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

December 2016

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

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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Children's Bureau

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CONTENTS

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TABLES

FIGURES

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EXECUTIVE SUMMARY

The experience of maltreatment has wide-ranging and long-lasting implications for the children who experience it. For instance, children with a history of maltreatment have an increased likelihood of teenage pregnancy (Barnes et al., 2009; Carrion & Steiner, 2000) and a heightened risk of juvenile delinquency (Carrion & Steiner, 2000; Marsh et al., 2006), and they are more likely than their non-maltreated peers to need substance use disorder treatment in the future (Drake et al., 2006; Swan, 1998). Children whose caregivers abuse drugs and alcohol have increased risks of future maltreatment and are more likely to misuse substances themselves (Hanson et al., 2006; Widom et al., 2007).

Since 2006, Congress has twice authorized competitive grants to support partnerships among organizations in child welfare, substance use disorder treatment, and other service systems to improve the well-being, permanency, and safety outcomes of children who were in, or at risk of, out-of-home placement as a result of a parent's or caregiver's substance use disorder. With this funding, the Children's Bureau within the Administration on Children, Youth and Families, Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services (HHS) established the Regional Partnership Grant (RPG) program.

The Child and Family Services Improvement Act of 2006 (Pub. L. 109-288) provided funding to 53 organizations in 29 states with grants lasting between two and five years, which have now ended. The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) reauthorized the RPG program and extended funding through 2016. In September 2012, the Children's Bureau awarded RPG funding under the grant program to 17 partnerships in 15 states (RPG2; Table 1).[1] In September 2014, the Children's Bureau awarded another round of five-year grants to four agencies in four states (RPG3). Grants ranged from $500,000 to $1 million annually, with increasing percentages of required grantee matching funds.

As part of the program, HHS is conducting a cross-site evaluation. The purpose of the RPG cross-site evaluation is to provide legislatively mandated performance measurement and assess the extent to which the grants have been successful in addressing the needs of families with substance use disorders who come to the attention of the child welfare system. HHS develops an annual report to Congress to describe the progress and summarize findings to date.

The first report to Congress (HHS, December 2014) focused on the award and initial implementation of the RPG2 program following reauthorization. The purpose of the second report to Congress was to describe progress in the early implementation of the RPG2 projects (HHS, August 2015).

[1] HHS also offered existing grantees new grants of $500,000 per year for up to two years (Administration for Children and Families 2012b) to extend their programs. This report does not discuss those grants.

Table 1. Grantees

Grantee	State
2012 (RPG2)	
Center Point, Inc.	California
Georgia State University Research Foundation, Inc.	Georgia
Judicial Branch, State of Iowa	Iowa
Northwest Iowa Mental Health/Seasons Center	Iowa
Children's Research Triangle	Illinois
Kentucky Department for Community Based Services	Kentucky
Commonwealth of Massachusetts	Massachusetts
Families and Children Together	Maine
Alternative Opportunities, Inc.	Missouri
The Center for Children and Families	Montana
Nevada Division of Child and Family Services	Nevada
Summit County Children Services	Ohio
Oklahoma Department of Mental Health and Substance Abuse Services	Oklahoma
Health Federation of Philadelphia, Inc.	Pennsylvania
Helen Ross McNabb Center	Tennessee
Tennessee Department of Mental Health and Substance Abuse Services	Tennessee
Rockingham Memorial Hospital	Virginia
2014 (RPG3)	
Our Kids of Miami-Dade/Monroe, Inc.	Florida
University of Kansas Center for Research, Inc./School of Social Welfare	Kansas
Montefiore Medical Center	New York
Volunteers of America Oregon	Oregon

The purpose of this third report to Congress is twofold: (1) to provide an early description of the families being served by the RPG2 projects and the services they are receiving; and (2) to introduce the 2014 RPG3 projects. The report focuses on activities from April 2014 through March 2015. This period is referred to as the *reporting period* or *year 3* throughout this report. The RPG projects are sometimes also referred to as *grantees* or *partnerships*. Sections A through D discuss the RPG2 projects funded in 2012. Section E introduces the RPG3 projects, funded in 2014. Section F describes next steps and future reports.

A. RPG Enrollment

By May, 2014, all grantees had begun enrollment, and by April 2015, the 17 RPG2 grantees combined had enrolled 5,157 people, 59 percent of whom were children. Once HHS received clearance from the Office of Management and Budget (OMB) in March, 2014, grantees began submitting data to the cross-site evaluation on people they had enrolled after January of that year. Data were of two types: (1) enrollment and services information, and (2) baseline and follow-up outcome data. Between January 2014 and February 2015, the grantees enrolled 625 RPG cases, consisting of 859 adults and 1,080 children, and provided data on them. These data are used in this report.

1. RPG cases

Because RPG addresses needs of children at risk of entering the child welfare system due to substance use disorder experienced by an adult close to them, by definition each RPG case includes at least two members: one adult and one child. Nearly half (46 percent) of cases enrolled during the reporting period included only these two members. In 94 percent of cases with only two members, the people enrolled were a biological parent (usually a mother) and her child. The remaining 54 percent of cases had more than two members. Cases with more than one *adult* typically included both biological parents of the child (or children) in the case (59 percent of these cases). Ninety-nine percent of cases with two or more adults included at least one biological parent. Of the 271 cases with more than one *child*, 97 percent were composed of biologically related siblings. In total there were 1,080 children in the 625 cases enrolled in RPG between January 1, 2014, and February 28, 2015.

Grantees submitted additional data to the cross-site evaluation on one "focal child" in each case. This enabled HHS to obtain detailed information on maltreatment, out-of-home placements, and child well-being in each RPG case without placing excessive burdens on grantees or families to provide baseline and outcome data on all children they enrolled. Of the 625 focal children in RPG cases, half were female and half male; their average age was five years. Forty-seven percent lived in the primary residence of an adult member of the case, while 28 percent were in foster care and 8 percent resided in a treatment facility, shelter, or correctional facility; the remainder lived in other residences at the time they were enrolled in RPG.

Most cases included at least one of the focal child's biological parents. Parents on average were 30 years old at the time of RPG enrollment, and 87 percent were the child's mother. Many parents faced financial hardship. Seventy-three percent reported earning an income less than $10,000 in the 12 months prior to enrollment, and 19 percent of parents reported no income from any source. Public assistance was the most common income source parents reported (39 percent), and wage or salary income was the second-most-common source (37 percent). At enrollment, 50 percent of parents reported being unemployed, and 20 percent reported that they were not in the labor force (that is, not employed and not actively seeking employment). Others were employed full time (13 percent) or part time (16 percent).

2. Maltreatment and out of home placement prior to RPG enrollment

Data obtained by grantees from their state or county child welfare agencies show that, as intended, RPG projects enrolled some children with documented maltreatment or other previous experience with the child welfare system. Of the 567 focal children in the sample for whom we received records, 31 percent (176 children) had one or more substantiated episodes of maltreatment in the year prior to enrollment in RPG. A report of maltreatment is substantiated when an investigation by child protective services concludes that the report was supported or founded as defined by state law or policy (HHS, 2015). Five percent were subjects of one or more instances of substantiated emotional, physical, or sexual abuse, and 24 percent were subjects of one or more instances of substantiated neglect.

Twenty-six percent of the 567 RPG focal children for whom we received administrative records (for a total of 148 children) were removed from their homes at some point during the year prior to RPG enrollment. This number does not include children who were already living outside the

home at the beginning of the one-year period prior to enrollment. Of the 148 children who were removed from their homes during the year prior to RPG enrollment, 15 percent (22 children) were reunited with their families. The average length of time between removal from the home and reunification in the family of origin for these children was 280 days. One other child was also placed in a permanent setting. Eighteen of these placements occurred after their enrollment in RPG. There were 84 children who experienced multiple rounds of removals and placements prior to RPG enrollment during the period covered by our data.

B. Adults and families at RPG enrollment

There are varied needs among RPG families. For example, caregiver substance misuse is a known risk factor for child maltreatment and involvement in the child welfare system (HHS, 2014). Substance use disorder is linked to adult stress, mental health issues, and trauma, such as post-traumatic stress disorder (PTSD; Najavits et al., 1997; Substance Abuse and Mental Health Administration, 2013). In turn, caregiver stress or mental health challenges can hinder appropriate or effective parenting, placing children at risk of maltreatment or leading to adverse effects on children's physical, mental, and emotional well-being (Staton-Tindall et al., 2013). Therefore, HHS asked grantees to obtain data on RPG participants at the time of enrollment, to paint a broad portrait of adult substance use disorder and treatment, and caregiver and adult functioning at baseline. Future reports will use followup data collected after participation in RPG to describe changes in these baseline measures.

1. Adult substance use disorder and treatment

To examine adult substance use disorder, grantees provided data on (1) substance use severity for RPG adults, (2) contextual/life factors affected by substance use, (3) participation in substance use disorder treatment, and (4) trauma exposure. These data show that:

- As measured by the Addiction Severity Index-Self-Report (ASI-SR), a total of 37 percent of RPG adults exhibited high severity of substance use (either drug or alcohol use or of both) in the past 30 days. *Drug use* was much more prevalent than *alcohol use*, with 36 percent reporting severe drug use, and 7 percent severe alcohol use. Four percent exhibited both severe drug and alcohol use.[2]
- Forty-six percent of those in the high-severity group reported using cannabis in the past 30 days, followed by 45 percent who reported using amphetamines and 41 percent who reported using alcohol. Nine percent or less of these adults reported using methadone, heroin, cocaine, barbiturates, or hallucinogens.
- Adults classified in this report as high-severity alcohol or drug users had higher rates of employment, legal, medical, psychiatric, or family or social problems commonly affected by substance use disorder than adults not in the high-severity category.

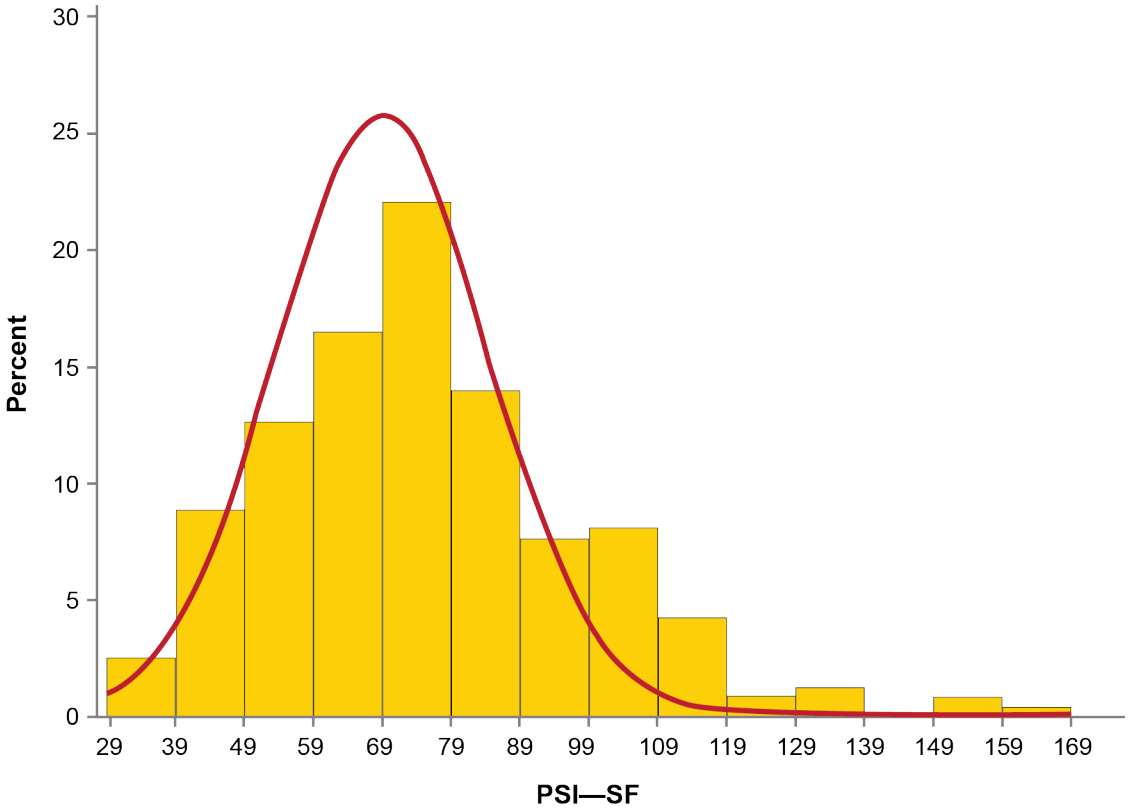
Grantees obtained administrative records from the agency in their state responsible for administering the Substance Abuse Prevention and Treatment Block Grant to examine whether adults who reported on substance use at baseline had participated in treatment before enrolling in

[2] The ASI-SR (McLellan et al., 1992) is a clinically validated assessment instrument.

RPG. These records show that at least 20 percent of adult RPG participants had been in one or more publicly funded substance use disorder treatment programs during the year prior to their enrollment in RPG. Of the 112 adults in this category, 30 (27 percent) completed at least one treatment program during that period.

In addition to bearing the burdens of high levels of substance use disorder and its concomitant life difficulties, adults with substance use problems often suffer from symptoms related to past or ongoing trauma exposure. A trauma assessment administered at baseline to the adults for whom substance use and treatment data were collected showed that adults in RPG had, on average, symptoms of post-traumatic stress disorder (PTSD) at rates similar to people who had previously experienced sexual abuse (Elliot et al., 1992; Whiffen, 1997), were enrolled in psychiatric settings (Zlotnick et al., 1996), or indicated alcohol use disorder (Heffner et al., 2011).

Figure 1. Distribution of scores on the PSI-SF for RPG adults compared to the national mean



Note: In this figure, the distribution of parenting stress scores for the RPG sample is shown by the yellow histogram, which is centered on the RPG sample mean score of 75. The height of each bar represents the proportion of the sample with scores in a given range. For example, about 14 percent of the sample has scores between 99 and 169. A red bell curve is overlaid on the histogram. The curve is centered on the national mean score of 69 and represents the distribution of normalized scores for a general population.

2. Caregiver well-being

Twenty-two percent of all primary caregivers of RPG children experienced elevated levels of parenting stress, and their mean score for parenting stress exceeded the national mean as measured by the Parental Stress Index-Short Form (PSI-SF, Abidin, 1995; Figure 1). Parenting stress contributes to dysfunctional parenting and is associated with child maltreatment potential (Testa & Smith, 2009; Berger, 2004). There is also a significant association between stress and substance use disorders. Studies have shown that people exposed to stress are more likely to misuse alcohol and other drugs, or to relapse after treatment (Sinha, 2001 and 2007).

On average, RPG adults also reported levels of depressive symptoms that are higher than observed in the general population. Among the adult respondents, 38 percent exhibited symptoms of severe depression as defined by the test manual for the instrument used by grantees. These people might need further evaluation and assessment to diagnose depression and to determine possible interventions to address it. In addition to using data on their participants for their local RPG evaluations, several RPG grantees were using information and scores from cross-site evaluation instruments to assess needs and plan services for people they enrolled in RPG (not all instruments were appropriate for uses other than research).

Finally, on their parenting attitudes and behaviors, RPG adults scored near the national averages. These parenting attitudes or behaviors include lack of empathy or use of corporal punishment, for example, that place children at risk for maltreatment. However, 44 percent of adults expressed at least one attitude that placed their child at risk for maltreatment.

C. Child well-being at baseline

Children's experiences with maltreatment or neglect, as well as the experiences and characteristics of key adults in their lives, have implications for their social-emotional and behavioral well-being and development. To obtain measures of well-being, at the time of RPG enrollment grantees asked the caregiver of each focal child to complete a set of standardized instruments, selected based on the ages of children for whom each instrument was designed.

Data from these instruments show that, at enrollment, RPG children are at higher risk than national samples of children in some, but not all, areas of well-being (Table 2). Risk is indicated by scores that exceed the relevant national mean for each instrument; for each measure, 16 to 43 percent of RPG children are in a high risk category. In some areas, RPG children show important strengths.

Table 2. Child well-being scores prior to receiving RPG programming

Aspect of child well-being	Age range	Sample size for analysis	Sample mean (standard deviation)	National mean (standard deviation)	Percentage of focal children in high-risk category
Sensory processing [a]	0 to 6 months	49	–0.13 (0.53)	0 (1)	31
	7 to 36 months	61	0.23 (0.72)	0 (1)	43
Executive functioning	2-5 years	66	55.80 (15.40)	50 (10)	27
	5-18 years	86	53.69 (13.48)	50 (10)	24
Emotional problems	1.5-5 years	85	51.56 (11.93)	50 (10)	16

Aspect of child well-being	Age range	Sample size for analysis	Sample mean (standard deviation)	National mean (standard deviation)	Percentage of focal children in high-risk category
	6-18 years	95	53.37 (11.65)	50 (10)	19
Behavioral problems	1.5-5 years	82	51.30 (13.46)	50 (10)	20
	6-18 years	95	54.91 (12.76)	50 (10)	27
Total problems score	1.5-5 years	83	51.40 (13.93)	50 (10)	18
	6-18 years	95	54.47 (12.57)	50 (10)	30
Socialization[b]	0-99 years	186	87.24 (23.80)	100 (15)	23
Trauma symptoms (PTSD)	3-12 years	131	37.35 (10.46)	50 (10)	37

Source: RPG baseline administration of standardized instruments.

Note: The sample sizes vary by measure because caregivers reported on different subsets of children depending on the child's age. In addition, the sample sizes in this table vary across instruments as a result of instrument nonresponse. The standard deviation is a measure of variability around the mean scores.

[a] Sensory processing was measured for children from birth to 36 months of age. "Typical" sensory processing occurs at a score of zero. Negative scores represent under-responsiveness to stimuli, and positive scores represent over-responsiveness to stimuli, both of which are problematic.

[b] For socialization, higher scores represent more positive socialization for children. For executive functioning, emotional, behavioral, and total problems, and trauma symptoms, higher scores represent more negative child well-being outcomes.

Sensory processing: For infants, over- or under-response to stimuli can be detrimental to well-being. Being *over-sensitive* to loud noise, light, or touch can be related to developmental delays. A child who *under-responds* may not jump at a loud noise, or react to a dangerous situation. For RPG, caregivers reported that focal children aged 0 to 6 months *under-responded* to stimuli, on average, with negative scores below the national mean of zero. RPG children aged 7 to 36 months were reported to *over-respond* to stimuli, having positive scores above the mean. Thirty-one percent of focal children aged 0 to 6 months, and 43 percent aged 7 to 36 months, fell into the high-risk category of scores for sensory processing. These findings indicate that RPG programs should be aware of potential sensory processing issues for a substantial portion of the children under age three they serve.

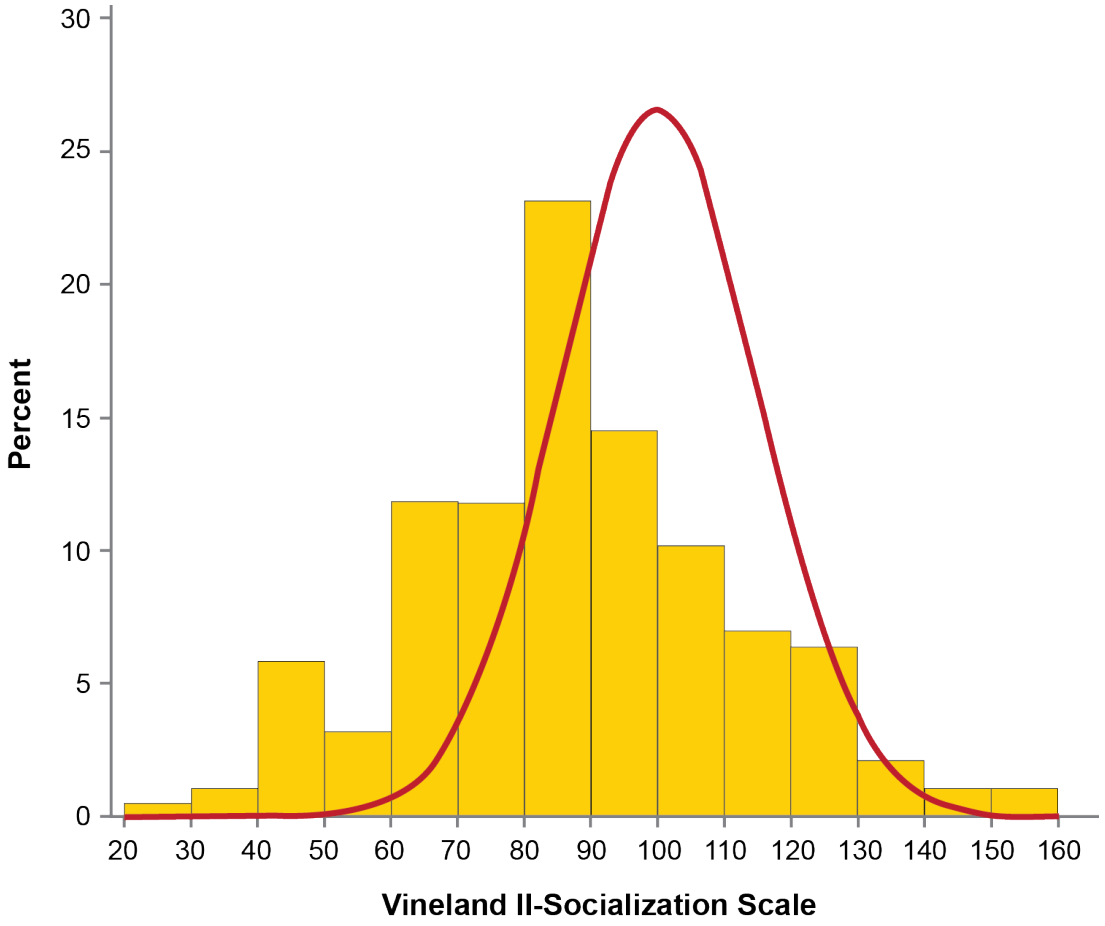
Executive functioning. Compared to the national mean, focal children in RPG exhibit limitations in their executive functioning. That is, as a group they have greater difficulties in tasks such as controlling their impulses, solving problems, and planning. However, many RPG children look similar to the national population in terms of executive functioning, and many are scoring as well as or better than the national mean. About a quarter of RPG focal children in each age group (27 percent among children aged 2-5, and 24 percent among older children) are in the high-risk group, meaning they are less proficient in executive functioning compared to the general population. This could affect their future or current social and behavioral well-being, and subsequent school success.

