substance use disorders who were seeking treatment, because they faced new and increasing caregiving responsibilities during the public health emergency. Similarly, some respondents expressed concern about the unknown risks of COVID-19 for pregnant women and infants in their target populations. Perceptions of risk may have led some agencies to limit referrals to treatment, thus reducing referral rates, and might also have made some individuals more reluctant to seek treatment.

Court systems. Several respondents noted that local court systems suspended or delayed operations due to the public health emergency, which slowed permanency hearings and delayed reunification.[35] One grantee noted that delays in the court proceedings were exacerbated because in-person visitation was also more difficult. Caseworkers need to conduct in-person visits with parents and children to assess whether parents are meeting case goals for reunification, and they could not make as many of those visits as they needed to. Respondents said that most family courts transitioned to broadcasting proceedings from the courtroom or holding them on virtual platforms with judges, clients, and legal teams participating from home. Some courts did not have wireless Internet in courtrooms to facilitate virtual hearings, and some local communities did not have the Internet connectivity necessary for clients to participate in virtual hearings from home.

Moving court proceedings to virtual formats had some positive aspects, however. One RPG grantee reported that judges in its service area supported virtual hearings because they allowed for more family involvement. For example, family members living outside the local area were able to join and contribute additional emotional support. Another respondent mentioned that virtual court hearings increased parent participation, especially for fathers. For reasons such as these, some local judges were interested in sustaining the use of virtual hearings for certain cases even after the public health emergency abates.

Other systems. The public health emergency affected other service systems, and thus heightened the needs of people in the RPG projects' target populations. Nearly half of the interviewees said that their RPG target populations had trouble obtaining food and meeting their other basic needs during the public health emergency. To help them overcomes these challenges, a few grantees had adjusted their operations to distribute food to their clients. Recommendations against using public transportation, or the fear of doing so, also presented problems for many adults in RPG, which virtual services helped to solve.

However, the lack of access to technology was also a widespread challenge for RPG projects and participants. Most of the respondents said it was difficult to use the technology needed to provide virtual services and to enable participants to access those services virtually. Although a few respondents had good things to say about telehealth promoting increased access to services, others described some participants' reluctance to engage virtually in counseling for mental health

[35] Child welfare cases are adjudicated in family court, where judges make key decisions about custody, including reunification and termination of parental rights. There are federal timelines specified in the Adoption and Safe Families Act to limit how long children remain in foster care before a permanency decision is made about whether to reunify a child with the parent or whether to terminate parental rights to pursue adoption. Court closures or delays in court hearings may prolong permanency decisions and extend the amount of time that children spend in foster care.

issues and/or SUD treatment because they strongly preferred to talk with a provider face to face or thought their home environments did not allow them to have a confidential conversation.

2. Effect on RPG project implementation and planning

The public health emergency affected operations in the social services and support systems, and it also influenced RPG projects' implementation (RPG4 and RPG5) and planning efforts (RPG6). Grantees and their RPG partners navigated staffing concerns; changes in recruiting, referring, and enrolling participants; adaptations to service delivery, and new ways to engage partners.

Staffing. Most respondents thought their RPG project staff adapted well to working remotely during the pandemic, although not all staff were able to work from home exclusively or long-term. Regardless of their work-from-home status, staff were reportedly anxious and stressed about the participants in their program, their own safety, and whether services would be virtual or in person at the moment and going forward. Some respondents were concerned that staff would be exposed to COVID-19, and at the time of the interview, some staff had already contracted the virus. Additionally, some respondents said their projects faced staffing challenges related to turnover, hiring delays, and furloughs. On the other hand, some respondents said that it was not as expensive to have a remote workforce that traveled less often.

Recruitment, referrals, and enrollment. Many RPG projects typically recruited families in person at a partner's facility (for example, a court, SUD treatment clinic, or child welfare agency). Because of the public health emergency, many projects shifted to virtual recruitment by calling eligible families or sending electronic recruitment forms. In some cases, this shift allowed projects to serve families in more rural areas who otherwise would not have received services. Some RPG projects had fewer referrals from SUD treatment providers, courts, and jails when these partners stopped services and/or shifted to virtual formats. For some, this decrease in referrals persisted from the time the public health emergency started in March through September 2020, when interviews were conducted. To increase enrollment, some projects offered online enrollment processes, but others halted their entire process as they awaited IRB approval for changes to their previously approved plans. Consequently, most respondents noted that their projects enrolled fewer participants than they had expected to.

Service delivery. Most RPG projects shifted from in-person to virtual service delivery, using text messages, phone calls, and videoconferencing platforms to offer their programs. For example, one project used text messaging for parts of its intake process and to send client satisfaction surveys following services. Projects also used videoconferencing platforms like Zoom to hold virtual therapy and support group sessions, offer modified versions of their interventions, and conduct individual appointments. Respondents reported positive experiences with shifting to virtual services, noting that their service array did not necessarily change. Some projects consulted with the developers of the program and practice models that they were offering to adjust the activities to work in a virtual format, and others adjusted the content on their own. Respondents generally thought their participants also adapted well to virtual services, and projects were generally able to keep participants engaged in services. Virtual services also allowed individuals who lacked transportation or faced other barriers to participate more fully in the program than they could when services were in person.

Although respondents thought that delivering services virtually was generally successful and even helped some expand the geographic area they could serve, they noted that some types of services such as dyadic sessions, infant mental health programs, and support groups did not work as well in virtual formats. Some projects consulted with the developers of EBPs, such as Child Parent Psychotherapy and Strengthening Families, to shift the interventions to a virtual format, whereas others adjusted the content on their own. Additionally, some respondents noted that projects partnered with behavioral health providers and/or residential facilities faced challenges adapting to new restrictions and safety protocols related to personal protective equipment, temperature checks, COVID screenings, and increased cleaning procedures.

RPG partner engagement. In some RPG projects, the grantee delivers services directly to families; in others, the grantee serves as a coordinator, and RPG partners are responsible for service delivery. Most respondents reported that their RPG partners that directly serve families provided a mix of in-person and virtual services for their RPG projects during the public health emergency, depending on local restrictions. When they could, RPG partners continued offering in-person services such as child welfare home visits, medication-assisted treatment, and prenatal medical exams. Aside from changes in services, most respondents maintained or improved their relationships and communication with their partners throughout the public health emergency. Although partner relationships and communications moved to virtual formats, attendance increased, and meetings took place as scheduled. Most respondents were able to keep partners engaged and informed of progress toward partnership goals through additional email and phone communication outside of group meetings. In some cases, however, RPG partners had to address issues related to the public health emergency, which delayed or distracted them from RPG projects.

RPG6 planning. Unlike RPG projects funded in 2017 and 2018, the RPG6 projects, funded in September 2019, were not delivering services when the public health emergency began. Instead, they were engaged in planning, as required by their grants. They were not expected to begin implementation until October 2020. Still, they faced similar challenges in their planning. Respondents highlighted challenges related to the public health emergency's impact on partners' time and availability, making changes to program designs, and needing time to implement technological changes to offer programs virtually.

About half of the respondents from RPG6 projects faced staffing challenges because they had to delay their initial project hiring and onboarding procedures during the public health emergency. Most respondents noted that they changed their RPG plans to accommodate virtual referral and recruitment processes. However, they expected this to be challenging because they cannot identify participants in person at partner facilities or directly engage with families to build rapport with them. Consequently, these respondents were also concerned about receiving fewer referrals.

In terms of their program implementation plans, all respondents planned to offer services or conduct some part of their program virtually until local guidance permits them to resume in-person services. Some respondents with RPG6 projects had already shifted programs to virtual formats for a previous RPG cohort or another population, and did not have significant problems adapting their plans. However, only some respondents noted that they had support from either program model developers or university partners to help shift their EBPs to virtual formats to

ensure participants could still receive services. Model developers generally helped RPG projects navigate the shift to virtual programming, but some respondents wanted more explicit guidance on how to best make the transition to ensure fidelity to the model(s) that they were using. However, model developers were also exploring these transitions themselves, and could not always provide clear guidance. Some respondents hoped that virtual services would allow them to increase participation by expanding their reach and eliminating barriers (such as transportation, child care, etc.), whereas others were concerned about a possible decrease in participation. They believe their participants may not be comfortable enough with the technology or the Internet, or might not have enough access to the Internet and technology devices that they need to participate in the program from home.

All respondents began holding virtual partnership and planning meetings through videoconferencing and email discussions instead of in-person. About half of the respondents reported that they had positive relationships and productive meetings, but some respondents found virtual partnership and planning meetings to be difficult because their partners generally had competing interests and have been prioritizing other core services during the public health emergency. Despite these challenges, about half of the RPG6 respondents still expected to begin their RPG programs on time in the fall of 2020, and the rest expected to be fully operational by the beginning of 2021.

3. Effect on RPG evaluations

The public health emergency also affected the RPG4 and RPG5 projects' evaluation efforts, and the RPG6 projects' evaluation plans. Across all cohorts, most projects changed their consent processes and submitted IRB modifications so they could conduct aspects of their evaluations virtually.