Emotional and behavioral problems. The levels of emotional, behavioral, and associated problems among RPG children are slightly elevated relative to national samples, though not markedly so. Compared to the national mean of 50, school-aged children scored a mean of 53 on the emotional problems scale (whether the child is emotionally reactive, anxious/depressive, withdrawn, or has somatic complaints), 55 for the behavior problems scale (example questions include "can't concentrate, can't pay attention for long" or "gets in many fights"), and 54 on the

total problems scale (emotional, behavioral, and other problems such as sleep problems). Likewise preschoolers, on average, scored close to the national means on all scales: a mean of 52 on the emotional problems scale, 51 on the behavior problems scale, and 51 on the total problems scale.

Socialization scales. These skills are defined as "the performance of daily activities required for personal and social sufficiency" (Sparrow et al., 2005, p. 6). The sample mean for RPG focal children was 87 compared to the national mean of 100; for this measure, lower scores indicate higher risk. Although on average RPG focal children score lower on this area of development relative to peers nationally, a substantial proportion of children score at or above the national mean, which indicates that many children are developing positive socialization skills (Figure 2).

Figure 2. Distribution of scores on the Vineland II for RPG focal children compared to the national mean



Trauma symptoms. Overall, children between ages 3 and 12 years in the RPG sample exhibited few signs of PTSD, an anxiety condition brought on by experiencing one or more traumatic events. The sample score for RPG focal children was 37 compared to the national mean score of 50. This is a positive finding for this group; however, it is possible that these scores underreport trauma in RPG children since the instrument is less sensitive to certain experiences, such as neglect. Despite lower than average scores for PTSD for the entire sample,

37 percent of RPG children were classified by their scores as high risk, meaning that they exhibited signs and symptoms of PTSD. HHS is concerned about trauma in children and has encouraged all grantees to provide trauma-informed care, and several grantees provide interventions specifically designed to address child and/or adult trauma. Thus, treatment for children exposed to trauma and its many interrelated problems is a central concern for RPG projects.

D. Participant enrollment in programs and services

To address the anticipated needs of their RPG cases, each RPG project designed a set of evidence-based or evidence-informed programs or practices (EBPs) that suited their intended target population and community context. The number of services and programs offered varied across the grantees. For example, two grantees offered one EBP through their RPG projects. Other grantees offered several EBPs in combination, planning to provide most or all cases with the same suite of services. Still others offered a range of EBPs and planned to provide a subset to each case based on participants' needs and progress. Of the 625 RPG cases enrolled in an RPG project during the reporting period, nearly three-fourths were enrolled in at least one specific EBP. In total, 16 grantees had enrolled 458 RPG cases (including 1,027 participants) in 19 different EBPs. By May 2015, most grantees had enrolled cases in at least some of the EBPs they planned to offer as part of their RPG projects.

The types of EBPs varied across RPG projects. Family-strengthening programs were implemented by the largest number of grantees. Twelve grantees had enrolled at least one case into this type of program by the end of the data collection period (Table 3). The other types of EBPs, and the number of grantees enrolling participants in each, are[3]:

- **Response to trauma.** These EBPs are designed to help clients cope with trauma and develop resilience. Ten grantees had enrolled cases in at least one EBP focused on coping with trauma.
- **Child-caregiver therapy.** These therapies focus on the child-caregiver relationship, but cut across several substantive areas, including family functioning, substance use disorder treatment, and response to trauma. Six grantees had enrolled cases in a child-caregiver therapy EBP.
- **Therapy or counseling styles.** These include cognitive behavioral therapy and other counseling styles, such as Motivational Interviewing. Four grantees had enrolled cases in at least one counseling style EBP.
- **Substance use disorder treatment.** This is intended to help clients overcome substance use disorder and avoid relapse. Four grantees had enrolled cases in one or more substance use disorder treatment EBPs.
- **Family treatment drug court.** These are specialized courts designed to work with families involved in the child welfare system primarily because of parental substance use disorder. One grantee had enrolled cases in this type of EBP.

[3] For information on how EBPs were placed into these categories, see Strong et al. (2013).

Table 3. EBP enrollments by type

EBP type	Number of grantees enrolling cases in EBP(s) of this type	Number of cases served by grantees enrolling cases in EBP(s) of this type	Percentage of all RPG cases enrolled in EBP(s) of this type
Family strengthening	12	520	53
Response to trauma	10	267	19
Substance use disorder treatment	4	230	13
Counseling style	4	102	6
Child-caregiver therapy	6	242	5
Family treatment drug court	1	8	1

Source: RPG Enrollment and Service Log data.

RPG2 projects were well underway in their implementation during their third year of work. During this phase, the projects addressed several issues, some of which were unique to a few states, while others were shared by multiple projects.

Significant state level changes affected several RPG projects. A law enacted in 2014 in one state allowed women to be prosecuted for the illegal use of a narcotic while pregnant if her child was born with a physical dependence on, or harmed by intrauterine exposure to, a drug as a result of the mother's illegal use of a narcotic drug (in the words of the legislation) taken while she was pregnant. The law led to a dramatic increase in referrals of pregnant women for substance use disorder treatment. Significant increases in reports of possible abuse and historically high numbers of foster care placements in another state constrained the capacity of the child welfare system to engage as fully in the RPG project as hoped.

Several grantees experienced improvements in relationships and communication with child welfare, though others continued to struggle in this area. A problem in some sites was turnover in child welfare staff, leading to the need to re-orient staff members to the RPG project and engage them in making referrals for RPG services.

Several RPG projects responded creatively to initial difficulties meeting enrollment targets and retaining participants. For example, grantees defined their target populations more broadly, such as by easing are restrictions on children eligible for RPG, or expanded screening for substance use problems or possible trauma to identify more people eligible for RPG services.

Substance use disorder treatment providers who were part of RPG instituted practices aimed at enhancing treatment or retaining clients in treatment or recovery, such as: (1) the use of goal-oriented, client-centered counseling to increase clients' self-motivation; (2) giving patients tangible rewards to reinforce positive behaviors such as abstinence; or (3) training specialists to help clients identify and get access to available services and supports.

E. RPG3 projects funded in 2014

HHS awarded four new five-year grants in September, 2014 (Table 4). Grant amounts were $564,914 or $600,000 annually, with increasing percentages of required grantee matching funds over time. One of the four grantees had also received RPG funding in 2007, but none were 2012

RPG2 grantees. One grantee was a university, and three were local service providers. With their partners, RPG3 grantees planned to provide a variety of services to children and their caregivers in their identified target groups. Planned services included, for example, parenting education or skills trainings programs, referral to substance use disorder treatment or other needed services, counseling, support from a peer specialist, and trauma interventions and/or trauma screening. One project planned to offer a drop-in center as a hub for all services.

Table 4. RPG3 projects and planned target population and program focus

State	Grantee organization	Organization type	Federal grant amount	Planned target population and program focus
Florida	Our Kids of Miami-Dade/ Monroe, Inc.	Child and family services provider	$600,000	Our Kids will provide a suite of services to families with children aged 0 to 11 who are referred through the Child Protective Investigation Process for diversion or prevention. Services include (1) the Engaging Moms/Parent Program, which provides additional support for engagement in substance use disorder treatment, family therapy interventions, and supports to improve parenting skills; (2) engagement with a peer specialist; (3) Intensive Family Preservation Services; and (4) referral to a motivational support program.
Kansas	University of Kansas Center for Research, Inc.	Public university	$564,914	The University of Kanas Center for Research will provide the Strengthening Families Program: Birth to Three (SFP B-3) among families with substance use disorders and children up to 47 months old in foster care or at risk of out-of-home placement.
New York	Montefiore Medical Center	Medical center, substance use disorder treatment provider, child and family services provider	$600,000	Montefiore will provide the Family Treatment/ Rehabilitation (FT/R) program and three program enhancements—Seeking Safety, Incredible Years, and contingency reinforcement—among families with substance use disorders and open and indicated child welfare cases where children are at risk for removal.
Oregon	Volunteers of America – Oregon (VOAOR)	Child and family services provider, substance use disorder treatment provider	$600,000	VOAOR will provide a Recovery Oriented System of Care for parents in recovery from substance use disorders who are either engaged with or at risk of engagement with child welfare. In eligible families, the adult in recovery will have already completed substance use disorder treatment. Families will be matched to a Certified Peer Recovery Mentor if requested, and they may also work with a resource specialist and/or therapist.

Source: Grantees' RPG applications, ongoing conversations with grantees, and other grantee materials.

As it had for RPG2, HHS required that every RPG3 grantee evaluate its project, saying that grantees should propose evaluation designs comparing participants with nonparticipants (ACF, 2014). In assessing the strength of these evaluation designs, HHS considered the level of evidence on program effectiveness that the evaluations could provide if they were well implemented. Based on the assessment of the local evaluation designs, HHS rated each design as one of the following:

- **Strong.** If the evaluation was implemented well, the design would provide credible, unbiased effects of the contrasts being evaluated.
- **Promising.** If the evaluation was implemented well, the design would provide suggestive information on the effects of the contrasts being evaluated.
- **Limited.** If the evaluation was implemented well, the design would provide limited information on the effects of the contrasts being evaluated.
- **Descriptive.** The design cannot isolate program effects from other factors but can provide useful information on participant outcomes or other aspects of the RPG program and partnerships.

After the evaluability assessment, two local evaluation designs received a rating of "strong" and two were rated "promising." The four grantees will launch their local evaluations and begin providing data to the cross-site evaluation in the coming year.

F. Next steps

In the coming year, RPG2 grantees will continue to provide data to the cross-site evaluation. HHS will analyze data from the grantees, along with new data collected through surveys of RPG2 grantee staff and partners. The cross-site evaluation contractor will conduct site visits to all 17 RPG2 grantees to collect additional data on implementation. The RPG3 cohort of grantees will begin enrolling cases in their RPG programs and providing data to the cross-site evaluation, and data from both cohorts will be used in future reports to Congress. HHS will also study the cost of trauma-specific EBPs implemented by grantees in both cohorts.

1. Collecting and analyzing data for the cross-site evaluation

RPG2 grantees will continue to provide implementation and outcome data for evaluation and reporting by HHS. In addition to data on enrollment in RPG and individual EBPs discussed in this report, grantees will provide detailed information about services participants receive for a subset of 10 "focal" EBPs selected for in-depth study. HHS will monitor data quality and completeness through use of automated validation procedures and manual examination of data, and will provide feedback and assistance to grantees as they submit data.

In the next reporting period, HHS will analyze data collected in spring of 2015 through web-based surveys of RPG partners and front-line staff. HHS will summarize quantitative data from the surveys using basic descriptive methods and use the quantitative data to contribute to studies of implementation and partnerships that area being conducted as part of the cross-site evaluation.

In the fall of 2015, the cross-site evaluation contractor will conduct site visits to each of the 17 RPG2 grantees. The visits will explore the RPG planning process, how and why particular EBPs

were selected, the ability of the child welfare, substance use disorder treatment, and other service systems to collaborate to support quality implementation for EBPs, challenges faced, and potential for sustainability of RPG partnerships and services after the grant period ends. Activities during the site visits will include individual and small-group interviews conducted by two-person teams.

2. A cost study of trauma-specific EBPs

HHS is asking its grantees to adopt and implement trauma-informed services and programs. This is an important focus for RPG projects, because most children involved in child welfare have been exposed to trauma (Kisiel, 2009), and most women in substance use disorder treatment have experienced it (Covington, 2010). Because RPG projects work with both groups, many grantees are also implementing EBPs that are specifically designed to address trauma in children and/or adults. In October 2015, HHS began developing data collection instruments for a cost study of trauma-specific EBPs implemented by RPG projects.

At minimum, the study will involve (1) selecting whether to study one or more trauma-specific EBPs or to develop an approach generalizable to all those being used in RPG, (2) developing methods for the study, and (3) creating measures and data collection instruments. Depending on available resources, HHS may be able to pilot-test the instruments and analysis approaches with selected RPG projects and launch a pilot cost study or conduct a full cost study. Even if it is not possible to conduct the cost study as part of RPG, developing an approach and data collection methods will set the stage for a future study and could be used by individual grantees for cost analyses they may wish to conduct.

3. Future reports to Congress

To support program development and improvement and inform stakeholders—including HHS, Congress, and the grantees themselves—results from the cross-site evaluation are released throughout the five-year evaluation period for the grants. Products include annual reports to Congress, annual cross-site evaluation program reports, special topics briefs, and a final evaluation report.

- The **2016 report** will include findings from the surveys of RPG2 partners, and of staff members providing EBPs being studied in depth for the cross-site evaluation. The report will also report on participants enrolled by RPG3 grantees.
- The **2017 report** is the final report on RPG required by the legislation. The report will (1) evaluate the programs and activities conducted, and the services provided, with the grant funds for fiscal years 2007 through 2016; (2) analyze the regional partnerships that have, and have not, been successful in achieving the goals and outcomes specified in their grant applications and with respect to the performance indicators; and (3) analyze the extent to which such grants have been successful in addressing the needs of families with methamphetamine or other substance use disorders who come to the attention of the child welfare system, and in achieving the goals of child safety, permanence, and family stability.
- Two additional reports to Congress (in 2018 and 2019) will report on the final two years of activity by the RPG3 projects.

HHS will then prepare a restricted-use file of data from the cross-site evaluation. This file will be made available to qualified researchers for future research through the National Data Archive on Child Abuse and Neglect.

I. INTRODUCTION

The experience of maltreatment has wide-ranging and long-lasting implications for the children who experience it. For instance, children with a history of maltreatment have an increased likelihood of teenage pregnancy (Barnes et al., 2009; Carrion & Steiner, 2000) and a heightened risk of juvenile delinquency (Carrion & Steiner, 2000; Marsh et al., 2006), and they are more likely than their non-maltreated peers to need substance use disorder treatment services in the future (Drake et al., 2006; Swan, 1998). Some research suggests that these survivors of abuse and neglect have an increased risk of maltreating the children they care for (Dixon et. al, 2005; Rittner, 2002; Scaramella & Cogner, 2003).

Studies have found that many, if not most, child welfare cases involve a parent with a substance use disorder (Niccols et al., 2012). Children whose caregivers have substance use disorders have increased risks of future maltreatment and are more likely to use drugs and alcohol themselves (Hanson et al., 2006; Widom et al., 2007). They have an increased risk of poor long-term development and mental health problems (Hanson et al., 2006; HHS, 2009) and are more likely to engage in illegal activity and become involved in the criminal justice system (Huebner & Gustafson, 2007; Murray et al., 2007).

For these reasons, (1) preventing or addressing maltreatment, and (2) identifying potential adult substance use disorders—and treating them if needed—are capacities needed within state and local child welfare and substance use disorder treatment systems. Although staff in both child welfare and substance use disorder treatment systems generally endorse the need for simultaneously addressing substance use disorder and child welfare issues (Drabble, 2007), the systems are not always well equipped to do so. The child welfare system is not mandated to consider substance use disorders unless they lead to abuse or neglect and is not designed to manage them (Young et al., 2007). Recovery from a substance use disorder is likely to be prolonged and may include relapses, whereas children need safe and stable environments immediately. Each system is embedded in different legal and policy environments, has a different perspective about who the "client" is (the parent or the child), has dissimilar timelines for families' outcomes, and is governed by confidentiality requirements that may impede collaboration (Marsh and Smith, 2011).

A. The Regional Partnership Grant Program

Since 2006, Congress has twice authorized competitive grants to support partnerships among organizations in child welfare, substance use disorder treatment, and other service systems to improve the well-being, permanency, and safety outcomes of children who were in, or at risk of, out-of-home placement as a result of a parent's or caregiver's substance use disorder. With this funding, the Children's Bureau within the Administration on Children, Youth and Families (ACYF), Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services (HHS) established the Regional Partnership Grant (RPG) program.

- **First round of grants (RPG1).** The law authorized and appropriated $145 million over five years for the first round of RPG funding. The Child and Family Services Improvement Act of 2006 (Pub. L. 109-288) provided funding to 53 organizations in 29 states with grants

lasting between 2 and 5 years. RPG projects[4] addressed five areas: (1) systems collaboration and improvements; (2) substance use disorder treatment linkages and services; (3) services for children and youth; (4) support services for parents and families; and (5) expanded capacity to provide treatment and services to families. To monitor program outcomes as required in the legislation, HHS established performance indicators that reflected the broad goals of the legislation and aligned with the diverse activities of the 53 regional partnerships. Grantees reported annually on those performance indicators most relevant to their specific partnership goals and target populations.[5] To support grantees in achieving their program and performance goals, HHS provided technical assistance (TA) to grantees through a federal contract. These grants have ended.

- **Second round of grants (RPG2).** The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) reauthorized the RPG program and extended funding through 2016. The legislation reauthorizing the RPG program (Pub. L. 112-34) removed references to methamphetamine, including the requirement that gave weight to grant applications focused on methamphetamine use. With the funding, HHS offered new competitive grants up to $1 million per year for five years (ACF, 2012a). In September 2012, the Children's Bureau awarded RPG funding under the grant program to 17 partnerships in 15 states.[6] HHS must now evaluate and report on the effectiveness of the grants.[7]
- **Third round of grants (RPG3).** With additional funds and the authorization of the legislation (P.L. 112-34), in September 2014, the Children's Bureau awarded another round of five-year grants of up to $600,000 to four agencies in four states. The law requires that RPGs select and report on performance indicators and evaluation measures to increase the knowledge that can be gained from the program.

B. Current Grantees

In 2011, Congress authorized $20 million annually for the RPG program (RPG2). In response to the grant announcement released on April 16, 2012, HHS awarded 17 grants in 15 states (Table I.1). With the remaining funds, HHS awarded a third round of grants (RPG3) to four agencies in four states.

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

[5] Information on program implementation and grantee performance for the 2007 RPG program is available in three reports to Congress (U.S. Department of Health and Human Services, 2012, 2013, and 2014).

[6] HHS also offered existing grantees new grants of $500,000 per year for up to two years (Administration for Children and Families 2012b) to extend their programs. This report does not discuss those grants.

[7] The reauthorizing legislation required a report on the first round of RPG funding by December 31, 2012, and the second round by December 31, 2017. These reports must include an analysis of the grantees' success in meeting performance indicators and addressing the needs of families with substance use disorders.

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

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

Grants ranged from $500,000 to $1 million annually, with increasing percentages of required grantee matching funds. Ten of the RPG2 grantees also received earlier RPG funding; the other seven are new to the RPG program. One of the RPG3 grantees, the University of Kansas, had also received funding as part of RPG1. Under both RPG2 and RPG3, grantees are mainly state agencies or local service providers:

- Six grantees are state agencies: four of these are state child welfare agencies or agencies responsible for administering the Substance Abuse Prevention and Treatment Block Grant (hereafter referred to as state substance use services agencies), and one is a state judicial branch. In one state, the state child welfare and substance use services agency jointly received the grant.
- One grantee is a county child welfare agency.
- Eleven of the 21 grantees are organizations that provide services to individuals and families: Three are substance use disorder treatment providers, three are health or mental health service providers, and five provide child welfare or other child and family services.
- Two grantees are hospitals, which provide substance use disorder treatment and related services.
- Two grantees are universities.

Because the grants were intended to improve collaboration between the substance use disorder treatment and child welfare systems, they supported partnerships between these two systems and other related agencies. The partners in each site have worked together to design the RPG program, identify families to participate, provide services, and promote systemic change.

1. Planned services

Services to be provided through RPG included, for example, case management, residential and outpatient substance use disorder treatment, parenting and/or family strengthening, treatment for trauma or mental health problems, family drug treatment courts, counseling and peer support groups, health care, housing support, employment services, and child development services. RPG projects focus on child well-being, though the target groups for services differ. Some grantees serve children in out-of-home care; others focus on families where children are at risk of an out-of-home placement. Grantees work with children of parents who are in, or have completed, substance use disorder treatment programs or are involved in adult criminal or family drug treatment courts. In addition, grantees take differing approaches to service provision. Some provide a focused suite of services to all participants; others will offer a range of interventions and customize the services each family receives.

2. Technical assistance

To support grantees as they serve families with evidence-based and trauma-informed programs and evaluate their efforts, HHS provided both program and evaluation TA through two contractors. As part of its contract to manage the National Center on Substance Abuse and Child Welfare (NCSACW)—which is funded by ACYF and the Substance Abuse and Mental Health Services Administration—the Center for Children and Family Futures, Inc., provides TA and other activities to support the RPG programs. Similarly, as part of its contract to design and

conduct the RPG cross-site evaluation, Mathematica provides TA to support the local RPG evaluations, and participation by the grantees in the cross-site evaluation.

C. RPG Reports to Congress

The purpose of the RPG cross-site evaluation is to provide legislatively mandated performance measurement and assess the extent to which the grants have been successful in addressing the needs of families with substance use disorders who come to the attention of the child welfare system. HHS develops an annual report to Congress to describe the progress and summarize findings to date.

1. First report to Congress

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

- **TA.** NCSACW responded to numerous requests from grantees on such topics as strategies to cross-train staff on child welfare and substance use disorder treatment and sustainability after the grant program ends. Mathematica responded to TA requests on such topics as designing an evaluation, obtaining families' consent, recruiting and enrolling families, and working with institutional review boards. In addition to responding to requests, both TA providers held monthly calls with grantees and met with them in-person at two meetings, to provide ongoing support and assistance.
- **RPG Partnerships and programs.** As required by the RPG funding, all partnerships included child welfare agencies responsible for the administration of the state's plan under Title IV-B or IV-E of the Social Security Act. In addition, grantees partnered with a number of other agencies—from 4 to 29—including state and county agencies; courts; and private, nonprofit, and faith-based organizations. Each partnership planned to offer between 1 and 15 evidence-based or evidence-informed programs and practices (EBPs) to RPG participants. Across all grantees combined, more than 50 EBPs were planned or in place.
- **Evaluation and accountability.** To contribute to the evidence base on effective programs for families served by RPG, HHS required that each grantee evaluate its project with a comparison group study or other rigorous design. HHS reviewed the rigor of the proposed designs, concluding that six local evaluations could offer the strongest level of evidence on program effects; six could offer promising or limited evidence on program effects; and seven could offer descriptive information, such as change over time. HHS also designed the cross-site evaluation.

2. Second report to Congress

The purpose of the second report to Congress was to describe progress in the early implementation of the RPG2 projects (HHS, August 2015). The main source of data for the report was the semiannual progress reports that grantees submitted in October 2013 and April 2014 (each covering their activities for the prior 6 months). Highlights of the report include:

- **TA.** Most of the formal requests grantees for TA made during this reporting period were for program TA. The 17 RPG2 grantees made a total of 63 requests to NCSACW for program

assistance between May 1, 2013, and April 30, 2014. Common requests were for help in developing strategies to cross-train staff in child welfare, substance use disorder treatment, and other agencies providing services to RPG clients, to expand their understanding of the child welfare, substance use disorder treatment, and court systems; planning to sustain the RPG projects after the grant program ends; and addressing underlying values among partners. In addition to program TA, Mathematica received 14 requests from 8 of the 17 grantees to provide TA on evaluation-related topics during the second year of the RPG2 program. Half the TA requests related to questions about data collection plans, which reflected the fact that most grantees were preparing to collect evaluation data. In addition, a "help desk" designed to quickly address questions on individual data collection instruments and processes received 69 inquiries.

- **Milestones reached.** During the second year of RPG2, HHS's accomplishments include finalizing the design of the cross-site evaluation and releasing a design report (Strong et al., 2014) and purchasing licenses for grantees' use of copyrighted data collection instruments to measure child and family outcomes. HHS also obtained Office of Management and Budget (OMB) clearance for collecting performance indicators and evaluation data from grantees, as required under the Paperwork Reduction Act of 1995 (Pub. L. 96-511, 94 Stat. 2812, codified at 44 U.S.C. § 3501-3521). Finally, HHS completed web-based data collection systems grantees used to submit implementation and outcome data for the cross-site evaluation. These accomplishments laid the foundation for fulfilling legislative requirements to collect performance data and evaluate the effectiveness of the grants.
- **Enrollment.** By April 2014, 16 of the 17 grantees had begun enrollment. The number enrolled at each site by then ranged from 35 to just over 700, for a total of 3,365 participants, 65 percent of them children.
- **Addressing trauma.** RPG projects addressed trauma by encouraging trauma-informed practices by providers and RPG partners, and through the programs they offered participants. Trauma-informed practices are based on an understanding of the vulnerabilities of trauma survivors that traditional service-delivery approaches may trigger or exacerbate, so that these services and programs can be more supportive and avoid retraumatizing participants. Ten grantees implemented EBPs specifically designed to address symptoms of trauma in children and/or adults.
- **Evaluation.** As of April 2014, 15 grantees had obtained Institutional Review Board (IRB) approval for their local evaluations, and others had applied for approval. By that time, of the 19 local evaluations (2 grantees are conducting 2 evaluations of separate projects), 13 had begun participating in the cross-site study, including obtaining IRB approval, enrolling families into the cross-site evaluation, and collecting data for the cross-site evaluation.
- **Data sharing.** For the RPG evaluations, grantees were encouraged to obtain administrative data on child welfare and substance use disorder treatment to measure outcomes for their local evaluations, and for use in the cross-site evaluation. Grantees had mixed success getting agreements in place to obtain these data. State agencies were reluctant to share information if they did not have established relationships with the requesting organizations. Such agencies also had competing demands and often found it difficult to marshal the resources needed to fulfill requests for data. While HHS strongly encourages state child welfare agencies to share data with discretionary grantees—only five grantees had failed to

establish agreements to receive these data—the grantees had less leverage with state substance use services agencies, and nine still had not received approvals for their requested substance use disorder treatment data. The experience of the RPG2 grantees suggests that challenges can undermine or prevent the use of administrative data for evaluation purposes.

3. Third report to Congress

The purpose of this third report to Congress is twofold: (1) to provide an early description of the families being served by the RPG2 projects and the services they are receiving; and (2) to introduce the 2014 RPG3 projects. The main sources of data are:

(1) **Grantees' semiannual progress reports.** Federal discretionary grantees are required to report semiannually on their spending and progress during the term of their grants. Their reports provide information on grantees' planned interventions, target populations and eligibility criteria, expected program outcomes, and changes or planned adaptations of their projects. The reports also describe leadership engagement, successes and challenges, and any changes in partnership members. Reports submitted in October 2014 and April 2015, covering activities during the previous six months of the grant period, provided data for this report.

(2) **Enrollment and services data (RPG2 only).** To facilitate the cross-site implementation study, grantees provide data on enrollment of and services provided to RPG cases. Data include demographic information on case members, dates of entry into and exit from the RPG program and each EBP, and information on each service delivery contact for a subset of EBPs implemented by grantees.[8] This report describes RPG cases and participants using data collected between February 2014 and April 2015.

(3) **Outcome data (RPG2 only).** To measure participant outcomes, grantees use self-administered instruments collected from RPG adults. These standardized instruments collect information on child well-being, adult and family functioning, and adult substance use. Grantees also obtain administrative data on a common set of child welfare and substance use disorder treatment elements. This report describes the characteristics measured at baseline, or program entry, for participants enrolled as of March 31, 2015. Later reports will analyze follow-up data to examine outcomes.

The report thus focuses on activities from April 2014 through March 2015. This period is referred to as the *reporting period* or *year three* throughout this report. The RPG projects are referred to as *grantees* or *partnerships*.

This is the first report to Congress for the RPG2 grantees that includes findings from the analysis of enrollment and services data and outcome data. We use these data to describe the participants in RPG2. Describing the characteristics of these participants at the time of their enrollment in RPG is the main focus of this report. Later reports will also describe participant outcomes and discuss the performance of RPG2 and RPG3 grantees and the program as a whole.

[8] As explained in Chapter III, these "focal" EBPs were selected for in-depth study based on criteria such as their importance to the field, their use in multiple RPG projects, and the degree to which they represent the variety of EBPs being supported by RPG.

This report is organized as follows:

- Chapter II reports on total enrollment to date across the RPG2 grantees. Then, using data provided by grantees after OMB granted clearance for data collection, it describes in more detail the cases and people enrolled from January 2014 through February 2015. Because RPG is intended to serve children in or at risk of out-of-home placement, and because children's safety and permanence are goals for the grant program, we discuss the prevalence of maltreatment and out-of-home placement for a selected child in each case during the year prior to their enrollment in RPG.
- RPG is also intended to protect and strengthen family functioning and child well-being. Chapters III and IV present measures related to both of these domains, respectively, at RPG enrollment prior to receiving RPG services, for adults and focal children. For selected adults who care for a focal child or receive RPG services, Chapter III also provides information on their receipt of publicly funded substance use disorder treatment during the year prior to enrollment in RPG, and on self-reports of substance use (using a clinically validated assessment instrument) prior to enrollment.
- To address child, adult, and family needs, grantees enrolled RPG case members into specific EBPs. Chapter V describes what types of EBPs were being offered and the number of cases enrolled.
- Chapter VI introduces the 2014 (RPG3) cohort of grantees. It details their plans for program services and their local evaluations.
- Chapter VII sets out the next steps and priorities for RPG2 and RPG3 projects and the cross-site evaluation. We describe the number of RPG2 cases enrolled into EBPs and review how grantees will collect follow-up data on participant outcomes. Chapter VII details surveys of front-line staff who work directly with RPG participants and of partners that will be analyzed next for the cross-site evaluation, and site visits planned for the coming year to collect additional data on implementation. The chapter also covers the planned content of, and schedule for, remaining reports to Congress.

II. RPG CASES, CHILDREN, AND ADULTS AT ENROLLMENT

Through RPG, Congress aimed to improve the well-being, permanency, and safety of children who were in, or at risk of, out-of-home placement as a result of a parent or caregiver's substance use disorder. Grantees operationalized this target group in different ways in their projects.

- Some grantees served families in which children had already been removed from their homes or were at imminent risk of removal, as identified by the local child welfare agency.
- One grantee served children removed from their home who were living in an alternative foster care system.
- Several grantees used RPG funds to work with women with diagnosed substance use disorders who were in treatment.
- Some received referrals from an adult criminal drug court or a family drug court—thus focusing on families that were already court involved for substance use, possession, or other criminal activities related to drugs.
- Other grantees sought to enroll families in which removal or even substantiated maltreatment of a child had not yet occurred, or in which adult substance use disorder had not been definitively diagnosed, but in situations that placed them at high risk for these outcomes.

Grantees also planned to serve children of different ages—some wanted to work with children aged 0-5, while others planned to serve children up to age 18 or above. Thus the circumstances of children and adults varied when they entered RPG.

This chapter describes RPG enrollees. First we report on total enrollment from the beginning of RPG2 (Section A). Next we define an "RPG case" and describe the composition of cases (Section B). Section C provides information on the demographics of RPG cases, with detailed descriptions of adults and children. For selected "focal" children, it then estimates the number who experienced maltreatment (Section C), then the number who were removed from their home (Section D), during the year prior to enrollment in RPG.[9]

A. RPG enrollment

Grantees and their partnerships were at different stages when the RPG2 grants began in October 2012. Ten had initially received grants during the first round of RPG funding in 2007 and were continuing their existing partnerships and projects or updating them (Table 1.1). The remaining seven grantees were receiving RPG grants for the first time. Grantees progressed toward beginning enrollment at different rates, with seven partnerships beginning enrollment in the first six months of the grant. By September 2013, the end of the first full year of the grants, 15 of the 17 grantees had begun enrollment. They had enrolled a total of 1,673 people; 65 percent of them

[9] "Focal child" refers to the child in each case on whom detailed data were collected for the cross-site evaluation, as described in Section C.1.

children (Table II.1). By April 2015, all grantees had begun enrollment and 5,157 had enrolled, 59 percent of whom were children.

Table II.1. Cumulative enrollment in RPG, by grantee

Grantee and state	Reported in October 2013		Reported in April 2015	
	Total enrolled	Percentage of total enrollment who are children	Total enrolled	Percentage of total enrollment who are children
Center Point, California	33	45	170	54
Georgia State University Research Foundation	4	75	58	5
Judicial Branch, State of Iowa	61	54	146	62
Northwest Iowa Mental Health Center/Seasons Center[a]	206	100	36	53
Children's Research Triangle, Illinois	132	85	244	82
Kentucky Department for Community Based Services	29	55	131	37
Commonwealth of Massachusetts	72	65	316	62
Families and Children Together, Maine	180	63	541	55
Alternative Opportunities, Missouri	169	68	670	67
The Center for Children and Families, Montana	28	61	120	65
State of Nevada Division of Child and Family Services	48	35	124	35
Summit County Children Services, Ohio	123	59	593	53
Oklahoma Department of Mental Health and Substance Abuse Services[b]	0	n.a.	158	48
Health Federation of Philadelphia[b]	0	n.a.	44	50
Helen Ross McNabb Center, Tennessee	502	67	1,130	63
Tennessee Department of Mental Health and Substance Abuse Services	65	58	368	52
Rockingham Memorial Hospital, Virginia	227	39	308	60
Total	**1,879**	**65**	**5,157**	**59**

Source: October 2013 and April 2015 RPG semiannual progress reports filed by grantees.

[a]Although families participate in treatment with their children, Seasons Center's focus is primarily on the outcomes and well-being of the child. Therefore, they initially counted all program enrollment on the basis of the number of children enrolled in their services. In 2015 they reported total enrollment in the RPG cross-site evaluation rather than cumulative enrollment from commencement of RPG services.

[b]These grantees began enrollment by May 2014.

n.a. = not applicable

To learn more about people served by RPG, HHS collects detailed data through the cross-site evaluation. HHS received clearance for data collection under the Paperwork Reduction Act of 1995 on March 18, 2014 (0970-0444; expires March 31, 2017), and began collecting cross-site evaluation and performance data at that time. Grantees began submitting data on people they had enrolled after January 1, 2014. Data were of two types: (1) enrollment and services

information, and (2) baseline and follow-up outcome data. Between January 2014 and February 2015, the grantees enrolled 625 RPG cases, consisting of 859 adults and 1,080 children, and provided data on them. These data are used in this report.

B. RPG cases

RPG projects do not always serve "families" in the traditional sense of the word (persons of common ancestry, or a basic social unit consisting of parents and their children), or "households" (related or unrelated persons living together in the same dwelling). Instead, depending on their program designs and target populations, grantees serve members of the family, household, or other individuals (who may be biologically related or not) that enroll together into their projects. An RPG "case" therefore consists of the group of individuals that present themselves to enroll in an RPG program (Strong et al., 2014).

Because RPG addresses needs of children at risk due to potential or actual substance use disorder by an adult close to them, by definition each RPG case includes at least two members: one adult and one child.[10] Nearly half (46 percent) of cases enrolled during the reporting period included only these two members (Table II.2). Among the remaining cases, most included three or four people (22 percent had three, 17 percent had four). There is no limit on the number that can be included in a case; the largest case enrolled included nine members (three adults and six children).

Forty-three percent of cases had more than 1 child enrolled, and 31 percent had more than 1 adult. The most children in a single case was seven; the most adults was four. The variation in case size reflected in part the differing objectives and services of the grantees' RPG projects. Some grantees provided individual therapies designed for a parent, child, or parent-child dyad, while other grantees offered group-based services intended to serve the whole family unit.

In 94 percent of cases with only 2 members, the people enrolled were a biological parent (usually a mother) and her child. In the remaining six percent of two-person cases, the adults were typically the child's adoptive or step-parents, grandparents, aunts, or uncles. Cases with more than one adult typically included both biological parents of the child (or children) in the case (59 percent of these cases). Ninety-nine percent of cases with two or more adults included at least one biological parent. Of the 271 cases with more than 1 child, 97 percent were composed of biologically related siblings.

[10] Some cases included foster parents, because some children served by RPG were in foster care. In such cases, the foster parents were part of the case only because of their relationship with one or more children in the case, not because they had, or were suspected of having, a substance use disorder. In one percent of cases, a foster parent was the only adult in the case because one grantee worked with children in an alternative foster care system but did not provide services to their families of origin.

Table II.2. Case size

Case composition	Number or percentage
Number of cases	**625**
Number of members per case	
Percentage of cases with two members	46
Percentage of cases with three members	22
Percentage of cases with four members	17
Percentage of cases with more than four members	15
Total number of children in RPG cases	1,080
Mean number of children per case	1.7
Percentage of cases with more than one child	43

Source: RPG Enrollment and Service Log data.

C. Demographics

We begin by describing the demographics of RPG children (Section C.1) and their biological parents who were also part of their RPG cases (Section C.2.). Data show that the adults and children who were enrolled in RPG cases at this stage of the grant program were predominantly White, non-Hispanic, and English-speaking. This reflected several factors. First, the racial and ethnic composition of the current RPG sample was heavily influenced by a small group of grantees. All 3 of these grantees were operating in congressional districts in which more than 90 percent of the population were non-Hispanic, and between 89 percent and 95 percent were identified as "White only" (U.S. Census Bureau, American Community Survey, 2014). These 3 grantees together made up 46 percent of the RPG cases enrolled during the period covered by this report. More than 85 percent of the focal children served by each of these grantees were identified as White only, and at least 95 percent were non-Hispanic. Additional grantees were providing services in geographic areas with similar demographics. Comparatively, the 6 grantees with 65 percent or fewer focal children identified as White made up only 20 percent of the total sample for this analysis. Four of these six identified more than half their focal children as non-White. If enrollment at these more diverse sites grows relative to the more homogeneous sites over time, the composition of the RPG caseload will change.

1. Children

In total there were 1,080 children in the 625 cases enrolled in RPG between January 1, 2014, and February 28, 2015. Seventy-six percent of children were eight or younger. All were enrolled to receive RPG services, but grantees submitted additional data to the cross-site evaluation on one "focal child" in each case. This enabled HHS to obtain detailed information on maltreatment, out-of-home placements, and child well-being in each RPG case without placing excessive burdens on grantees or families to provide baseline and outcome data on all children they

enrolled. The relationships between case members were also defined in terms of each person's relationship to the focal child. Because of the importance of this child in the cross-site evaluation, we describe the demographics for focal and other children in RPG cases separately.

Selecting a focal child. If more than one child was enrolled in an RPG case, grantees had to select one as the focal child, on whom more detailed data would be collected. Before beginning data collection, each grantee established a systematic rule by which to select the focal child across all cases enrolled. Because RPG projects offered different services and served different populations, each grantee was in the best position to define which child within a case would be of greatest interest to the cross-site evaluation. Therefore, each grantee defined its own rule. The most common rule, employed by about a third of grantees, defined the focal child as the youngest child in the case. Other grantees chose rules based on the specific target population for their programs. For example, one grantee whose intervention was designed for children around age 4 to 5 defined the focal child as the child closest to age 4; if two children were equally close to age 4, the grantee selected the older of the two.

On average, the focal children in RPG cases were five years old. Furthermore, more than half (59 percent) were under 5, including 26 percent who were younger than 1 year (Table II.3). In a small number of cases (four percent), the mother was pregnant when the case enrolled, and the unborn child was designated as the focal child for the case. The rules grantees established to select the focal child influenced the age distribution. While several grantees selected the youngest child in the case as the focal child, two others established a rule that the focal child be five or younger. Only two grantees made the focal child the oldest child in the case. Therefore non-focal children in RPG cases were six years old, on average—a year older than that of focal children.

Seventy-seven percent of focal children were identified as White only, and 12 percent were Black only; 8 percent were identified as being multiracial. Twelve percent were identified as Hispanic. Most focal children (95 percent) spoke English as their primary language at home, with Spanish the second-most-common language, at 4 percent. The most prevalent race, ethnicity, and language categories overlapped: 70 percent of focal children were identified as White, non-Hispanic, and English-speaking.[11]

Some children were in foster care at the time of enrollment into RPG, according to data provided by the case members at enrollment. More than one quarter (28 percent) of focal children lived in a foster parent's home or group home at enrollment. This figure may undercount the number who were in foster care, because some children who were in informal, voluntary, or formal foster kinship care were not described as living in a foster parent's home.[12]

However, nearly half (47 percent) of focal children lived in the primary residence of an adult in the case. Another 8 percent of focal children lived in a treatment facility, shelter, or correctional

[11] This includes 533 focal children on whom race, ethnicity, and primary language data were available.

[12] *Informal kinship care* refers to arrangements made by the parents and other family members without any involvement from either the child welfare system or the juvenile court system. *Voluntary kinship care* refers to situations in which the children live with relatives and the child welfare system is involved, but the State does not take legal custody. *Formal kinship care* refers to cases in which the children are placed in the legal custody of the State by a judge, and the child welfare system then places the children with grandparents or other kin (HHS, 2010).

facility—almost always with a parent—and the remaining 17 percent lived in another location (most often with a relative or family friend).

Table II.3. Demographics of focal and other children in RPG cases

Characteristic	Percentage unless otherwise noted	
	Focal child	Other children
Total number of children	**625**	**455**
Average age	5 years	6 years
Age by category		
Younger than 1[a]	26	12
1 to 4	33	38
5 to 8	22	25
9 or older	19	25
Gender		
Female	50	53
Male	50	48
Race (n=595; 431)[b]		
White only	77	83
Black or African American only	12	7
American Indian or Alaska Native, Asian, or Native Hawaiian or Pacific Islander only	3	10
More than one race	8	0
Ethnicity (n=547; 403)[c]		
Hispanic	12	16
Non-Hispanic	88	84
Primary language spoken at home (n=614; 436)		
English	95	91
Spanish	4	9
Other	1	0
Residence (n=617; 435)		
Primary residence of adult case member[d]	47	47
Foster parent's residence or group home	28	29
Treatment facility, shelter, or correctional facility	8	4
Other residence	17	20

Source: RPG Enrollment and Service Log data.

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

[a] Includes 23 focal children who were unborn at the time the mother enrolled in RPG.

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

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

[d] In 5 percent of cases, the child's residence was reported as the primary residence of the case members, but the child was not living with the adult in the case. At enrollment, the adult's residence (if known) was either another residence, or a treatment facility, shelter, or correctional facility.

Although many cases have only one child (who is then by default the focal child), other children in RPG cases look similar to focal children. Forty-three percent of cases include at least one child in addition to the focal child—usually a biological sibling. Fewer of the non-focal children were younger than one, and as a result, their average age was six. This difference in age may be

due to the fact that grantees were more likely to define the focal child as the youngest, not the oldest, child in a case. In addition, fewer of these other children lived in treatment facilities, shelters, or correctional facilities. This could be because some RPG projects serve parents who are undergoing inpatient substance use disorder treatment in facilities where their children may stay with them; these facilities may not be able to accommodate multi-child families.

2. Biological parents

Most cases included at least one of the focal child's biological parents. Information about the circumstances and characteristics of these parents sheds light on the situations of the focal children. Since family preservation or reunification is, by law, an important goal of the child welfare system, these circumstances may have implications for how grantees approached working with each case. For example, among cases that included a biological parent, 45 percent of parents were caring for the focal child at enrollment, while 40 percent were known not to have care of the child (Table II.4). In cases with two biological parents, we examined the parent who was defined as the caregiver of the focal child for purposes of data collection.

Parents on average were 30 years old at the time of RPG enrollment, and 87 percent were the child's mother. On race, ethnicity, and primary language spoken at home, biological parents were similar to their children: mostly (83 percent), non-Hispanic (90 percent), and English-speaking (96 percent). In addition, 19 percent of parents lived in an institutional setting at the time of enrollment. Institutional settings included treatment facilities—the most common type—as well as shelters and correctional facilities.

Table II.4. Demographics of biological parents in RPG cases

Characteristic	Average (percentage unless otherwise noted)
Number of biological parents	**604**
Average age in years	30 years
Gender	
Female	87
Male	13
Race (n=588)[a]	
White only	83
Black only	11
American Indian or Alaskan Native, Asian, or Native Hawaiian or Other Pacific Islander only	3
More than one race	3
Ethnicity (n=488)[b]	
Hispanic	10
Non-Hispanic	90
Primary language (n=600)	
English	96
Spanish	4
Other	0
Lived in institutional setting at enrollment (n=594)	19

Characteristic	Average (percentage unless otherwise noted)
Highest level of education (n=515)	
Some high school	30
High school diploma/GED	39
Some postsecondary education[c]	29
Bachelor's degree or higher	3
Income in past 12 months (n=568)	
$0-$9,999	73
$10,000-$19,000	17
$19,001-$24,999	6
$25,000 or higher	5
Income source[d] (n=567)	
Wage or salary	37
Public assistance	39
Retirement or pension	0
Disability	8
Other	14
None	19
Employment status (n=579)	
Full-time employment	13
Part-time employment	16
Self-employed	1
Unemployed	50
Not in the labor force	20
Relationship status (n=581)	
Single, divorced, separated, or widowed	59
Married to or cohabiting with focal child's biological parent	28
Married to or cohabiting with other individual	13
Focal child in parent's care at enrollment	
Yes	45
No[e]	39
Unknown[f]	16

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

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

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

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

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

[f] Includes adults who were the primary caregiver from the family of origin for whom the grantee did not know whether the focal child was in their care at enrollment as well as adults for whom the data were missing.