Almost all respondents of RPG4 and RPG5 projects adapted their data collection procedures to use phone, mail, or other virtual methods instead of administering surveys or conducting interviews in person. Some respondents also made changes to their local evaluation study design or their data collection procedures to reduce their sample size or the number of measures that they expected to include in the evaluation. Respondents pointed out that delayed recruiting processes raised concerns or made them update plans that they had for recruiting study participants, collecting and submitting data, and adhering to deadlines for their own local evaluation. However, not all respondents had problems implementing their own local evaluations. Also, even though respondents noted that the public health emergency will impact their local evaluations, they did not think that this would lead to any substantial changes in or raise any concerns about their ability to perform necessary activities in the RPG cross-site evaluation, such as collecting data.

The public health emergency prompted most RPG6 projects in the study to change their evaluation plans to collect data virtually online, by phone, or by mail. Most of them stated that they sought IRB approval to allow them to obtain verbal consent instead of having to collect written consent forms, and to conduct certain aspects of the evaluation virtually.[36] About half of

[36] HHS required grantees to obtain IRB approvals for their research; a condition of approval is to obtain informed consent from participants in the study.

the respondents expressed concerns about implementing a virtual data collection process, because they worried about the possibility of low response rates and small sample sizes, poor quality or incomplete data from virtual data collection, and confidentiality procedures when collecting data by mail. One respondent also highlighted that outcome measures may be influenced more than usual by factors outside the project's intervention and may misrepresent the program's success. Follow-up data may reveal that measures of family well-being, for example, are lower than they were at enrollment not because the program was ineffective, but because of the public health emergency.

C. Implications for evaluation

The RPG grantees' experiences with adapting their RPG programs during the first 6 months of the public health emergency will have varying degrees of influence on their ability to meet their project objectives. However, after the first 6 months of the public health emergency, it was too early for them to tell precisely what those effects will be. Based on early information from the qualitative study in September 2020, it is likely that the RPG grantees may have additional challenges with reaching their program enrollment targets, retaining participants in their program, and delivering virtual services with fidelity. Furthermore, the disruptions and adaptations to the RPG program models, such as changes in service availability or transitions to virtual service delivery, might make it difficult to interpret the results of local evaluations.

Also, several respondents expressed uncertainty about the effect that external factors associated with the public health emergency will have on their achievement of participant outcomes, including parent recovery and child safety. A successful comparison group evaluation would be able to isolate the effects of the program, which is received only by the treatment group, from those of COVID-19, which would affect both the treatment and comparison group. However, these effects could be harder to detect if evaluations are challenged by smaller sample sizes than planned, or low response rates for data collection. Future reports to Congress will need to consider how the public health emergency influenced RPG program operations and participant outcomes. Future reports can also cover the challenges faced by RPG grantees during the public health emergency and the solutions that were implemented to address these challenges.

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APPENDIX A:

PROGRAM MODELS PROPOSED BY RPG5 AND RPG6

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Table A.1. Program models that RPG5 projects proposed to implement (by state)

Program model	FL (Citrus)	FL (North)	IA (Judiciary)	IA (Seasons)	IL	MA	MO	NY	PA	SD	Total
Parent training/family strengthening											
Active Parenting		X									1
Child Adult Relationship Enhancement (CARE)				X							1
Family Assessment Support Team (FAST)		X									1
Incredible Years								X			1
Mothering from the Inside Out									X		1
Nurturing Parenting Program		X			X	X	X			X	5
Parent-Child Assistance Program							X				1
Parenting Wisely				X							1
Strengthening Families Program			X		X						2
Walk away, It's private, Share, and Educate (W.I.S.E-Up!)				X							1
White Bison Fathers/Mothers of Tradition										X	1
Substance use disorder treatment											
Contingency management								X			1
Criminal and Addictive Thinking Workbook										X	1
Dialectical behavioral therapy		X		X						X	3
Hazelden's Relapse Prevention Program and Personal Recovery Plan Work Book										X	1
Helping Men Recover							X				1
Helping Women Recover							X				1
Integrated Dual Disorders Treatment Recovery Life Skills Program										X	1
Living in Balance		X					X				2
Matrix Model							X			X	2
Peer recovery support	X					X	X				3
Seeking Safety				X		X	X				3