Information on biological parents' income and employment show that many parents in RPG cases faced financial hardship. Seventy-three percent reported earning an income less than $10,000 in the 12 months prior to enrollment, and 19 percent of parents reported no income from any source. Public assistance was the most common income source parents reported (39 percent), and wage or salary income was the second-most-common source (37 percent). At enrollment, 50 percent of parents reported being unemployed, and 20 percent reported that they

were not in the labor force (that is, not employed and not actively seeking employment). Others were employed full time (13 percent) or part time (16 percent). While 30 percent did not have a high school diploma or equivalent, 39 percent did, and 32 percent of the biological parents we examined had at least some postsecondary education, including 3 percent who had attained a degree.

Most parents described themselves as neither married nor cohabiting at the time of enrollment: 59 percent reported being single, divorced, separated, or widowed. The rest said they were married to or cohabiting with the focal child's other biological parent (28 percent) or another person (13 percent). Information about parents' relationship status, however, suggests that not everyone in the focal child's life is enrolled into the RPG case. For example, 10 percent of cases include only 1 adult case member—almost always a biological parent—but that adult's relationship status is listed as married to or living with the focal child's (other) biological parent.

D. Maltreatment of focal children prior to RPG enrollment

In authorizing RPG, Congress intended to help ensure the safety of children who experienced, or were at risk of experiencing, maltreatment due to a parent or caretaker's substance use disorder. Thus, grantees planned to target their services to groups involved in the child welfare system, or at risk of such involvement. Data obtained by grantees from their state or county child welfare agencies show that RPG projects enrolled some children with documented maltreatment or other previous experience with the child welfare system.

Of the 567 focal children in the sample for whom we received records, 31 percent (176 children) had 1 or more substantiated episodes of maltreatment in the year prior to enrollment in RPG (Table II.5).[13] A report of maltreatment is substantiated when an investigation by child protective services concludes that the report was supported or founded as defined by state law or policy (HHS, 2015).

Maltreatment includes two primary categories: *abuse* and *neglect.*[14] *Abuse* is defined as any recent act that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or that presents an imminent risk of serious harm (HHS, 2015). Among focal children in the study, five percent were subjects of one or more instances of substantiated abuse. Physical abuse, or emotional or psychological abuse, were more common than sexual abuse. *Neglect* is defined as any recent failure to act on the part of a parent or caretaker that may result in any of the same types of harm or presents an imminent risk of serious harm to the child. Twenty-four percent of focal children were subjects of one or more instances of substantiated neglect, including one percent who were subject to medical neglect. Twenty-two children (four percent) had more than one substantiated episode of maltreatment including either abuse or neglect.

[13] Two grantees were unable to provide administrative records from their state or county child welfare agency in time for inclusion in this report; hence, we lacked such records for 58 of the focal children in our overall sample.

[14] Children may also be subject to maltreatment and reported as "other" if it does not fit within abuse or neglect categories, or is unknown. We report the percentage of children experiencing any maltreatment in Table II.5, including abuse, neglect, and "other."

Table II.5. Percentage and number of focal children with substantiated and unsubstantiated reports of maltreatment in the year prior to entering RPG

	Percentage of focal children who were the subject of at least one report		Number of focal children who were the subject of at least one report	
Type of maltreatment	Substantiated	Unsubstantiated	Substantiated	Unsubstantiated
Maltreatment: abuse, neglect, and other types	31	24	176	137
Abuse: any type	5	10	30	57
Abuse: physical	3	5	17	31
Abuse: sexual	1	2	3	11
Abuse: emotional or psychological	2	4	14	21
Neglect: any type	24	13	136	74
Neglect: medical	1	1	5	6
Neglect: other types	24	13	134	72

Note: Records for 567 focal children were examined to obtain these statistics.

While some grantees serve children once they have a substantiated maltreatment report, others target children who may be at risk of maltreatment. Administrative data records indicate that possible maltreatment was reported for one-fourth of focal children—that is, 137 children (24 percent) were the subject of maltreatment reports that were not substantiated, at least as of the date of their enrollment in RPG. Although this is not a direct measure of their risk of future maltreatment, we report unsubstantiated maltreatment because children with both unsubstantiated and substantiated child maltreatment are at similar risk for poor child well-being outcomes (Casanueva et al., 2012).

As might be expected given grantees' different targeting strategies and referral sources, rates of maltreatment varied widely across grantees. One RPG grantee served a population where nearly all (95 percent) focal children were subjects of one or more instances of substantiated maltreatment in the prior year; while a different grantee served a population where none of the focal children had any record of substantiated maltreatment.[15] This wide variation across grantees is not surprising, because grantees used different enrollment criteria to target different populations. Future reports will describe reported and substantiated maltreatment before, during, and up to one year after RPG participation.

E. Out-of-home placements for focal children

Many children who are referred to the child welfare system are not removed from their homes. Instead, the family receives support and services intended to improve family functioning. However, if the risk to a child is considered too high for him or her to remain in the home, then the child may be removed from the home and given an out-of-home placement.

[15] We have highlighted results only for single grantees as extremes in this chapter provided that there were at least five individuals contributing to the grantee prevalence rate.

Twenty-six percent of the 567 RPG focal children for whom we received administrative records were removed from their homes at some point during the year prior to RPG enrollment (Table II.6). This number does not include children who were already living outside the home at the beginning of the one-year period prior to enrollment.[16] Similar to the variability across grantees in the rates of maltreatment, there was variability in the prevalence of removal. The highest rate was experienced by 1 grantee where over 71 percent of focal children had been removed from their homes during the year prior to enrollment; in contrast, none of the focal children served by another grantee had been removed from the home.

Table II.6. Percentage of focal children in out-of-home placements in the year prior to entering RPG

Removal or placement	Percentage of focal children experiencing event	Number of focal children experiencing event
Removed from home (n = 567)	26	148
Reunified with family (n = 148)[a]	15	22
Placed in permanent setting (n = 148)	16	23

[a] Percentage of focal children removed during the time period of interest who were reunified at least once during the period.

Foster care is not intended to be a permanent solution for a child; the goal is always to find a permanent, stable, and safe home, such as by reunifying the family or through adoption of the child (Center for Advanced Study of Child Welfare, n.d.). We followed the 148 children who were removed from their homes during the year prior to RPG enrollment to determine their subsequent placements from the time of their removal through the end of the administrative data collection in October 2014. Fifteen percent of those removed (22 children) were reunited with their families during the period, and one other child was also placed in a permanent setting. Eighteen of these placements occurred after their enrollment in RPG.

The Adoption and Safe Families Act requires, and agencies strive for, quick reunification as long as the child will be safe. Out-of-home placement may be short-term (as short as a few hours) or longer. The average length of time between removal from the home and reunification in the family of origin for the children in our sample was 280 days. There were 84 children who experienced multiple rounds of removals and placements prior to RPG enrollment during the period covered by our data. Future reports will describe removals and placements that happen before, during, and after focal children enroll in RPG.

[16] We know that some children were already living outside the home before the year prior to RPG enrollment, but we cannot count the total number. This is because our data are in the form of removal dates and placement dates starting in the year prior to RPG enrollment. Some children have placement dates but no removal date, which indicates that they were removed prior to the start of the data collection period. In addition, there are probably more children who were removed prior to the data collection period but were not subsequently placed, so we have no way of identifying them as living outside the home.

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III. ADULTS IN RPG AT PROGRAM ENTRY

Families are diverse, and the context in which children are raised can take many forms. The traditional definition of a family focuses on biological relationships; however, children grow up with many kinds of caregivers, including kin, such as grandparents, or foster or adoptive parents. Thus, the definition of family extends well beyond biological ties. Regardless of biology, families operate as systems that are interconnected and highly dependent, where members of the familial system exert reciprocal influence on one another (Bronfenbrenner, 1986; Belsky, 1980; Sameroff & Fiese, 2000). Consequently, services, programs, and policies aimed at vulnerable adults and children cannot aim to address the needs of one member of a family system without acknowledging the "ripple" effect they have on the other members of the group.

HHS funded various RPG projects that aim to address the needs of children and families affected by substance use disorders who are involved or at risk of becoming involved with child welfare. There are varied needs among these RPG families. For example, caregiver substance use disorder is a known risk factor for child maltreatment and involvement in the child welfare system (HHS, 2014). Substance use disorder is linked to adult stress, mental health issues, and trauma, such as post-traumatic stress disorder (PTSD; Najavits et al., 1997; Substance Abuse and Mental Health Administration, 2013). In turn, caregiver stress or mental health challenges can hinder appropriate or effective parenting, placing children at risk of maltreatment or leading to adverse effects on children's physical, mental, and emotional well-being (Staton-Tindall et al., 2013).

To take account of the complexity in the family contexts for children, for the cross-site evaluation HHS selected measures to paint a broad portrait of adult substance use disorder and treatment, caregiver and adult functioning (referred to as "family functioning" in the cross-site evaluation), and child well-being in RPG cases. Using this wide range of measures, HHS will examine adults and children in RPG cases at program entry (baseline) and program exit, for each of the varied service models delivered by grantees. This chapter describes adults at baseline. It first describes the measures used to assess adults (Section A). It then describes the samples of adults in RPG cases from whom data on the measures were collected, in Section B. Section C describes adult substance use disorder and prior participation in substance use disorder treatment; Section D discusses family functioning at baseline.. The next chapter will discuss baseline child well-being. Future reports will compare baseline measures to those at program exit, once more cases have exited their RPG programs.

A. Measures

Because adult substance use disorder is a risk factor for child maltreatment and child welfare involvement, RPG projects aim to address this risk factor. Adults with substance use disorders who are co-involved with child welfare typically have poorer outcomes compared to those who do not report a substance use issue, such as prolonged time to reunification (Barth, 2009). However, the means through which substance use disorder is linked to risk of maltreatment is not well understood, because substance use disorders occur in conjunction with a complex set of individual and familial characteristics, such as severe depression or social isolation (Brook et al., 2012; Kessler et al., 2003; Testa & Smith, 2009). Thus, HHS selected measures that reflect

associated issues that tend to co-occur with substance use disorder, such as mental health problems, parenting stress, and parenting attitudes.

Substance use. For example, HHS selected the Addiction Severity Index, Self-Report Form (ASI-SR) to examine the extent and severity of substance use by adults in RPG cases. The ASI-SR measures not only substance use, but other factors that substance use affects, such as health, employment, family relationships, and involvement with the criminal justice system. Documented consequences of substance use disorders include adverse health outcomes, loss of employment, and legal issues associated with illicit drug sales or use (McGinnis et al., 1999; Wu et al., 2000). Data from the ASI-SR provide information on a few of these characteristics associated with substance use disorder.

Mental health. Substance use disorder in adulthood is often connected with mental health issues, particularly depression and post-traumatic stress disorder (PTSD) (Kessler et al., 2003; Swendensen et al., 2000). Major depression can impair a person's ability to have healthy social and family relationships, prevent them from working, or have other devastating effects (Kessler et al., 2003). In particular, research has found that children are at a higher risk of maltreatment as a result of parental or caregiver depression (Chaffin et al., 1996; Shay & Knutson, 2008). The Center for Epidemiologic Studies Depression Scale (CES-D), which screens for depressive symptoms, and the Trauma Symptoms Checklist-40 (TSC-40), a measure of adult traumatic distress, provide baseline characteristics on these factors for adults in RPG cases.

Parent well-being. Adult substance use can reduce a caregiver's ability to control stress and anger related to child-rearing, preventing them from providing adequate supervision for children and heightening the possibility of child neglect or abuse (Testa & Smith, 2009). Parenting stress has repeatedly been shown to relate to parenting behavior and contributes to dysfunctional parenting (Belsky, 1984). More recent evidence suggests that parenting stress is also associated with increased likelihood of child maltreatment (Berger, 2004). The Parenting Stress Index-Short Form (PSI-SF) was chosen to assess levels of parenting stress among RPG adults.

Parenting attitudes. HHS chose the Adult-Adolescent Parenting Inventory-2 (AAPI-2) to measure aspects of parenting attitudes and knowledge and highlight well-known parenting risk factors associated with poor child outcomes. The AAPI-2 captures reports of caregiver behaviors that are known to be associated with child maltreatment

Future reports will compare baseline and follow-up data for RPG participants to examine program outcomes. Because of the early stage of data collection, only baseline data were available for the vast majority of participants during the period covered by this report. To provide context for understanding baseline status, we therefore compared most measures to those for nationally representative samples. Where possible, we suggest cutoff points that indicate elevated levels of risk on key measures, and we report the proportion of the RPG sample falling at or above the cutoff. When nationally representative samples were not available or relevant, we sought other data sources to identify similar cutoff scores or levels, applied these scores to our sample, and report the proportion of the RPG sample falling at or above the cutoff. Next, we describe the sample of parents for whom we have data on these measures.

B. Adults providing data

RPG cases are sometimes complex. They may include only a subset of the adults and children who make up the focal child's family or household. Sometimes they include adults not part of either, such as a foster parent. So all grantees could provide uniform data HHS could use to assess grantee performance and program outcomes, HHS asked grantees to obtain data on case members according to rules established for the cross-site evaluation.

- Data on family functioning was requested from the person who was the focal child's primary caregiver from the child's family of origin—defined as the family in which the focal child grew up or usually resided. This person was nearly always a biological parent, but six percent of these adults were not (Table III.1). Some, for example, were the focal child's grandmother or aunt.
- In 18 percent of cases, data on substance use and substance use disorder treatment were collected for a different adult from the one who supplied data on family functioning (Table III.1). This was because in a subset of cases, the primary caregiver from the family of origin was not intended to receive RPG services. For example, if the primary caregiver of the child was his or her mother, but the father was the one receiving services (because he was the one with the potential or diagnosed substance use disorder) then data on substance use was collected from the adult in the case who was going to receive RPG services (the father in the example above).

Due to these rules for data collection, the samples of adults in this chapter differ slightly from the biological parents described in Chapter II. In practical terms, these three groups are very similar on most demographic characteristics (Table III.1). A higher percentage of adults reporting on substance use were male (16 percent), and a higher percentage of adults reporting on family function were caring for the focal child at the time of enrollment in RPG.

Table III.1. Differences between biological parents and adults from whom data on family functioning or substance use were collected

Characteristics	Percentage		
	Biological parents	Adults reporting on family functioning	Adults reporting on substance use
Number in sample	**604**	**583**	**617**
Relationship to focal child			
Biological parent	100	94	97
Adoptive parent, step-parent by marriage or parent's partner	0	2	2
Grandparent, aunt/uncle, or other[a]	0	5	1
Gender			
Female	87	86	84
Male	13	14	16
Lived in a treatment facility, correctional facility, or shelter at enrollment	19	18	20

Characteristics	Percentage		
	Biological parents	Adults reporting on family functioning	Adults reporting on substance use
Focal child in adult's care at enrollment			
Yes	45	52	40
No	39	31	46
Unknown[b]	16	17	14

Source: RPG Enrollment and Service Log data.

Note: Excludes data for 42 cases from which data on family functioning were not collected. Because of rounding, category percentages may add to slightly more or less than 100 percent. The sample size for each statistic was the number of adults with a nonmissing response to the question.

[a] Most adults reporting on family functioning included in this category are grandparents (20 of 28). Six were the focal child's aunt or uncle. Two have another relationship to the focal child: one is a kinship care provider to the focal child's sister and the other is the paternal grandmother of the focal child's sibling. Among adults reporting on substance use, six fall into this category: four are grandparents, and two are aunts or uncles.

[b] Includes 71 cases (across all columns) in which the variable indicating whether or not the child is in the adult's care is missing because the variable was added to the data collection system after collection began. In 31 cases across all columns, the grantee responded "Don't know" to the question.

C. Adult substance use

In this section, we describe four characteristics of RPG adults that are potential risk factors for child maltreatment and child welfare involvement. We present findings on (1) substance use severity for RPG adults, (2) contextual/life factors affected by substance use, (3) participation in substance use disorder treatment, and (4) trauma exposure.

To describe these areas, we highlight information collected at baseline about the study sample prior to entry into the RPG program. In the tables in this section used to describe the findings, we show the general topic areas, or constructs being assessed, the measure used (also referred to as standardized instruments), and the sample size contributing to the analysis (which varies by measure as a result of instrument nonresponse).

Note about baseline measures of substance use severity and substance use treatment prior to RPG: Data on substance use, trauma, and substance use treatment prior to RPG were requested for a single adult in each RPG case. However, the adult in our sample might not be the adult in the focal child's family with the potential or diagnosed substance use problem, or the one who was enrolled in substance use treatment prior to RPG. In addition, we use self-reports to diagnose substance use severity—but underreporting of drug and alcohol use is common, due perhaps to lack of recall, or to social desirability bias (Del Boca & Darkes, 2003; Chermack et al., 2000; Dawson, 1998). As a result, data in this report might understate the prevalence of substance use severity in RPG cases. In addition, state substance abuse agencies do not collect data on treatment funded by private insurance, so only a subset of the 16 grantees in our sample were able to obtain such data for the study. Therefore, the number of RPG adults who received and completed treatment prior to RPG may also be understated.

1. Substance use

A total of 37 percent of RPG adults who reported fully on the ASI-SR substance use measures exhibited high severity of either drug or alcohol use or of both in the past 30 days as measured

by the ASI-SR and defined for this report (Table III.2). Drug use was much more prevalent than alcohol use among adults providing substance use severity data. On a scale from zero to one, with zero representing the lowest severity rating and one the highest, the mean composite score for drug use for RPG adults was 0.13.[17] This is slightly higher than the mean score for people in substance use disorder treatment settings (0.10) described in McClellan et al. (2006), which reported on a nationally representative sample of such people. We used the nationally representative mean as a cutoff score to indicate a high level of severity of drug use, since it was above-average use among participants already in treatment. That is, any person with an ASI-SR score of 0.10 or higher was included in the high severity category.

Table III.2. Substance use among adults prior to RPG enrollment

Baseline scale	Instrument	Sample size[a]	Sample mean score (SD)	National mean score (SD)	Percentage of adults in high severity category
Drug use	ASI-SR	349	0.13 (0.16)	0.10 (0.13)	36[b]
Alcohol use	ASI-SR	329	0.05 (.14)	0.22 (0.25)	7[b]
Use of drugs or alcohol or both[b]	ASI-SR	380	NR	NR	37

Source: RPG baseline administration of ASI-SR instrument.

[a] Sample sizes vary by measure due to instrument or item nonresponse.

[b] A total of 380 adults completed the alcohol use scale, the drug use scale, or both. The percentage of adults in the high severity category is calculated relative to the number with complete data for a given type of substance use.

NR = not reported; SD = standard deviation.

Based on this measure, of the adults reporting on drug use, 36 percent were categorized as having a high level of severity for drug use (that is, higher than the national mean among people in a treatment setting). The proportion of participants in this category ranged from as low as 12 percent to as high as 55 percent across RPG projects. These differences may reflect different drug use patterns by geographic area, but also (and perhaps more important) differences in target populations and core services provided. For example, some RPG grantees were substance use disorder treatment providers or provided services within treatment programs

Means and standard deviations (SD). In reporting information about the scores on each instrument, we present the means estimated for the RPG sample, and a mean obtained from a national population. We also present the SD for both the sample and national means. The mean is an indicator of central tendency that is represented by a single number; it describes the average value of an entire set of values. The SD represents how varied or dispersed the values in the data are around the mean. If everyone in the study had a score very close to the mean, then the SD would be small. If instead the scores ranged from very low to very high (that is, were not closely dispersed around the mean), then the SD would be large. The sample mean and SD are calculated based on the observations in the data. The national means and SD are based on a nationally representative sample for most measures or another sample with similarities to those served in RPG. They provide an anchor point from which to compare the mean scores and variability among samples of RPG case members.

[17] These ratings are based on answers to several questions within each problem area addressed by the ASI-SR.

and thus served a larger proportion of participants who reported high substance use in the month leading up to enrollment in RPG.

The ASI-SR also asks respondents to indicate which of several types of drugs they used in the past 30 days. We report these results for the subset of RPG adults in our sample in the high-severity category for either drug or alcohol use (37 percent; Table III.2). Among this group, the most common type of substances used were cannabis (46 percent), followed by amphetamines (45 percent), and alcohol (41 percent; Table III.3). Nine percent or less of these adults reported using methadone, heroin, cocaine, barbiturates, or hallucinogens.

In contrast to the high scores for drug use, the mean composite score for alcohol use among RPG participants was 0.05, well below the mean score for people in substance use disorder treatment settings described in the McClellan (2006) study (0.22). Thus, as a group, RPG adults had very low levels of severity for alcohol use, relative to the national sample. Of 380 adults in the sample, only 7 percent had a score for alcohol use severity at or above the national mean of 0.22. Several grantees had no adults in their samples with severe levels of alcohol use.

Table III.3. Substances used by adults in the high severity category

Type of substance	Percentage using substance
Cannabis (marijuana, hashish, pot)	46
Amphetamines (Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, methamphetamine, ice, crystal)	45
Alcohol	41
Other opiates/analgesics (morphine; Dilaudid (hydromorphone); Demerol (meperidine); Percocet (oxycodone + acetominophen); Darvon (propoxyphene); Talwin; codeine; Tylenol 2,3,4; syrups, Robitussin, Fentanyl)	40
Sedatives/hypnotics/tranquilizers (Valium, Xanax, Librium, Ativan, Serax, Quaaludes, Tranxene, Dalmane, Halcion, Miltown)	25
Methadone	9
Heroin	6
Cocaine (cocaine crystal, free-base cocaine, or “crack” or “rock”)	6
Barbiturates (Nembutal, Seconol, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol)	4
Hallucinogens (LSD [Acid], Mescaline, Mushrooms [Psilocybin], Peyote, Green, PCP [Phencyclidine], Angel Dust, Ecstasy)	4

Source: RPG baseline administration of ASI-SR instrument.