Program model	FL (Citrus)	FL (North)	IA (Judiciary)	IA (Seasons)	IL	MA	MO	NY	PA	SD	Total
Trauma and behavioral health care											
Attachment, Regulation, and Competency (ARC) framework						X					1
Child–Parent Psychotherapy			X			X			X		3
Cognitive Behavioral Therapy or Trauma-Informed Cognitive Behavioral Therapy		X			X		X				3
Duluth Model of Power and Control		X									1
Eye movement desensitization and reprocessing therapy				X			X				2
Functional Family Therapy				X							1
Incredible Years, Small Group Dinosaur										X	1
Motivational Enhancement Therapy		X					X	X			3
Motivational Interviewing		X				X	X			X	4
Parent-child attachment therapy				X							1
Parent-child interactive therapy				X			X				2
Person-centered therapy		X									1
Play therapy										X	1
Rational emotive behavior therapy										X	1
Therapeutic respite care				X							1
The Salvation Army Batterers Intervention		X									1
Trauma Recovery and Empowerment Model										X	1
Case management and navigation or legal services											
Court Appointed Special Advocates (CASA)										X	1
Integrated Practice Team/case management	X	X									2
Other											
Individual placement and support							X				1
Total	**2**	**12**	**2**	**10**	**3**	**6**	**14**	**3**	**2**	**14**	**68**

Sources: Summaries of projects provided by the National Center on Substance Abuse and Child Welfare; information provided by grantees to the cross-site evaluation team.

Table A.2. Program models that RPG6 projects proposed to implement (by state)

Program model	CO	GA	IL	MO	NH	NJ	OK	WV	Total
Parent training/family strengthening									
Intact Family Services/Intact Family Recovery Program			X						1
Keeping Families Together						X			1
Nurturing Parenting Program				X					1
Parent-Child Assistance Program				X					1
SafeCare		X							1
Signs of Safety				X					1
Triple P						X			1
Substance use disorder treatment									
12-Step Facilitation Therapy				X					1
Circle of Parents in Recovery	X								1
Community Reinforcement Approach							X		1
Family-Centered Substance Use Disorder Treatment			X		X				2
Gender-specific treatment								X	1
Helping Men Recover				X					1
Helping Women Recover				X					1
Living in Balance				X					1
Medication-assisted treatment			X	X				X	3
Modified Attachment and Biobehavioral Catch-Up							X		1
Peer recovery support				X		X			2
Seeking Safety		X					X	X	3
Sober Parenting Journey					X				1
Trauma and behavioral health care									
Child–Parent Psychotherapy					X				1
Cognitive Behavioral Therapy or Trauma-Informed Cognitive Behavioral Therapy		X		X		X		X	4
Cognitive Process Therapy for Trauma							X		1
Functional Family Therapy						X			1
Motivational Interviewing				X		X	X	X	4
Parent-Child Interactive Therapy		X				X		X	3

Program model	CO	GA	IL	MO	NH	NJ	OK	WV	Total
Case management and navigation or legal services									
Enhanced/intensive case management				X	X	X		X	4
The Dependency and Neglect System Reform (DANSR) case management approach	X								1
Total	**2**	**4**	**3**	**12**	**4**	**8**	**5**	**7**	**45**

Sources: Summaries of projects provided by the National Center on Substance Abuse and Child Welfare; information provided by grantees to the cross-site evaluation team.

APPENDIX B:

STANDARDIZED INSTRUMENTS FOR ASSESSING ADULT RECOVERY, FAMILY FUNCTIONING, AND CHILD WELL-BEING

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A standardized instrument or test 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. It is scored in a standard or consistent manner, which makes it possible to compare the relative performance of individuals or groups (Adapted from The Glossary of Education Reform (http://www.edglossary.org/standardized-test/).

Standardized instruments are always administered, scored, and interpreted the same way. These instruments undergo a robust development process and extensive field testing. The cross-site evaluation scored these instruments using the rules provided by the publishers, and compared the RPG sample with a normative population to provide context for all findings from the instruments.

Instruments to assess adult recovery

Recovery from substance use is a process of change that permits individuals to make healthy choices and improve the quality of their life (Substance Abuse and Mental Health Services Administration, 2012). Supporting adult recovery can be an explicit or implicit goal of RPG projects. The standardized instruments that the cross-site evaluation uses to assess adult recovery include: (1) the Addiction Severity Index, Self-Report Form (ASI-SR; McLellan et al., 1992) and (2) the Trauma Symptoms Checklist-40 (TSC-40; Briere & Runtz, 1989).

Adult substance use. The cross-site evaluation uses the 10 questions in the drug/alcohol use subscale[37] of the ASI-SR, a widely used tool in the addiction field, to measure the extent and severity of substance use by adults in RPG. Examples of questions include, “How many days have you used more than one substance (including alcohol) in the past 30 days?” and “In the past 30 days, how many days have you experienced drug problems?” Along with indicating the use of alcohol and other drugs, the ASI has been shown to be predictive of substance use disorder (Rikoon et al., 2006). However, the results of the instrument alone are not enough to establish this diagnosis, and it was not used for that purpose in the cross-site evaluation.