2. Problems related to substance use disorder

Substance use disorder can impair functioning in other important areas of life, such as career, legal status, physical health, mental health, and family and other relationships. For this reason, the ASI-SR also collects data on these contextual characteristics. We compared the adults classified in this report as high-severity substance users to all other adults in our sample among several other problem areas commonly affected by substance use disorder and measured by the ASI-SR (Table III.4).

Composite scores representing problems in these other aspects of life are also measured on a scale from zero to one, with zero representing no problems in the area and one very severe problems. For example, in the psychiatric status section, respondents estimate the number of days they experienced psychological or emotional problems, the extent to which they were bothered by their problems, how important it is that they receive treatment, and whether they have been prescribed any psychiatric medications.

Table III.4. Comparison of functioning in five key life areas between adults in high severity category and other adults in the sample

ASI-SR scale	Adults in high severity category		All other adults in the sample		National mean (SD)[a]
	Sample size for analysis	Mean (SD)	Sample size for analysis	Mean (SD)	
Employment	134	0.72 (0.24)	219	0.64 (0.28)	0.65 (0.32)
Legal	137	0.26 (0.34)	223	0.21 (0.32)	0.18 (0.21)
Medical	139	0.31 (0.35)	226	0.21 (0.31)	0.17 (0.30)
Psychiatric	110	0.42 (0.21)	126	0.29 (0.20)	0.19 (0.23)
Family/social	127	0.34 (0.22)	160	0.21 (0.21)	0.16 (0.21)

Source: RPG baseline administration of ASI-SR instrument.

[a] As reported in McClellan, 2006.

Note: The high severity category includes those identified in Table III.2 as having high severity drug use, high severity alcohol use, or both. See Appendix A for more details on the definitions of the risk indicators for high drug and alcohol use.

The sample sizes in this table vary across ASI-SR scales because of survey or item nonresponse.

SD = standard deviation.

As might be expected, the results show that on average, adults in the high severity category exhibited higher levels of problems related to their employment; their legal status; their medical and psychiatric well-being; and their family and social lives compared to all other adults. In addition, this group had higher mean problem scores on these lifestyle areas than the mean score of the nationally representative sample of people in treatment programs (McClellan, 2006). This confirms that substance use in this sample is associated with impairments in other aspects of adult life, which RPG programs may need to address, often within substance use disorder treatment.

3. Substance use disorder treatment

In addition to administering the ASI-SR to assess substance use prior to RPG enrollment, grantees obtained administrative records from state substance use services agencies to examine whether adults who reported on substance use at baseline had participated in treatment before enrolling in RPG. These records show that at least 20 percent of adult RPG participants had been in one or more publicly funded substance use disorder treatment programs during the year prior to their enrollment in RPG (Table III.5). Of the 112 adults in this category, 30 (27 percent) completed at least one treatment program during that period.

Table III.5. Substance use disorder treatment participation among adults prior to RPG enrollment

Baseline measure	Sample size	Percentage of adults
Percentage enrolled in at least one treatment in year prior to programming	559	20
Percentage of those enrolled in at least one treatment who completed at least one treatment program in year prior to programming	112[a]	27

Source: RPG administrative data from state substance use services agencies on treatment participation.

[a] 112 adults enrolled in treatment (20 percent of the 559 adults) at some point prior to enrolling in RPG programming. Among these 112 adults, 30 (27 percent) ultimately completed their treatment program.

As would be expected given variability in target populations and RPG services across grantees, the proportion of enrollees who participated in treatment varied among grantees. Whereas some programs served no adults with records of prior enrollment in treatment, others had higher proportions of adults who had been in treatment prior to RPG. For one grantee, 68 percent of the adults they served, and for whom treatment data were requested, had enrolled in such treatment prior to RPG. As a caveat to these findings on substance use disorder treatment, participating grantees have expressed concern that there are adults who they know have received treatment services but were not identified within the administrative records states provided, and thus do not appear in the administrative data requested. Therefore, the enrollment rates we report may underestimate the true proportion of adults receiving substance use services prior to RPG enrollment.

4. Trauma symptoms

In addition to bearing the burdens of high levels of substance use and its concomitant life difficulties, adults with substance use disorders often suffer from symptoms related to past or ongoing trauma exposure. Therefore every adult who completed the ASI-SR was also asked to complete the TSC-40 to measure symptoms of significant childhood or adult trauma (for example, sexual overactivity or desire to physically hurt oneself). Scores on the TSC-40 range from 0 to 120, where 0 represents never having experienced any symptoms, and 120 represents experiencing a wide variety of symptoms with regularity, across the 40 symptoms presented on the instrument. Among the RPG participants who completed the TSC-40, the mean total score was 30.99 (Table III.6).

Table III.6. Trauma symptoms among adults prior to enrollment in RPG

Baseline scale	Instrument	Sample size	Sample mean score (SD)	National mean score for similar populations (SD)[a]
Childhood/adult trauma symptoms	TSC-40	354	30.99 (20.60)	33.39 (22.23)

Source: RPG baseline administration of TSC-40 instrument.

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

SD = standard deviation.

In comparison, people who had previously experienced sexual abuse (Elliot et al., 1992; Whiffen, 1997), were enrolled in psychiatric settings (Zlotnick et al., 1996), or indicated alcohol use disorder (Heffner et al., 2011) had levels of trauma similar to those observed among the RPG participants. The mean total trauma score in these studies was 33.4 (the mean ranged from 23.1 to 71.8 across samples).

D. Caregiver well-being and parenting

Nearly one-quarter of primary caregivers of RPG children experienced elevated levels of parenting stress, and their mean score for depressive symptoms exceeded the national mean (Table III.7). Some caregivers in RPG cases also expressed negative parenting attitudes, though their mean scores were more similar to those of national samples.

Table III.7. Caregiver well-being and parenting at enrollment in RPG

Aspect of family functioning	Instrument	Sample size for analysis	Sample mean (SD)	National mean (SD)	Percentage of adults in high-risk category
Parenting stress	**PSI-SF**	**236**	**74.92 (22.75)**	**69 (15.5)[a]**	**22%**
Depressive symptoms	**CES-D**	**338**	**12.17 (9.13)**	**9.25 (8.58)[b]**	**38%**
Inappropriate expectations for child	AAPI-2	313	5.57 (1.88)	5.5 (2)[c]	14%
Lack of empathy for child	AAPI-2	312	5.88 (2.15)	5.5 (2)[c]	22%
Values corporal punishment	AAPI-2	312	5.17 (1.90)	5.5 (2)[c]	12%
Treats child like an adult peer, not a child	AAPI-2	313	5.02 (2.32)	5.5 (2)[c]	14%
Oppresses child's independence	AAPI-2	312	5.39 (2.18)	5.5 (2)[c]	17%

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

Note: See Appendix A for more details on the risk category definitions. The sample sizes in this table vary across instruments because of survey nonresponse.

[a] National means and SD for the PSI-SF were calculated based on the percentile ranks associated with raw scores in the scoring manual (Abidin, 1995).

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

[c] National means and SD for the AAPI-2 are presented in the scoring manual for the instrument (Bavolek & Keene, 1999). Note: these scales are transformed so that higher scores always indicate negative parenting attitude.

SD = standard deviation.

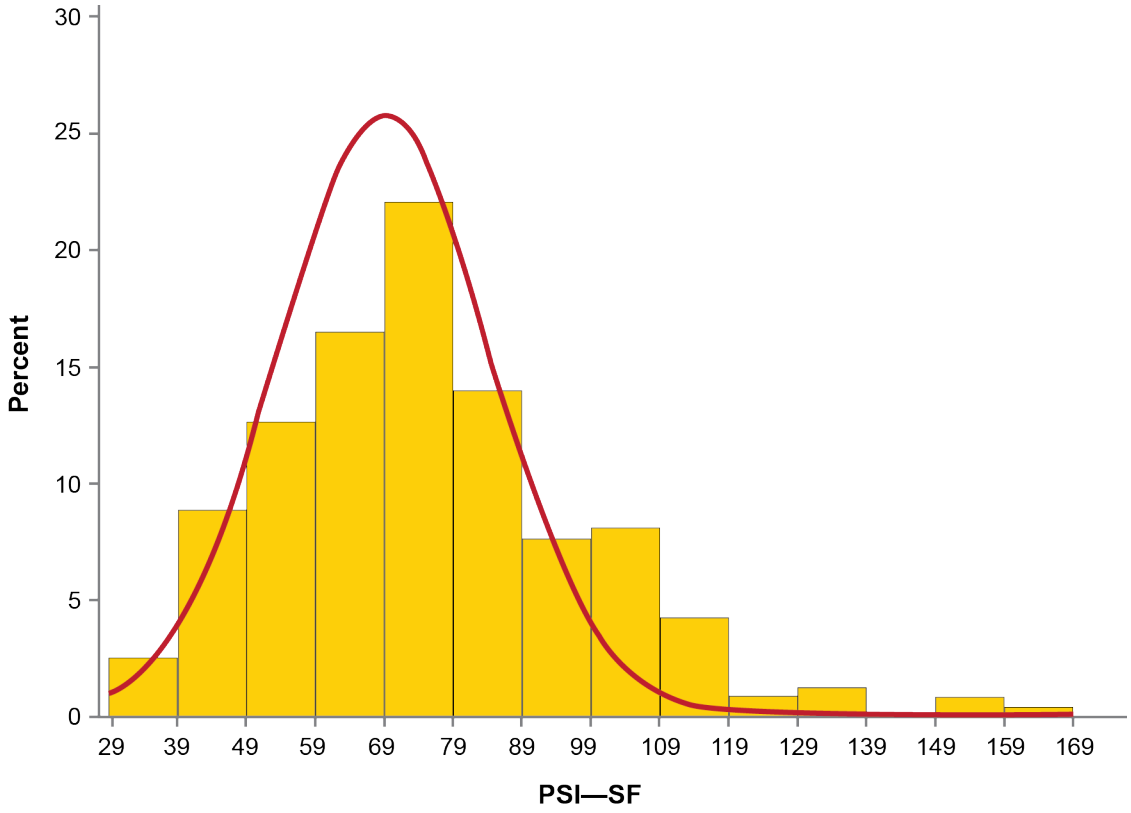
Parenting stress. Parenting stress among adults in RPG was slightly higher than what is typically observed among the general population. The mean score on the PSI for RPG adults was 75, compared to the national mean score on this instrument of 69, described in the PSI scoring manual. Furthermore, 22 percent of RPG adults had scores that placed them in the high risk category for levels of stress. Figure III.1 visually illustrates the distribution of scores among RPG adults, relative to national means.

In this figure, the distribution of scores is shown by the yellow histogram, which is centered on the sample mean of 75. The height of each bar represents the proportion of the sample with

scores in a given range. For example, about 14 percent of the sample has scores between 99 and 169. A red bell curve is overlaid on the histogram. The curve is centered on the national mean score of 69 and represents the distribution of normalized scores for a general population. Most of the yellow histogram bars representing the RPG population follow the distribution of the general population. However, the RPG distribution is somewhat skewed to the right, with nearly a quarter of the adults scoring in the high-risk category for parenting stress. As described in the PSI scoring manual, a score above 90 indicates that the adult is in the high-risk category, which means that they report what would be considered a clinically significant level of stress.

As noted in Section A, parenting stress contributes to dysfunctional parenting and is associated with child maltreatment potential (Testa & Smith, 2009; Berger, 2004). There is also a significant association between stress and substance use disorders. Studies have shown that people exposed to stress are more likely to misuse substances, or to relapse after treatment (Sinha, 2001 and 2007).

Figure III.1. Distribution of scores on the PSI-SF for RPG adults compared to the national mean



Depressive symptoms. On average, RPG adults reported levels of depressive symptoms that are higher than observed in the general population. The mean score on the CES-D (a measure of depression) among the RPG adults was 12.17, above the national mean of 9.25. Among the adult respondents, 38 percent exhibited symptoms of severe depression as defined in the test manual

and thus are classified in the high-risk category. These people might need further evaluation and assessment to diagnose depression and to determine possible interventions to address it.

Parenting attitudes. The AAPI-2 assesses parenting and child-rearing attitudes of parents. For example, the instrument provides information about parental expectations of their children (whether they are age appropriate or not), and their use of corporal punishment (whether they value this approach or prefer alternatives). Across the 5 scales of the AAPI-2, scores range from 1 to 10, with higher scores indicating attitudes more strongly associated with maltreatment.

On all five constructs related to parenting attitudes, RPG adults scored close to the national mean (Table III.8). Compared to a national mean of 5.5, the mean score of RPG adults ranged from 5.02 for the construct "treats child like an adult peer, not a child" to 5.88 for the construct "lack of empathy for child" (where higher scores represent a greater risk for maltreatment). While two of the five attitude scores are above the national average, the averages observed among RPG adults are not markedly different from the national samples, suggesting that on average, RPG adults express attitudes that are consistent with parenting attitudes in the broader population. However, about 44 percent of adults expressed at least one attitude that was categorized as high-risk for maltreatment, and approximately 10 percent expressed sufficiently problematic attitudes categorized as high-risk for maltreatment in at least three out of five categories.

Table III.8. Number of adults with high-risk attitudes in multiple categories measured by the AAPI-2

Number of AAPI-2 risk categories	Number of RPG adults classified as high risk	Percentage of adults classified as high risk
0	176	56
1	65	21
2	42	13
3	19	6
4	9	3
5	1	<1
Total	**312**	**100**

Source: RPG baseline administration of AAPI-2 instrument.

Note: See Appendix A for more details on the risk category definitions.

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IV. CHILD WELL-BEING AT BASELINE

Children's experiences with maltreatment or neglect, as well as the experiences and characteristics of key adults in their lives, have implications for their social-emotional and behavioral well-being and development. For example, maltreatment or exposure to traumatic events diminishes children's cognitive and intellectual functioning and increases their aggression (National Scientific Council on the Developing Child, 2010; Crozier & Barth, 2005; Jaffee & Maikoich-Fong, 2011; Manly et al., 2001). Early exposure maltreatment or neglect has long-lasting effects into adolescence and adulthood, including poor school achievement or dropout and mental health problems (Egeland et al., 2002; Lansford et al., 2002). Moreover, children who experience abuse or neglect or witness violence have higher rates of depression, hopelessness, and low self-esteem than their peers (Cerezo & Frias, 1994; Herrenkohl & Herrenkohl, 2007; Herrenkohl et al., 2008; Margolin & Gordis, 2000; Osofsky, 2004).

For these reasons, legislation establishing RPG focused not only on ensuring the safety and permanency of children, but on protecting and enhancing their well-being. All these goals are given primary attention throughout the child welfare system, so examining child well-being is thus a major component of the cross-site evaluation. This chapter describes measures HHS is using to assess child well-being (Section A), then provides initial findings on child well-being at baseline when children entered RPG (Section B). Future reports will analyze follow-up data to examine whether and how child well-being changed among RPG participants.

A. Measuring child well-being

In an effort to understand risks to functioning for children exposed to potential maltreatment and to adults with substance use disorders, the RPG cross-site evaluation includes measures that span various dimensions of child well-being. The measures selected reflect child behavioral and social well-being as well as measures of development known to be threatened by prenatal exposure to drugs and alcohol, such as difficulties with sensory integration and cognitive control and attention. For the cross-site evaluation, RPG projects used common instruments to collect detailed, comprehensive outcome data on one "focal" child in each case, even if multiple children in the case received RPG services.[18]

1. Measures selected

Fetal exposure to drugs or alcohol can have a wide range of negative effects on early development. Such effects can have far-reaching consequences long into childhood and adolescence. One known correlate of prenatal substance exposure is sensory-processing difficulties in infancy, part of the broader diagnosis of fetal alcohol syndrome (Chasnoff, 2010). *Sensory processing* is defined as the way the brain takes in information from the senses and turns it into appropriate behavioral responses. A child with a sensory-processing disorder can find it difficult to act on information received through the senses, which often leads to difficulties

[18] These data are collected from appropriate adults, such as the child's primary caregiver in his/her family of origin, rather than from the child. That is, primary caregivers provide information about the focal child in the study. Because administering direct observation and child assessment instruments require extensive training and in-field reliability checks is difficult and costly, the cross-site evaluation instruments did not incorporate them.

performing day-to-day tasks. For example, children with sensory-processing difficulties are more prone to social-emotional and behavioral problems, and have lower levels of adaptive social skills and executive functioning (Ben-Sasson et al., 2009; Aron & Aron, 1997; Goldsmith et al., 2006). HHS included the Infant-Toddler Sensory Profile (ITSP) as a measure of sensory processing to better understand the baseline prevalence of children in RPG with sensory-processing difficulties.

Experiences of parents and caregivers can affect the parent-child relationship and child development through multiple pathways. For example, parenting skills are known to be strongly associated with *executive functioning* (Masten et al., 2006; 2011), an overarching term for a set of mental skills that facilitate planning, focusing attention, multi-tasking, and inhibiting impulses. Executive functioning in turn is related to academic success in the early grades (Herbers et al., 2011). The selection of the Behavior Rating of Executive Function (BRIEF) for RPG acknowledges that parenting and caregiver skills affect executive functioning and that it is a positive correlate of cognitive and social outcomes for children.

We also included measures of subsequent sequelae of difficulties in sensory processing and executive functioning, such as behavior problems with the Child Behavior Checklist (CBCL) and social and adaptive behavior with the Vineland Adaptive Behavior Scales II – Socialization subscale (Vineland II). In addition to their relationship with executive functioning and sensory processing, child emotional and behavior problems (measured by the CBCL) are also closely tied to caregiver well-being and parenting stress and skills (Neece et al., 2012). Likewise, Vineland II is included because deficits in socialization skills are also tied to histories of maltreatment (Viezel et al., 2014; Becker-Weidman, 2009), which places the child at risk of developmental delay, poor relationships with peers and family, and even school setbacks or failure.

Finally, focal children in RPG are screened for trauma symptoms using the Trauma Symptom Checklist for Young Children (TSCYC). Just as trauma is a key factor for adults in RPG cases, trauma exposure for children affects many of the dimensions of well-being discussed earlier. About half the children seen in public mental health settings were also part of a child welfare case within the past two years (Lau & Weisz, 2003). Many of these children are brought to services not because of exposure to trauma, but because of its consequences, such as behavioral or emotional problems (Cohen et al., 2010). Often a child's past traumas are not known but become apparent during treatment. Many children in treatment have ongoing exposure to traumatic situations, such as violence, caregivers with their own mental health needs, or unsafe communities (Cohen et al., 2010). Trauma in childhood, most often caused by maltreatment or abuse, is also related to increased odds of developing substance use disorders in adolescence and adulthood, as well as serious mental health issues (De Bellis 1997a; 2002b). Therefore, describing the baseline incidence of trauma exposure for young children contributes to the overall understanding of the risk factors for the group of children served under RPG.

2. Measurement and developmental stages

For the RPG cross-site evaluation, HHS selected measures that are broadly applicable to a sample of children aged newborn to 18 years. However, this was done with the acknowledgement that not every measure would apply to every focal child served in RPG, because key developmental tasks differ across stages of development. For example, the ITSP, a measure of sensory processing, is appropriate for infants aged 0 to 36 months. It is not

administered to older children. The measure of executive functioning (BRIEF) is appropriate only between ages 2 and 18 years. It does not apply to infants, whose skills have not yet emerged, so the measure is not developmentally appropriate.

There is also variation within a single measure, depending on the developmental stage of the child. The CBCL has preschool and school-aged versions to include developmentally appropriate items on the respective assessments. For example, preschool-aged children may exhibit different patterns of behavior problems covered by the CBCL compared to school-aged children, depending on environment (attending school or not yet in school), physical development (whether language is developed versus only a few words or utterances; or walking versus crawling), or even emotional development (verbalizing emotions or feelings versus crying).

For these reasons, we indicate the age range for each measure below. Future reports will likely have sufficient sample sizes to discuss results by developmental groups (such as preschool, school-aged, and adolescents) rather than across all age groups, but at this stage we present results in aggregate.

3. Describing results

To obtain measures of well-being, grantees asked the caregiver of each focal child to complete the set of standardized instruments at the time of RPG enrollment. Researchers and clinicians use these instruments by calculating scores from combinations of the individual questions as prescribed by the developer of the instrument. The calculated score is compared to the scores of a normative sample (from large, randomly selected groups in the broader population) to gauge how the child compares. Thus, the normative population's distribution of scores on a particular measure or instrument provides a way to compare the scores of an RPG focal child to the "typical" child. This comparison indicates whether the child's scores are better or worse than those of a hypothetical average child in the normative group. That is, the comparison provides an estimate of the position of the participant in a predefined population (such as in RPG) on the trait, behavior, or attitude being measured.[19]

To score the child well-being instruments discussed in this chapter, we first created scale scores based on instructions provided by the instrument developer or publisher. Next, to provide an easily understandable picture of the overall status of RPG children for each measure, we placed children into risk categories based on their scores and using definitions of *risk* articulated in the instruments' scoring manuals. For each measure, we report the mean and SD of each score, as well as the proportion of focal children in the high-risk category. As in the previous chapter, the high-risk category reflects the group of children that have elevated scores on the measure corresponding to concerning symptoms or behaviors captured by each measure. For selected measures, we also show how the distribution of all scores for RPG focal children compares to the distribution in the reference normative population.

[19] Some instruments use specific criteria rather than normed scores. For example, the CES-D, discussed in the previous chapter, is scored by summing the number of items in the instrument endorsed to see whether an individual endorses enough items to have severe depressive symptomatology, rather than by comparing the score to a normative population to determine the individual's depressive symptoms in relation to the general population.

B. Child well-being at entry into RPG

Data collected when children enter RPG provide baseline measures that can be compared with a second measurement obtained later to learn whether well-being is stable, has improved, or has declined. Grantees and clinicians working with children and families can also use baseline information (1) to refine their programs to meet participant needs, (2) to identify children who need specific interventions to address potential problems indicated by one or more measures, and (3) to track individual children's progress over time. For this report, the baseline scores provide a snapshot of the status of focal children prior to each case's receipt of RPG services. These scores show that, at enrollment, RPG children are at higher risk than national samples of children in some, but not all, areas of well-being.

1. Sensory processing

The ITSP measures over- or under-response to stimuli, both of which can be detrimental to well-being. For example, children who are born with sensory-processing difficulties might over-respond to normal everyday experiences, such as being sensitive to loud noise, light, or touch. This can be related to developmental delays. However, under-response to stimuli is also of concern. Some children with such difficulties may appear numb to some occurrences, whether common or uncommon. For instance, a child who under-responds may not jump at a loud noise, or react to a dangerous situation.

ITSP scores for infants aged 0 to 6 months range from –1 to 1, and scores for toddlers aged 7 to 36 months range from –1 to 2. A negative score indicates that the child is under-responsive to stimuli, and a positive score means the child is over-responsive. A score of zero indicates no issues with sensory processing—that is, the level of sensory processing is appropriate. For RPG, caregivers reported that focal children aged zero to six months under-responded to stimuli, on average. RPG children aged 7 to 36 months were reported to over-respond to stimuli. RPG infants had mean ITSP scores below 0 (–0.13), and RPG toddlers had scores above 0 (0.23) (Table IV.1).

We also examined ITSP scores that were either very low (indicating under-response to stimuli) or very high (indicating over-response). Following the instrument developer's guidelines, we defined *very low* or *very high* as any normed score above or below zero, which is considered typical sensory processing, and characterized them as our risk groups. Thirty-one percent of focal children aged 0 to 6 months, and 43 percent aged 7 to 36 months, fell into our high-risk category of ITSP scores, which indicates that they were rated as displaying over-response or under-response to stimuli. These findings indicate that RPG programs should be aware of potential processing issues for a substantial portion of the children they serve.

Table IV.1. Child well-being scores prior to receiving RPG programming

Aspect of child well-being	Instrument	Sample size for analysis	Sample mean (SD)	National mean (SD)	Percentage of focal children in high-risk category
Sensory processing	ITSP (age 0 to 6 months)[a]	49	–0.13 (0.53)	0 (1)	31
	ITSP (age 7 to 36 months)[a]	61	0.23 (0.72)	0 (1)	43
Executive functioning	BRIEF-P (age 2-5 years)	66	55.80 (15.40)	50 (10)	27
	BRIEF (age 5-18 years)	86	53.69 (13.48)	50 (10)	24
Emotional problems	CBCL (age 1.5-5)	85	51.56 (11.93)	50 (10)	16
	CBCL (age 6-18)	95	53.37 (11.65)	50 (10)	19
Behavioral problems	CBCL (age 1.5-5)	82	51.30 (13.46)	50 (10)	20
	CBCL (age 6-18)	95	54.91 (12.76)	50 (10)	27
Total problems score	CBCL (age 1.5-5)	83	51.40 (13.93)	50 (10)	18
	CBCL (age 6-18)	95	54.47 (12.57)	50 (10)	30
Socialization	Vineland II (age 0-99)[b]	186	87.24 (23.80)	100 (15)	23
Trauma symptoms (PTSD)	TSCYC	131	37.35 (10.46)	50 (10)	37

Source: RPG baseline administration of the ITSP, BRIEF, BRIEF-P, CBCL, Vineland II, and TSCYC instruments.

Note: See Appendix A for more details on the risk category definitions. The sample sizes vary by measure because caregivers reported on different subsets of children depending on the child's age. For example, the ITSP has a very narrow age range (0 to 36 months), so a small number of children were analyzed for that measure. Conversely, the Vineland II, which has essentially no age restriction, applies broadly to all focal children in RPG cases and consequently has a much larger sample of children. In addition, the sample sizes in this table vary across instruments as a result of instrument nonresponse.

[a] On the ITSP, "typical" sensory processing occurs at a score of zero. Negative scores represent under-responsiveness to stimuli, and positive scores represent over-responsiveness to stimuli.

[b] On the Vineland II, higher scores represent more positive socialization for children. On the BRIEF-P, CBCL, and TSCYC, higher scores represent more negative child well-being outcomes.

SD = standard deviation.

2. Executive functioning

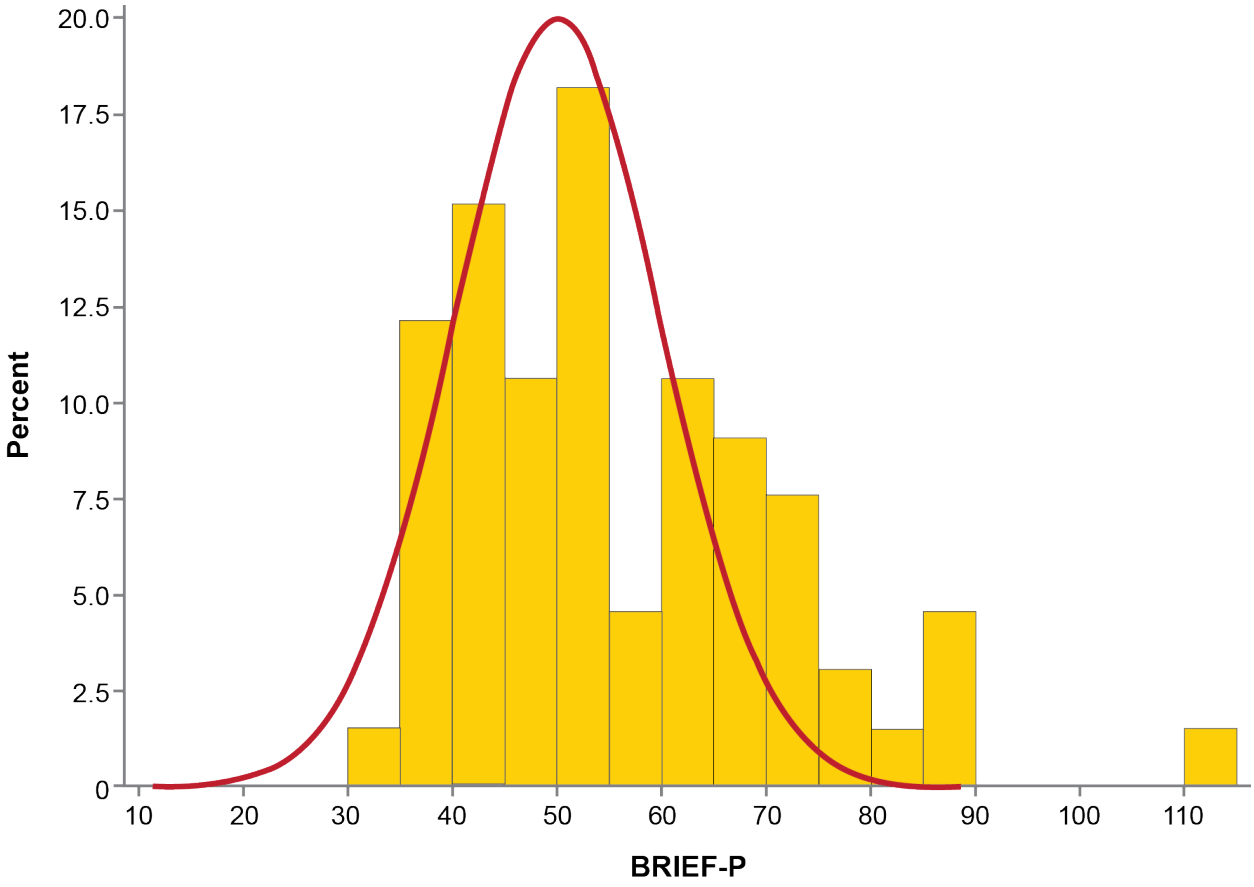
Compared to the national mean, focal children in RPG exhibit limitations in their executive functioning (Table IV.1). That is, as a group they have greater difficulties in tasks such as controlling their impulses, solving problems, and planning. These patterns emerge in both age groups assessed by age-specific versions of the BRIEF: preschool children (aged 2-5, the *BRIEF-P*) and school-aged children (aged 5-18). For the former, the mean score was 56; for the latter, it was 54. Both groups scored higher than the national mean of 50.[20] For this instrument, higher scores represent more limitations in executive functioning; therefore, RPG focal children have more difficulties in this area than children in the general population.

Figure IV.1 illustrates these findings by showing the distribution of the scores of RPG children on the BRIEF-P, whose relative frequency of scores is represented by yellow bars indicating the percentage of focal children with scores in a given range. This histogram of scores among the RPG children can again be compared against the national distribution, represented by the red

[20] Small sample sizes for the RPG focal children on the BRIEF and BRIEF-P make the means on these samples susceptible to outliers in the distribution. In other words, children with very high or very low scores may influence the overall mean, thus increasing or decreasing the RPG sample mean.

curve centered at a mean score of 50. The scores of RPG focal children are distributed to the right of the national mean. The majority of the two distributions overlap, which suggests that many RPG children look similar to the national population in terms of executive functioning, and many are scoring as well as or better than the national mean. The figure also shows that RPG scores are more variable (with some very high or very low), and this is reflected in the SD of the data around the sample mean). For this measure, the SD (15.1) is larger than the SD in the national normative sample (10.0).

Figure IV.1. Distribution of scores on behavioral and emotional problems (BRIEF-P instrument) for RPG focal children aged 2-5 compared to the national mean



The percentage of children classified as high risk (with scores of 65 or above as prescribed by the instrument developer)[21] was similar for the two RPG age groups, with 27 percent of preschoolers and 24 percent of school-aged children considered high risk. RPG focal children in the high-risk group are less proficient in executive functioning compared to the general

[21] Scores of 65 or above were established by the developer of the instrument as the cutoff point for high risk. This score is 1.5 SD above the national population mean. All instruments in this chapter use the developer's guidelines to establish the cutoffs for high risk.

population, which could affect their future or current social and behavioral well-being, and subsequent school success.

3. Child emotional and behavioral problems

The levels of emotional, behavioral, and associated problems among RPG children were slightly elevated relative to national samples, though not markedly so. Higher scores on the CBCL indicate greater reported problems. The emotional problems scale (negative behaviors that are inward focused) includes subscales that assess whether the child is emotionally reactive, anxious/depressive, withdrawn, or has somatic complaints (example questions include "stares into space or seems preoccupied" or "avoids looking others in the eye"). The behavior problems scale (negative behaviors that target the external environment) includes subscales that assess whether the child has attention problems or exhibits aggressive behavior (example questions include "can't concentrate, can't pay attention for long" or "gets in many fights"). Both instruments also collect information on additional problems, such as sleep problems, to provide an overall total problem score. There are two versions of the CBCL—one for preschool-aged and one for school-aged children, so we report on the two versions of the instrument separately in this section.

Both school-aged and preschool children's scores on average, were close to the national mean on behavioral, emotional, and total problems. Compared to the national mean of 50, school-aged children scored a mean of 53 on the emotional problems scale, 55 for the behavior problems scale, and 54 on the total behavior problems scale. Preschool children scored a mean of 52 on emotional problems, 51 on behavioral problems, and 51 on total problems.

We characterized high risk for emotional, behavioral, and total problems as standard scores over 64 on each scale, using measure developers' guidelines. Among preschoolers, 16 percent were at high risk for emotional problems, 20 percent were at high risk for behavior problems, and 18 percent met the threshold for high risk for the total problem score. Among school-aged children, 19 percent scored at high risk for emotional problems, 27 percent at high risk for behavior problems, and 30 percent at high risk for the total problems.

4. Socialization skills

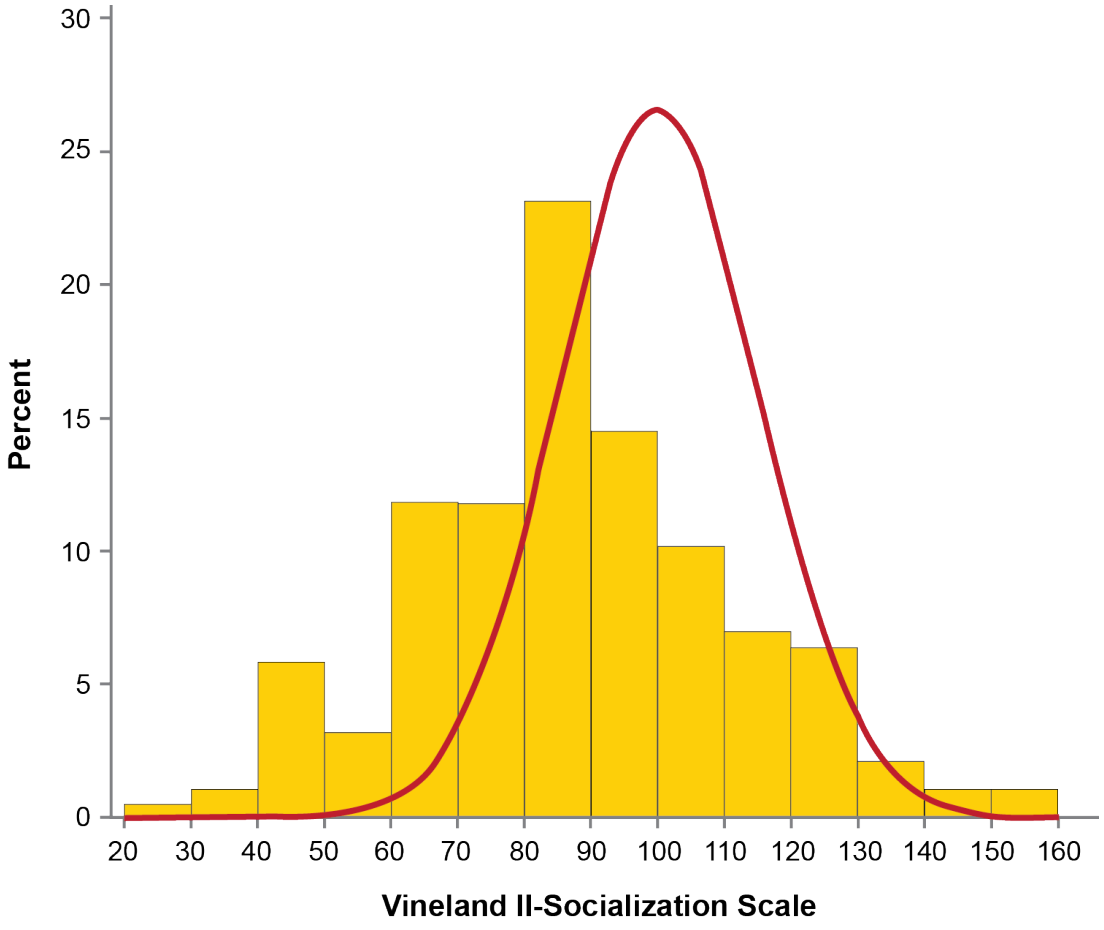
Focal children in RPG struggle with socialization skills, such as interacting with others, using play and leisure time, and using effective coping strategies. Socialization skills are part of the larger bundle of adaptive behavior, measured by the Vineland II, which is defined as "the performance of daily activities required for personal and social sufficiency" (Sparrow et al., 2005, p. 6). The sample mean for focal children was 87 compared to the national mean of 100 (Table IV.1). In contrast to the BRIEF, ITSP, and CBCL, where higher scores represent problems, higher scores on the Vineland II socialization scale indicate higher levels of these positive adaptive social behaviors (lower scores indicate lower levels).

Figure IV.2 shows the distribution of scores for children in RPG in relation to the national mean. Unlike the previously presented histograms, where the observed scores fell to the right of the national mean (shown as a red curve centered at 100), indicating more problems, the RPG distribution of scores for the socialization scale lies somewhat to the left of the national mean of 100 (indicating lower levels of socialization skills). Although on average RPG focal children

scored lower on this area of development relative to peers nationally, a substantial proportion of children scored at or above the national mean, which indicates that many children had developed positive socialization skills.

We characterized children with normed scores of 70 or lower to be at high risk. Among all focal children, 23 percent met this risk threshold for socialization problems.[22] That is, some RPG focal children may be at a disadvantage for learning to interact with friends, peers, or teachers compared to children in the general population, and hence, are at risk for developmental delays in their ability to effectively manage themselves and be independent.

Figure IV.2. Distribution of scores on the Vineland II for RPG focal children compared to the national mean



5. Trauma symptoms

Overall, children in the RPG sample exhibited few signs of trauma, as measured by the TSCYC. The TSCYC captures symptoms of post-traumatic stress disorder (PTSD), an anxiety condition brought on by experiencing one or more traumatic events. The TSCYC best measures children's

[22] Because of an error with the electronic form for the Vineland II, children aged 0-15 were not administered the full set of items. Therefore, their scores might be lower than they would have been otherwise, and the percentage of children identified as at high risk might be slightly inflated. This error did not affect children 16 or older.

trauma related to childhood sexual abuse, physical abuse, and witnessing of domestic violence (Briere et al., 2001). It is less able to capture trauma related to experiences of neglect, emotional abuse, or community and neighborhood violence, and can therefore underestimate trauma for children with those experiences. Recall from Chapter II that among focal children with substantiated maltreatment reports the year before enrollment in RPG, 24 percent were the subject of neglect, and a smaller group (5 percent) were the subject of abuse (Table II.5). Unlike the other measures of child well-being discussed in this chapter, on average, focal children in RPG cases appeared to exhibit fewer symptoms of PTSD compared to the national mean (Table IV.1). The sample score for RPG focal children was 37 compared to the national mean score of 50. This is a positive finding for this group; however, it is possible that these scores underreport trauma in RPG children.

As with the other measures, we also looked at those in a high-risk group (defined as children with total scores of 40 or higher). Thirty-seven percent of RPG children were classified by their scores as high risk, meaning that they exhibited signs and symptoms of PTSD. HHS is concerned about trauma in children and has encouraged all grantees to provide trauma-informed care, and several grantees provide EBPs specifically designed to address child and/or adult trauma, as discussed in Chapter VI. Thus, treatment for children exposed to trauma and its many interrelated problems is a central concern for RPG programs.

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V. PARTICIPANT ENROLLMENT IN PROGRAMS AND SERVICES

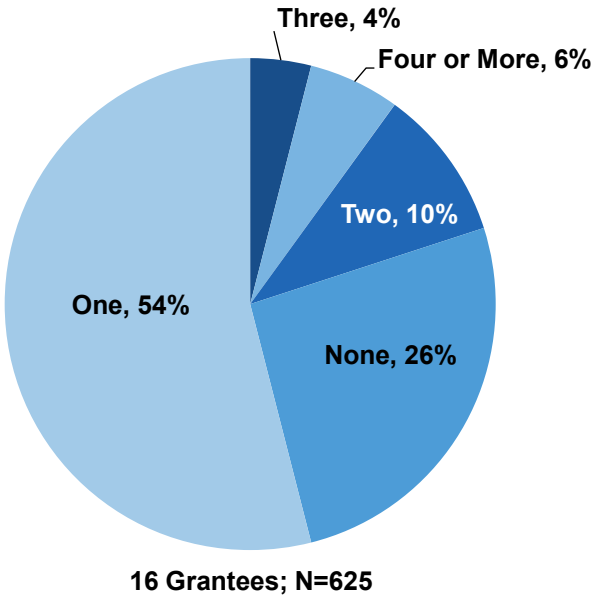
In recent years, federal agencies and policymakers, funders, practitioners, and providers have sought to identify, implement, scale up, and sustain interventions that have research demonstrating their effectiveness. By expanding the use of such evidence-based or evidence-informed interventions, stakeholders aim to better allocate resources when they are scarce and, ultimately, improve the effectiveness of their work (Strong et al., 2013). RPG2 grantees proposed a total of 51 distinct evidence-based or -informed program and practice models (EBPs) they planned to use to serve families.

Each grantee designed a set of services that suited their target population and community context, so the number and types of services and programs offered varied across the grantees. For example, two grantees offered one EBP through their RPG project. Other grantees offered several EBPs in combination, with most or all cases receiving the same suite of services. Still others offered a range of EBPs and provided a subset to each case based on participants' needs and progress. By the end of the reporting period for this report, most participants had been enrolled in at least one EBP: in total, 16 grantees had enrolled 458 RPG cases (including 1,027 participants) in 19 different EBPs. This chapter describes the number of EBPs in which RPG cases were enrolled (Section A), the use of multiple EBPs by grantees (Section B), and the types of EBPs in which participants were enrolled (Section C). Future reports will update these numbers, and provide detailed discussions of the implementation and use of a subset of EBPs being closely examined for the cross-site evaluation. The final section describes several issues that affected the overall implementation of RPG projects during the reporting period.

A. Number of EBPs in which cases were enrolled

Most RPG cases had been enrolled in an EBP by the end of the reference period. Of the 625 RPG cases in our data, nearly three-fourths were enrolled in at least one EBP by that time (Figure V.1). Among these EBP-enrolled cases, the average number of EBPs in which they had been enrolled was 1.5. That is, cases were most commonly enrolled in either one or two EBPs. Slightly more than half (54 percent) of cases were enrolled in one EBP, while an additional 9 percent were enrolled in two EBPs. Nine percent of all cases were enrolled in 3 or more different EBPs, the remaining 27 percent in none. These results reflect the total number of EBPs that grantees chose to implement, as well as the number of EBPs for which services had actually begun or that participants needed at this stage in the grant program.