Adult symptoms of trauma. Experiences of trauma are strongly predictive of subsequent substance misuse (National Child Traumatic Stress Network, 2008) and also create their own difficult problems for families and programs to address. The cross-site evaluation measures adult trauma symptoms using the TSC-40 as one measure of adult recovery from substance use issues. The TSC-40 measures aspects of post-traumatic stress and other symptom clusters in adults who have experienced traumatic experiences as children or adults. It is a self-administered questionnaire, and its items combine in six subscales: (1) anxiety, (2) depression, (3) dissociation, (4) Sexual Abuse Trauma Index (SATI), (5) sexual problems, and (6) sleep disturbance. The questionnaire also tabulates a total score. Adults answered questions such as “How often have you experienced each of the following in the last two months?” and then identify how often symptoms such as “headaches,” “sadness,” or “anxiety attacks” have been occurring.

[37] The full ASI-SR has six subscales: (1) medical status, (2) employment/support status, (3) drug/alcohol use, (4) legal status, (5) family/social relationships, and (6) psychiatric status. To limit the burden on participants, the cross-site evaluation only uses the drug/alcohol use subscale.

Instruments to assess family functioning

Family functioning can be affected by parents' mental health and parenting attitudes. SUD can cause, or result from, mental health problems such as depression (Grant & Harford, 1995). Issues with parents' mental health and their parenting abilities are linked to the risk of child maltreatment and poor child outcomes (Budd et al., 2006; Dubowitz et al., 2011; Sidebotham et al., 2001). The cross-site evaluation collects data on adult mental health and parenting attitudes to assess family functioning. Information about parenting attitudes is not included in this report because of some issues with the data that are still under investigation, but it will be included in future report.

Depressive symptoms. The cross-site evaluation measures adult depressive symptoms using the CES-D, a screening tool assessing the presence and severity of depressive symptoms occurring over the past week. Respondents are asked to rate how often each of the items (for example, "I was bothered by things that usually don't bother me") applied to them in the past week. Respondents with a score of 15 or higher are categorized as having "severe depressive symptoms."

Instruments to assess child well-being

It is well established that the experience of maltreatment has comprehensive and lasting implications for children (Institute of Medicine & National Research Council of the National Academies, 2013). The RPG program seeks not only to maintain or increase children's safety and the permanency with their family, but also to improve their well-being. The standardized instruments that are used to assess child well-being include: (1) the Infant-Toddler Sensory Profile (ITSP) (Dunn, 1999, 2002), which measures sensory-processing difficulties of children in the RPG; and (2) the Child Behavior Checklist (CBCL), which measures children's emotional and behavior problems.

Sensory processing. Sensory processing, the way the brain takes the information from the senses and turns it into appropriate behavioral responses, is one of the areas that has been shown to be affected by prenatal substance exposure (Chasnoff, Wells, Telford, Schmidt, & Messer, 2010). Children who have difficulties processing sensory information or responding to the information with appropriate behavior are considered to have sensory processing disorder. They often have difficulty performing everyday tasks and exhibit elevated emotional and behavioral problems and low levels of adaptive social behaviors (Ben-Sasson, Carter, & Briggs-Gowan, 2009). The cross-site evaluation uses the ITSP to examine sensory processing difficulties of children in RPG. Each item in this questionnaire, which is filled out by parents, describes children's responses to various sensory experiences. The ITSP identifies children who are under-responsive in terms of registering audio, visual, or tactile stimulation, and children who are over-responsive to these stimuli. Both under- and over-responsiveness indicate sensory processing difficulties and can be detrimental to children's well-being. These children are characterized as being at high risk for future problems related to sensory processing. The ITSP can be used with children ages birth to 36 months.

Children's behavior. Children's emotional and behavioral problems are associated with caregiver substance use (Behnke et al., 2013), caregiver well-being, and parenting stress and skills (Neece et al., 2012). The cross-site evaluation uses the Child Behavior Checklist (CBCL;

Achenbach & Rescorla, 2000, 2001) to measure children's emotional and behavior problems, including internalizing (for example, anxiety, depression) and externalizing (for example, attention, aggression) problems, and measures total problems (a combination of emotional, behavior, and other problems). There are two versions of the CBCL—one for preschool-age children (ages 1.5 to 5) (Achenbach & Rescorla, 2000) and one for school-age children (ages 6 to 18) (Achenbach & Rescorla, 2001).

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