Figure V.1. Number of EBP enrollments per case



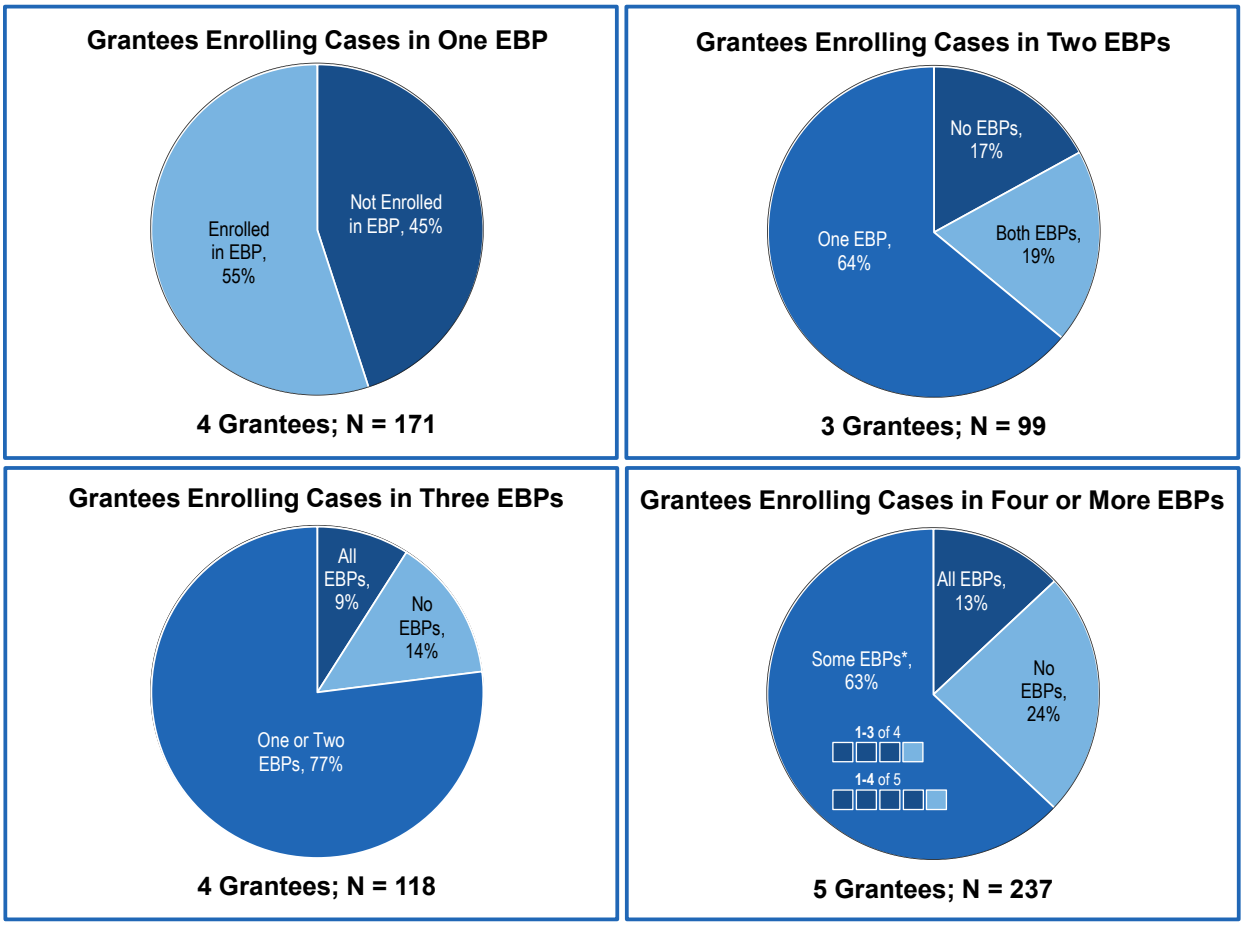
Source: RPG Enrollment and Service Log data.

B. Grantees offering multiple EBPs

Fourteen grantees are offering more than one EBP (with 15 being the most EBPs offered in one RPG project). The maximum number of EBPs in which any grantee had enrolled any cases between January 2014 and March 2015 (the period covered by the enrollment data available for this report) was four.[23] Of the 16 grantees in our data, 4 had enrolled cases in one EBP, 3 had enrolled cases in 1 or both of 2 EBPs, 4 had enrolled cases in 1 or more of 3 EBPs, and 5 had enrolled cases in 1 or more of 4 different EBPs offered by their project (Figure V.2).

[23] The reference period for measuring EBP enrollment was three months longer than the period used for baseline data collection. This allowed us a cushion to account for delays in case take-up of services after initial enrollment into RPG.

Figure V.2. Percentage of cases enrolled in EBPs, by number of EBPs with enrollments



Source: RPG Enrollment and Service Log data.

N = number of cases.

* Two grantees had enrolled at least one case in four different EBPs. Within this group, the percentage of cases enrolled in "some EBPs" refers to cases enrolled in one to three EBPs. Three grantees had enrolled at least one case in five different EBPs. Within this group, the percentage of cases enrolled in "some EBPs" refers to cases enrolled in one to four EBPs.

By March 2015, most grantees had enrolled cases in at least some of the EBPs available to them (Figure V.2. For example, among the four grantees that had enrolled cases in one EBP, about half the cases were enrolled in that EBP and half were not. Among grantees that had enrolled cases in at least two EBPs, the majority of cases were enrolled in some, but not all, of those EBPs.

Differences between the large number of EBPs offered by some grantees and the smaller number in which cases were enrolled reflect three main factors. First, some grantees planned to implement some EBPs later in their RPG projects, or to do so only if they enrolled participants who were a good match for the potential additional EBP(s). Second, some grantees had implemented multiple EBPs but planned to enroll participants in them only if a participant was a good match for the existing EBP, reached a stage of progress at which the additional EBP(s) would be appropriate, or experienced a particular need served by that EBP. Finally, a few

grantees dropped EBPs they had initially planned to implement, based on practical considerations such as a mismatch with participant needs, because they duplicated other existing services, or because expected adaptations to selected program models by developers did not materialize in time.

C. Types of EBPs in which cases were enrolled

Family-strengthening programs were implemented by the largest number of grantees. Twelve grantees had enrolled at least one case into this type of program by the end of the data collection period (Table V.1). The other types of EBPs, and the number of grantees enrolling participants in each, are[24]:

- **Response to trauma.** These EBPs are designed to help clients cope with trauma and develop resilience. Ten grantees had enrolled cases in at least one EBP focused on coping with trauma.
- **Child-caregiver therapy.** These therapies focus on the child-caregiver relationship, but cut across several substantive areas, including family functioning, substance use disorder treatment, and response to trauma. Five grantees had enrolled cases in a child-caregiver therapy EBP.
- **Therapy or counseling styles.** These include cognitive behavioral therapy and other counseling styles, such as Motivational Interviewing. Four grantees had enrolled cases in at least one counseling style EBP.
- **Substance use disorder treatment.** This is intended to help clients overcome substance use disorder and avoid relapse. Four grantees had enrolled cases in one or more substance use disorder treatment EBPs.
- **Family treatment drug court.** These are specialized courts designed to work with families involved in the child welfare system primarily because of parental substance use disorder. One grantee had enrolled cases in this type of EBP.

Table V.1. EBP enrollments by type

EBP type	Number of grantees enrolling cases in EBP(s) of this type	Number of cases served by grantees enrolling cases in EBP(s) of this type	Percentage of all RPG cases enrolled in EBP(s) of this type
Family strengthening	12	520	52
Response to trauma	10	267	18
Substance use disorder treatment	4	230	13
Counseling style	4	102	6
Child-caregiver therapy	5	221	5
Family treatment drug court	1	8	1

Source: RPG Enrollment and Service Log data.

Across all grantees, family-strengthening EBPs were the most common. More than half of all 625 RPG cases (52 percent) were enrolled in such an EBP. Response to trauma EBPs were the

[24] For information on how EBPs were placed into these categories, see Strong et al. (2013).

next most common, with 18 percent of cases enrolled. Thirteen percent of cases were enrolled in a substance use disorder treatment EBP, 6 percent in a therapy or counseling style EBP, 5 percent in a child-caregiver EBP, and 1 percent in family treatment drug court.

D. Implementation

As the enrollment information shows, RPG2 projects were well underway in their implementation during their third year of work. During this phase, the projects addressed several issues, some of which were unique to a few states, while others were shared by multiple projects. By the end of the third year, most grantees had begun planning how to sustain the partnerships and projects funded by RPG after the end of the five-year grants.

1. State-level factors

Significant state level changes affected several RPG projects. For example:

- A law enacted in 2014 in one state allowed women to be prosecuted for the illegal use of a narcotic while pregnant if her child was born with a physical dependence on, or harmed by intrauterine exposure to, a drug as a result of the mother's illegal use of a narcotic drug (in the words of the legislation) taken while pregnant. The bill made it an affirmative defense if the woman actively enrolled in a long term substance use disorder treatment program before the child was born, remained in the programs after delivery, and successfully completed the program. One RPG project in the state experienced a dramatic increase in referrals of pregnant women for substance use disorder treatment, resulting in waiting lists for treatment services and the need to refer women to other agencies for treatment.
- In another state, demands on the child welfare system severely constrained its capacity to engage as fully in the RPG project as hoped. For unknown reasons, the state experienced substantial increases in reports of possible abuse; currently there are nearly historic high numbers of children in foster care within the state. An unfortunate result has been a lack of referrals from child welfare to the RPG project. (Citing demands on the system, the state's child welfare director even terminated the state's participation in a IV-E waiver program, designed to implement and test new approaches to child welfare, in order to preserve resources for meeting the rising need for basic services.)

2. Maintaining the involvement of child welfare

Several grantees experienced improvements in relationships and communication with child welfare, though others continued to struggle in this area. A problem in some sites was turnover in child welfare staff.

- One grantee needed to meet frequently with child welfare to re-introduce new front line child welfare staff to the RPG project and re-develop relationships and referral paths.
- Another RPG partnership faced challenges retaining buy-in when a regional child welfare administrator who was highly supportive of RPG left.
- Budget cuts in one state led to the consolidation of several local child welfare offices, eliminating office space RPG hoped to use to co-locate staff within child welfare.

3. Enrollment and retention

Several RPG projects responded creatively to initial difficulties meeting enrollment targets and retaining participants. For example:

- Some grantees defined their target population more broadly to serve a larger pool of families—such as by easing age restrictions on children eligible for RPG.
- RPG partnerships were sometimes able to expand the use of screening to identify more families that could benefit from RPG, such as by implementing expanded or universal screening for substance use disorder, or screening for PTSD to identify more adults eligible for RPG interventions designed to address trauma.

4. Enhancing substance use disorder treatment

Substance use disorder treatment providers who were part of RPG instituted practices aimed at enhancing treatment or retaining clients in treatment or recovery, such as the use of:

- Motivational interviewing: Goal-oriented, client-centered counseling intended to facilitate and engage intrinsic motivation within the client, in order to change behavior.
- Contingency management: Giving patients tangible rewards to reinforce positive behaviors such as abstinence.
- Recovery coaches: One-on-one strengths-based support for those with substance use disorders or in recovery.
- Navigators: Specialists who help clients identify and get access to available services and supports.
- Peer support: People with similar problems, such as substance use disorder, receive specialized training so they can draw on their own experiences to support and encourage those in treatment.

5. Model fidelity

Four grantees increased their emphasis on maintaining fidelity to the evidence-based models they were implementing:

- One grantee contracted with a developer of their EBP to provide on-site training in implementing the EBP.
- Two grantees implementing Living in Balance, an EBP that did not include developer-provided fidelity monitoring tools, began working together to develop a monitoring tool they could use in their RPG projects.
- One partnership began a study of their fidelity to the principles of motivational interviewing, as part of their local evaluation.

VI. THE RPG3 PROJECTS

The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) reauthorized the existing RPG program and extended funding through 2016. With the funding, in 2012 HHS funded the RPG2 grantees for five years. At that time, HHS also invited existing RPG grantees funded prior to 2012 to apply for new grants of $500,000 per year for up to two years to extend their RPG programs (ACF, 2012c). Eight partnerships received "extension grants," which came to an end in September 2014. HHS decided to use the remaining authorized funds for a third cohort of five-year RPG projects (RPG3).

On January 9, 2014, HHS published a discretionary grant forecast announcing its intention to provide additional targeted RPG competitive grant funds. HHS anticipated making four grants ranging from $500,000 to $600,000 a year for 5 years. As with the RPG grants funded in 2012, the primary applicant had to be a regional partnership organization of one of 11 types (Table VI. 1) and had to include the state child welfare agency responsible for the administration of the state plan under Title IV-B or Title IV-E of the Social Security Act and at least one of the other parties. Other announced requirements also matched the 2012 grants; the partnerships would be required:

- To select and report on performance indicators and evaluation measures to increase the knowledge that can be gained from the program.
- To use specific, well-defined, evidence-based programs that are also trauma-informed and targeted to the identified population.
- To conduct an evaluation rigorous enough to contribute to the evidence base on service delivery and outcomes associated with the project's chosen interventions.

Table VI.1. Allowable types of regional partners for RPG grants

Types of partners[a]
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[b]
The state agency responsible for administering the substance use disorder 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. § 300x-21 et seq.]
An Indian tribe or tribal consortium
Nonprofit or for-profit child welfare service providers
Community health service providers
Community mental health service providers
Local law enforcement agencies
Judges and court personnel
Juvenile justice officials
School personnel
Tribal child welfare agencies or a consortia of such agencies
Any other providers, agencies, personnel, officials, or entities that are related to the provision of child and family services under this subsection

Source: U.S. Department of Health and Human Services. HHS Grants Forecast (ACF-2014-FCAST-0189). Available at http://www.acf.hhs.gov/hhsgrantsforecast/index.cfm?switch=grant.view&gff_grants_forecastInfoID=66981. Accessed October 12, 2014.

[a] RPG partnerships must include at least two of the partner types.

[b] Every RPG partnership must include this organization. If the regional partnership consists of a county located in a state that is state-supervised and county-administered, the county child welfare agency satisfies this requirement.

The new partnerships would also be expected to participate in the national cross-site evaluation that was under way for the 2012 grants, including the implementation, partnership, and outcomes studies, as well as an impact study, if appropriate given the design of their local evaluations.

In April 2014, HHS released a funding opportunity announcement for the grants (ACF, 2014), which constituted the third round of five-year RPG grants made pursuant to federal legislation. Applications were due by June 10, 2014, and HHS made the awards on September 29, 2014.

A. Grant recipients

In response to its funding opportunity announcement (FOA) regarding four additional RPG projects (ACF, 2014), HHS received applications and awarded the grants (Table I.1). Grant amounts were $564,914 or $600,000 annually (Table VI.2), with increasing percentages of required grantee matching funds over time. One of the four grantees had also received RPG funding in 2007, but none were 2012 RPG2 grantees. One grantee was a university, and three were local service providers.

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

The RPG3 projects focused on child well-being, though the target groups for services differed. One of the grantees (the University of Kansas Center for Research, Inc.) targeted primarily children in out-of-home care; the other three targeted families where children were at risk of an out-of-home placement. Grantees planned to work with families in which parents were in, or had completed, substance use disorder treatment programs. In addition, grantees were each taking differing approaches to service provision. Three planned to provide a set suite of services to all participants; the fourth (Volunteers of America – Oregon) expected to offer a range of customized services from a menu of options, depending on family needs.

Table VI.2. RPG3 projects and planned target population and program focus

State	Grantee organization	Organization type	Federal grant amount	Planned target population and program focus
Florida	Our Kids of Miami-Dade/ Monroe, Inc.	Child and family services provider	$600,000	Our Kids will provide a suite of services to families with children aged 0 to 11 who are referred through the Child Protective Investigation Process for diversion/prevention. Families are eligible if they have either suspected or verified substance use disorder indicators but do not have an open dependency court case. The suite of services includes (1) the Engaging Moms/Parent Program, which provides additional support for engagement in substance use disorder treatment, family therapy interventions, and supports to improve parenting skills; (2) engagement with a peer specialist; (3) Intensive Family Preservation Services; and (4) referral to the Motivational Support Program, a voluntary program that is the gateway to substance use disorder treatment for families with child welfare involvement.
Kansas	University of Kansas Center for Research, Inc.	Public university	$564,914	The University of Kanas Center for Research will provide the Strengthening Families Program: Birth to Three (SFP B-3) among families with substance use disorders and children up to 47 months old in foster care or at risk of out-of-home placement. SFP B-3 is a family skills training program that focuses on increasing resilience and reducing risk factors in behavioral, emotional, cognitive, and social domains. The scripted curriculum is delivered in 14 consecutive weekly sessions, with booster sessions occurring after 6 and 12 months. The program will also provide caregiver substance use disorder assessment, child and parent trauma assessment, and referral.
New York	Montefiore Medical Center	Medical center, substance use disorder treatment provider, child and family services provider	$600,000	Montefiore will provide the Family Treatment/ Rehabilitation (FT/R) program and three program enhancements—Seeking Safety, Incredible Years, and contingency reinforcement—among families with substance use disorders and open and indicated child welfare cases where children are at risk for removal. Through FT/R families will receive comprehensive clinical assessment of substance use and other clinical and service needs, referrals to treatment and other services, home visits to monitor safety, and case management. Seeking Safety is a trauma-informed treatment to reduce the risk of substance use disorder. Incredible Years is a parenting education program. Contingency reinforcement provides financial incentives to keep substance use disorder treatment appointments and maintain abstinence.

State	Grantee organization	Organization type	Federal grant amount	Planned target population and program focus
Oregon	Volunteers of America – Oregon (VOAOR)	Child and family services provider, substance use disorder treatment provider	$600,000	VOAOR will provide a Recovery Oriented System of Care (ROSC) for parents in recovery from substance use disorders who are either engaged with or at risk of engagement with child welfare. In eligible families, the adult in recovery will have already completed substance use disorder treatment. Services will be available through the Family Recovery Support program, which serves as a drop-in center for families. As part of the ROSC, families will receive a recovery support plan that includes services aligned with that family's particular needs selected from a menu of options. Families will be matched to a Certified Peer Recovery Mentor if requested, and they may also work with a resource specialist and/or therapist.

Source: Grantees' RPG applications, ongoing conversations with grantees, and other grantee materials.

B. Number and types of partner organizations

The need for partnerships to serve families involved in both the child welfare and the substance use disorder treatment systems was one motivation for the creation of the RPG program. The differing legal and policy contexts, perspectives, and practices within both systems—as well as logistical concerns, such as the need to ensure the security of client records—present challenges for families and service providers. To apply for RPG funding, grantees formed partnerships that they continued to develop during the first year of the program. By April 2015, the new grantees reported having 4 to 11 partners (Table VI.3).

Table VI.3. Number of RPG partners identified by RPG3 grantees as of April 30, 2015

Grantee	Number of partners
University of Kansas Center for Research, Inc.	7
Montefiore Medical Center	4
Our Kids of Miami-Dade/Monroe, Inc.	11
Volunteers of America – Oregon	4

Source: Grantees' Semiannual Progress Reports for October 2014-March 2015.

RPG3 partners were diverse. They included state agencies, county agencies, courts, and independent private and nonprofit organizations. Their missions varied; some provided services to families, others set state or county child welfare or other policy, and still others advocated on behalf of children and families. In addition, as the requirements for the grant program suggest, partners worked in a range of fields such as health or child welfare.

As the grant required, each partnership included the state or county child welfare agency, either as the primary grantee or as a partner. In addition to child welfare agencies, the most common members of RPG partnerships included (1) state substance use services agencies, (2) local substance use disorder treatment providers, and (3) nonprofit or private child welfare services providers. Two of the grantees identified existing community collaborations or partnerships focused on child welfare as part of their RPG3 partnerships; two partnered with the developer of their primary EBP, and one identified the family court as an RPG partner.

C. Grantee local evaluations

HHS required that every RPG3 grantee evaluate its project, saying that grantees should propose evaluation designs comparing participants with nonparticipants (ACF, 2014). Comparison group designs were preferred because they could, if well designed, identify the influence of project services and activities on participant outcomes.[25] The program and local evaluation plans described in many of the grantees' applications were brief, and some grantees were still planning specifics of their programs and/or evaluations in the initial months of the grant—though others had already formulated detailed plans. A liaison from the cross-site evaluation contractor (Mathematica) explored grantees' proposed evaluation plans as part of initial monthly calls.

During these conversations, the cross-site evaluation liaison (CSL) helped grantees flesh out more detailed evaluation designs and plans as needed; responded to questions from grantees, their evaluators, or their federal project officer about proposed or potential designs; or offered suggestions to bring some designs into closer alignment with goals articulated in the FOA. The CSL conducted a more formal evaluability assessment using a template developed by Mathematica and approved by HHS, along with offering continued advice and assistance to address design difficulties or take advantage of opportunities to implement more-rigorous designs.[26] Characteristics of grantees' local outcome evaluations are shown in Table VI.4.

In assessing the strength of these evaluation designs, HHS considered the level of evidence on program effectiveness that the evaluations could provide if they were well implemented. While assessing the quality of the proposed designs, HHS also considered factors that could interfere with the ability of the local evaluations to detect program effects. These included whether the proposed sample size would be large enough to detect the likely impacts of the RPG projects, and whether the data sources include newly collected primary data on children and families or only the secondary data already available from administrative records kept by child welfare, foster care, and substance use disorder treatment agencies.

Based on the assessment of the local evaluation designs, HHS rated each design as one of the following:

- **Strong.** If the evaluation was implemented well, the design would provide credible, unbiased effects of the contrasts being evaluated.

[25] Other evaluation designs, such as pre-post designs that compare participants before and after a program rather than to a separate comparison, are unable to attribute changes to the program being evaluated.

[26] Extensive detail on the evaluability assessment process is in the RPG First Annual Report (Strong et al., 2015).

- **Promising.** If the evaluation was implemented well, the design would provide suggestive information on the effects of the contrasts being evaluated.
- **Limited.** If the evaluation was implemented well, the design would provide limited information on the effects of the contrasts being evaluated.
- **Descriptive.** The design cannot isolate program effects from other factors but can provide useful information on participant outcomes or other aspects of the RPG program and partnerships.

After the evaluability assessment, two local evaluation designs received a rating of "strong" and two were rated "promising." The four grantees will launch their local evaluations and begin providing data to the cross-site evaluation in the coming year, as described in Chapter VII.[27]

D. Activities in the first six months of RPG3

During the first six months of RPG3, grantees focused on finalizing their program and evaluation plans. Through this process, grantees also developed strong relationships with the federal TA team, which included the CSL and a program management liaison provided by NCSACW, and became familiar with procedures for requesting TA.

1. Finalizing program plans

Work to finalize program plans fell into two overarching categories: staffing and establishing processes for service delivery. In terms of staffing, all four of the grantees identified current staff and/or began hiring new staff to deliver RPG services. Two of the grantees began training staff, and all four identified and developed schedules for future training needs. Grantees also developed procedures for supervising staff who will be delivering services.

In establishing procedures for service delivery, grantees reviewed their program plans and worked with internal staff and partners to develop a shared understanding of how RPG clients would be recruited and how services should be delivered. They also documented procedures to be shared among staff and partners. For example, one grantee began weekly meetings among staff (at the grantee organization and at a partner agency), and another began service delivery to pilot cases to help staff prepare for full-scale implementation. As necessary, grantees also worked with EBP developers to determine how best to implement EBPs in their local contexts.

[27] Data on RPG participants in this report are from RPG2 grantees only.

Table VI.4. Characteristics of RPG3 grantees' local outcome evaluations

Grantee organization	Evaluation design	Expected sample size	Contrast in services the program and comparison groups will receive	Outcome domains	Data sources	Additional analyses
University of Kansas Center for Research, Inc., Kansas	Randomized controlled trial	720 to 864 families (360 to 432 program, 360 to 432 comparison)	**Program group:** Strengthening Families Program: Birth to Three, a family skills training program that focuses on increasing resilience and reducing risk factors in behavioral, emotional, cognitive, and social domains; caregiver substance use disorder assessment; child and parent trauma assessment; and referral. **Comparison group:** An array of business-as-usual services that likely include substance use disorder assessment and referral.	Child well-being Permanency Safety Recovery Family functioning	Direct assessments Administrative records	The grantee will also conduct a process evaluation and a cost study.
Montefiore Medical Center, New York	Matched comparison group design	280 families (80 program, 200 comparison)	**Program group:** Family Treatment/ Rehabilitation program, which provides families with comprehensive clinical assessment of substance use disorder and other clinical and service needs, referrals to treatment and other services, home visits to monitor safety, and case management; Seeking Safety (a trauma-informed treatment to reduce the risk of abuse), Incredible Years (a parenting education program), and contingency reinforcement (financial incentives to keep substance use disorder treatment appointments and maintain abstinence). **Comparison group:** Substance use disorder treatment from Montefiore and business-as-usual services from New York's Administration for Children's Services.	Child well-being Permanency Safety Recovery Family functioning	Direct assessments Administrative records	The grantee will also conduct an implementation evaluation and a partnership study.

Grantee organization	Evaluation design	Expected sample size	Contrast in services the program and comparison groups will receive	Outcome domains	Data sources	Additional analyses
Our Kids of Miami-Dade/Monroe, Inc., Florida	Randomized controlled trial	288 families (144 program, 144 comparison)	**Program group:** The Engaging Moms/Parent Program, which provides additional support for engagement in substance use disorder treatment, family therapy interventions, and supports to improve parenting skills; engagement with a peer specialist; Intensive Family Preservation Services (IFPS); and referral to the Motivational Support Program (MSP), a voluntary program that is the gateway to substance use disorder treatment for families with child welfare involvement. **Comparison group:** IFPS and MSP.	Child well-being Permanency Safety Recovery Family functioning	Direct assessments Administrative records	The grantee will also conduct an implementation evaluation and a partnership study.
Volunteers of America – Oregon (VOAOR), Oregon	Matched comparison group design	400 families (200 program, 200 comparison)	**Program group:** Recovery Oriented System of Care, which includes development of a recovery support plan that includes services aligned with that family's particular needs selected from a menu of options; access to the Family Recovery Support program, which serves as a drop-in center for families; and access to a Certified Peer Recovery Mentor a resource specialist and/or therapist. **Comparison group:** Any available business-as-usual services, though services are likely to be limited because substance abuse treatment will have ended.	Child well-being Permanency Safety Recovery Family functioning	Direct assessments Administrative records	The grantee will also conduct an implementation evaluation and a partnership study.

2. Finalizing evaluation plans

A key step in finalizing local evaluation plans was participating in the evaluability assessment process. This involved fleshing out evaluation plans included in their applications, considering approaches to improve the rigor of their outcome evaluations, making final decisions about what direct assessments to use in their local evaluations, and adjusting their evaluations based on implementation decisions (if needed). All four grantees maintained close communication between program and implementation team members throughout this process and were able either to submit or to finalize their institutional review board (IRB) application by the end of the first six months of the grant.[28] Grantees also worked on establishing agreements with state and local partners for obtaining administrative data related to safety, permanency, and recovery for the cross-site evaluation, and participated in trainings supporting participation in the cross-site evaluation.

E. Challenges and next steps

Each grantee experienced challenges in finalizing program and evaluation plans or starting operations. Most challenges tended to be specific to each grantee. In each case, the grantee worked with the federal team and local partners to develop a solution and move forward. For example, one grantee faced unexpected staff turnover at a key partner organization. The partner organization moved quickly to replace staff that were critical to the RPG3 project, and those staff were successfully integrated into the RPG team. All four of the grantees learned from their early challenges and used these lessons whenever relevant when finalizing their program and evaluation plans.

Because of the substantial progress the four RPG3 projects made during their first six months, they will obtain IRB approval and be able to begin implementing both their programs and their evaluations by September 2015. Key upcoming activities include the following:

- Grantees will conduct outreach activities to recruit eligible families for their RPG services. They will also continue staff training and provide supervision to staff who are providing services.
- To support cross-system collaborations, the grantees will continue regular meetings with their partner agencies.
- For the local and cross-site outcome evaluations, grantees will begin to conduct data collection with families as they enter and exit the RPG program. They will also conduct outreach activities to begin enrolling comparison group members. As necessary, grantees will continue working to establish data-sharing agreements with state agencies for accessing safety, permanency, and recovery data.
- Grantees conducting process evaluations and partner studies will begin collecting data from RPG program staff and partners.

[28] HHS required that grantees obtain IRB review for their planned evaluations.

- To meet the requirements of the cross-site evaluation, grantees will begin providing the evaluation with data, including enrollment and services data, and baseline data that were used in this report to describe RPG2 cases and participants.
- Finally, with program and evaluation procedures established and implementation of both under way, grantees will begin developing plans and strategies to sustain their partnerships and programs after the end of their five-year RPG grants.

VII. LOOKING AHEAD

In the coming year, RPG2 grantees will provide data to the cross-site evaluation. HHS will analyze data from the grantees, along with new data collected through surveys of RPG2 grantee staff and partners. The cross-site evaluation contractor will conduct site visits to all 17 RPG2 grantees to collect additional data on implementation. The RPG3 cohort of grantees will begin enrolling cases in their RPG programs and providing data to the cross-site evaluation, and data from both cohorts will be used in future reports to Congress. HHS will also study the cost of trauma-specific EBPs implemented by grantees in both cohorts. This chapter describes these upcoming activities.

A. RPG2 grantees: Cross-site evaluation data collection

RPG2 grantees will begin their fourth year of activities in October 2015. During the year, they will provide services to participants including through the EBP enrollments described earlier. They will implement their local evaluations, and continue contributing data to the cross-site evaluation. HHS will conduct analysis of two surveys fielded for the cross-site evaluation and conduct site visits to each of the 17 grantee sites.

1. Implementation and outcome data

RPG2 grantees will continue to provide implementation and outcome data for evaluation and reporting through the two web-based data collection systems developed by HHS. In addition to data on enrollment in RPG and individual EBPs discussed in this report, grantees will provide detailed information about services participants receive for the 10 focal EBPs. For these EBPs, grantees will provide data on the number of program or therapy sessions received and who participated, the content and quality of each session, and the degree to which participants actively engage in the sessions. To assess the well-being, family functioning, and recovery outcomes of children, adults, and families, grantees are collecting and will submit data from follow-up administration of the instruments described in chapters III and IV. They will also obtain and submit data from child welfare and substance use disorder treatment records to examine the safety and permanency outcomes of children, and participation in treatment by adults during their enrollment in RPG and up to one year after. HHS will monitor data quality and completeness through use of automated validation procedures and manual examination of data, and will provide feedback and assistance to grantees as they submit data.

2. Staff and partner surveys

Between April and June of 2015, two surveys will be conducted as part of the cross-site evaluation partner and implementation studies—one of RPG2 grantees and their partners, and another of direct service staff working with RPG2 participants.

- Partners who participate in the RPG projects play a crucial role in planning and coordinating services for families across service-delivery systems. The partner survey will be administered to the grantees and their primary partners, including those who refer families to the RPG projects, operate EBPs or provide services to RPG families, and play other key roles in the RPG projects.

- Staff who deliver EBP services contribute directly to the quality of EBP implementation. The staff survey will be administered to staff implementing the 10 focal EBPs being studied in depth. Those to be surveyed include staff who provide direct services to children, adults, and families, such as caseworkers, therapists, and session facilitators, and their supervisors. This group includes staff employed directly by the grantee organization, as well as staff employed by other implementing agencies that are partnering with the grantee.

Analysis. In the next reporting period, HHS will complete analysis of the data collected as part of the RPG2 partner and staff surveys. HHS will summarize quantitative data from the surveys using basic descriptive methods and use the quantitative data to contribute to the implementation and partnerships studies.

The analysis of the partner survey will investigate the quality of collaboration and the extent of service coordination, information about partner characteristics, partners' goals for RPG and their relationships within the partnership, and outputs of the partnerships (e.g., case management, data sharing, and service planning). The partner survey analysis will also examine standardized scales, such as the quality of the collaborative effort among the partners. Finally, using a set of network data, the analysis will describe the levels of communication and collaboration among partner organizations, the size of the partnership, and the density of the partnership (such as how closely connected the partners are within a site).

The analysis of the staff survey will examine information collected on staff characteristics and attitudes toward implementing EBPs, organizational characteristics, staff supports, and implementation experiences. In addition, the analysis will look closely at several standardized scales typically used in implementation research, such as staff retention and implementation climate scales.

3. Site visits

The detailed data submitted by grantees and obtained through surveys provide a valuable picture of RPG implementation. Further, HHS will improve understanding of the design and implementation of RPG projects by conducting, in the fall of 2015, site visits to each of the 17 RPG2 grantees. The visits will focus on the RPG planning process, how and why particular EBPs were selected, the ability of the child welfare, substance use disorder treatment, and other service systems to collaborate to support quality implementation for EBPs, challenges faced, and potential for sustainability. Activities will include individual and small-group interviews conducted by two-person teams.

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

- **Interview with RPG project director and key staff.** Site visits will begin with interviews of the person who directs the RPG project and any key staff (those with major roles in administering the RPG project, such as working with key partners or overseeing program operations). Topics discussed may include the RPG project design, selection of EBPs,

referral sources and processes, state and local context, and implementation experiences, changes to implementation plans, and the potential for sustainability of the projects.

- **Group discussion with partners involved in design and implementation of the RPG project.** Participants in this interview will represent organizations with either (1) a role in the project; or (2) responsibilities for, or affiliations with, key RPG resources, participants, or program elements. Participants could include, but are not limited to, providers of EBPs or services, the child welfare agency or substance use disorder treatment provider involved in RPG, or a key referral source, such as a family treatment drug court. Topics discussed will include the decision processes surrounding the initial design of the RPG project, selection of services and EBPs, implementation plans, and state and community context.
- **Individual interviews with supervisors, managers, and direct service staff of focal EBPs.** Interviews will be conducted with supervisors and managers of a maximum of two focal EBPs implemented as part of the RPG project. The interview will focus on their satisfaction with implementing the EBP, as well as their perceptions about the consistency with which service delivery adheres to the EBP's service delivery guidelines and the quality of service delivery. Individual interviews will take place with two direct service staff in each location where the two focal EBPs are implemented. The interviews will cover the same topics as the individual supervisor and manager interviews but will reflect the perspectives of front-line staff.

C. Cost study

HHS is asking its grantees to adopt and implement trauma-informed services and programs. This is an important focus for RPG projects, because most children involved in child welfare have been exposed to trauma (Kisiel, 2009), and most women in substance use disorder treatment have experienced it (Covington, 2010). Trauma-informed practices are based on an understanding of the vulnerabilities of trauma survivors that traditional service-delivery approaches may trigger or exacerbate, so that these services and programs can be more supportive and avoid retraumatizing participants. Because RPG projects work with both groups, many grantees are also implementing EBPs that are specifically designed to address trauma in children and/or adults, such as Seeking Safety, Trauma-Focused Cognitive Behavioral Therapy, Child-Parent Psychotherapy, and Parent-Child Interaction Therapy (Table VII.2).

HHS believes that information on how RPG projects are addressing trauma would be of high interest to child welfare policymakers, practitioners, and funders and contribute to the knowledge base on trauma-informed care. It has therefore asked grantees to provide information about their efforts as part of their semiannual progress reports. In October 2015, HHS will begin developing data collection instruments for a cost study of trauma-specific EBPs implemented by RPG projects.[29]

At minimum, the study will involve (1) selecting whether to study one or more trauma-specific EBPs or to develop an approach generalizable to all those being used in RPG, (2) developing

[29] A cost analysis was identified at the inception of the cross-site evaluation as a possible optional element of the cross-site evaluation. It was included in the OMB materials, and is thus covered under the OMB clearance for data collection, received on March 18, 2014 (0970-0444).

methods for the study, and (3) creating measures and data collection instruments. Depending on available resources, HHS may be able to pilot-test the instruments and analysis approaches with selected RPG projects and launch a pilot cost study or conduct a full cost study. Even if it is not possible to conduct the cost study as part of RPG, developing an approach and data collection methods will set the stage for a future study and could be used by individual grantees for cost analyses they may wish to conduct.

Table VII.2. Trauma-specific EBPs implemented by RPG2 and RPG3 grantees

Program or practice	Description	No. of grantees offering
Trauma Focused Cognitive Behavior Therapy (TF-CBT)[a]	TF-CBT is a clinic-based model of psychotherapy designed to treat post-traumatic stress and related emotional and behavioral problems in children and adolescents aged 3 to 18.	7
Seeking Safety[a]	Seeking Safety is a manualized treatment for female adolescents and adults with a history of trauma and substance use disorder.	6
Child-Parent Psychotherapy (CPP)[a]	CPP is a model of child and family therapy designed for children aged birth to 5 who have experienced at least one traumatic event and, as a result, are experiencing behavior, attachment, or mental health problems, including post-traumatic stress disorder (PTSD).	4
Parent and Child Interactive Therapy (PCIT)[a]	PCIT, targets families with children aged 3 to 6 who have behavior and parent-child relationship problems; an adaptation is available for physically abusive parents with children aged 4 to 12.	3
Trauma Recovery and Empowerment Model (TREM)	TREM is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse.	1
Attachment, Self-Regulation, and Competence Model (ARC)	ARC is an approach to therapy for youth from early childhood to adolescence who have been exposed to complex trauma. It is a flexible framework rather than a protocol-based intervention.	1
Lifespan Integration[b]	Lifespan Integration therapy guides clients to examine memories to determine the relationship with present-day trauma symptoms and allow the client to gain insight into particular patterns or behaviors.	1
Prolonged Exposure (PE)	PE Therapy for Post-traumatic Stress Disorders is a cognitive-behavioral treatment program for adults aged 18 and over who have experienced single or multiple/continuous traumas and have PTSD.	1
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	SPARCS is a group intervention that was designed specifically to address the needs of chronically traumatized adolescents aged 12 to 19 who may still be living with ongoing stress and are experiencing problems in several areas of functioning.	1

[a] EBP is one of the 10 focal EBPs under in-depth study for the cross-site evaluation.

[b] This program was not included in the evidence review of RPG-proposed interventions.

Data collected for the cost study would focus on resources used for program operations (for example, salaries and benefits, supplies and materials, and contracted services), staff time use, and characteristics of the families served. This information would allow HHS to derive an estimate of the costs per family served and the costs of specific program components. The findings from a cost study could inform the decisions of other agencies wishing to implement trauma-specific EBPs for the families they serve.

In September 2015, HHS will convene an initial workgroup of federal contractors and RPG2 and RPG3 grantees and evaluators to develop the study design, identify the EBP(s) to study and

develop instruments. Pilot-tests of the instruments will occur in the spring or summer of 2016. If feasible, a study among interested RPG grantees will follow.

D. Future reports to Congress

To support program development and improvement and inform stakeholders—including HHS, Congress, and the grantees themselves—results from the cross-site evaluation are released throughout the five-year evaluation period for the grants. Products include annual reports to Congress, annual cross-site evaluation program reports, special topics briefs, and a final evaluation report.

Annual reports to Congress, such as this one, summarize findings from the cross-site evaluation and describe implementation of the grants. The content of each report depends on the phase of the project and available data. Table V.3 summarizes the data sources to be used for the future reports.

Table VII.3. Data sources for future annual reports to Congress

	RPG2 and RPG3		RPG3 only	
Data source	2016	2017	2018	2019
Semiannual progress reports	X	X	X	X
Enrollment and Services Log data collection system (implementation data)	X	X	X	X
Outcome and Implementation Study Information System data collection system (outcomes data)	X	X	X	X
Partner survey	X	X	X	
Staff survey	X	X	X	
Site visits		X		X
Cost study[a]			X	

[a] HHS will issue a separate report on the cost study, but will summarize findings in the 2018 report to Congress.

- The **2016 report** will include findings from the surveys of RPG2 partners, and of staff members providing EBPs being studied in depth for the cross-site evaluation. The report will also include semiannual progress reports, implementation, and outcomes data for RPG3 grantees in addition to RPG2 grantees.
- The **2017 report** is the final report on RPG required by the legislation, as described next. It will make use of all data sources, including site visits conducted with the RPG2 grantees. It will present findings from all four of the cross-site studies, including the impact study that compares participant outcomes among families receiving RPG services against families not receiving RPG services. It will discuss potential implications of the evaluation findings for federal policy and programs addressing the needs of families in which children are in, or at risk of, out-of-home placement as a result of a parent's or caregiver's methamphetamine or other substance use disorder.
- In 2018, a separate **cost study report** will summarize initial findings from the cost study activities conducted with RPG2 and RPG3 grantees.

As required by the legislation, HHS will submit a final report not later than December 2017 evaluating the effectiveness of the grants for fiscal years 2012 through 2016. The report will (1) evaluate the programs and activities conducted, and the services provided, with the grant funds for fiscal years 2007 through 2016; (2) analyze the regional partnerships that have, and have not, been successful in achieving the goals and outcomes specified in their grant applications and with respect to the performance indicators; and (3) analyze the extent to which such grants have been successful in addressing the needs of families with methamphetamine or other substance use disorders who come to the attention of the child welfare system, and in achieving the goals of child safety, permanence, and family stability. HHS will then prepare a restricted-use file of data from the cross-site evaluation. This file will be made available to qualified researchers for future research through the National Data Archive on Child Abuse and Neglect.

Two additional reports to Congress (in 2018 and 2019) will report on the final two years of activity by the RPG3 projects.

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APPENDIX A

RISK INDICATOR TABLES

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

Construct	Risk indicator	Instrument	Description	Criteria for risk category
Substance use severity	High level of alcohol use	Addiction Severity Index (ASI), Self-Report Form (McLellan et al., 1992)	This is an indicator of whether an adult has excessive alcohol use and intoxication frequency, and severity of problems caused by alcohol use, drawn from the alcohol use score.	Alcohol use score is above the national average of people in substance use disorder treatment settings described in McClellan et al. (2006). Specifically, we used an alcohol use score of 0.22 and 0.20 for males and females, respectively, as the threshold.
Substance use severity	High level of drug use	ASI	This is an indicator of whether an adult has excessive drug use and severity of problems caused by drug use, drawn from the drug use score.	Drug use score is above the national average of people in substance use disorder treatment settings described in McClellan et al. (2006). Specifically, we used a drug use score of 0.10 and 0.15 for males and females, respectively, as the threshold.
Adult trauma symptoms	Elevated symptoms of childhood/adult trauma	Trauma Symptom Checklist-40 (TSC-40; Briere & Runtz, 1989)	This is an indicator of whether an adult has symptoms of significant childhood or adult trauma, based on the TSC-40 total score. This score includes the following subscales: anxiety, depression, dissociation, Sexual Abuse Trauma Index (SATI), sexual problems, and sleep disturbance.	TSC-40 total score exceeds an average level computed across the following studies serving high-risk populations (Elliott and Briere, 1992; Zlotnick, 1996; Heffner et al., 2011; Whiffen and Benazon, 1997). Specifically, we used a TSC-40 score of 33.4 as the threshold for both males and females.

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

Construct	Risk indicator	Instrument	Description	Criteria for risk category
Parenting stress	Elevated level of parenting stress	Parental Stress Index–Short Form (PSI-SF) (Abidin, 1995)	This is an indicator of whether a caregiver has a clinically significant level of stress, based on the PSI total score. This score is a summary of the overall level of parenting stress, drawing on information from the parental distress, parent-child dysfunctional interaction, and difficult child scales.	PSI-SF total score in the "clinically significant" range described in the PSI-SF test manual.
Depressive symptoms	Symptoms of severe depression	Center for Epidemiologic Studies Depression Scale (CES-D), 12-Item Short Form (Radloff, 1977)	This is an indicator of whether an adult demonstrates severe depression symptoms, based on the CES-D total score.	CES-D total score in the "severely depressed" range described in the CES-D test manual.
Parenting attitudes	Inappropriate expectations for child	Adult-Adolescent Parenting Inventory (AAPI-2; Bavolek & Keene,1999)	This is an indicator of whether a caregiver has inappropriate or unrealistic expectations for a child's development, based on the AAPI-2 expectations score.	AAPI-2 expectations score in the "high risk for child maltreatment" range described in the AAPI-2 test manual.
Parenting attitudes	Lack of empathy for child	AAPI-2	This is an indicator of whether a caregiver has low levels of empathy/nurturing for their child, based on the AAPI-2 empathy score.	AAPI-2 empathy score in the "high risk for child maltreatment" range described in the AAPI-2 test manual.
Parenting attitudes	Values corporal punishment	AAPI-2	This is an indicator of whether a caregiver is overly reliant on corporal punishment as a means of discipline, based on the AAPI-2 corporal punishment score.	AAPI-2 corporal punishment score in the "high risk for child maltreatment" range described in the AAPI-2 test manual.
Parenting attitudes	Treats child like an adult peer, not a child	AAPI-2	This is an indicator of whether a caregiver perceives a child as a means to meet self-needs (i.e., an object for adult gratification), based on the AAPI-2 family roles score.	AAPI-2 family roles score in the "high risk for child maltreatment" range described in the AAPI-2 test manual.
Parenting attitudes	Oppresses child's independence	AAPI-2	This is an indicator of whether a caregiver has inappropriate understanding of child independence (i.e., interprets independence as a threat or as disrespect to the caregiver), based on the AAPI-2 power/independence score.	AAPI-2 power/independence score in the "high risk for child maltreatment" range described in the AAPI-2 test manual.

Table A.3. Child well-being risk indicators

Child well-being aspect	Risk indicator	Instrument	Description	Criteria for risk category
Executive functioning	Impairments in executive functioning	Behavior Rating of Executive Function–Preschool (BRIEF-P; Gioia et al., 2000)	This is an indicator of clinically significant impairments in global executive functioning, drawn from the global executive composite summary score. This score captures information on all the instrument's clinical scales, including scores on the (1) inhibit, (2) shift, (3) emotional control, (4) working memory, and (5) plan/organize scales.	Global composite summary score exceeded the clinically significant threshold described in the BRIEF-P test manual.
Executive functioning	Impairments in executive functioning	Behavior Rating of Executive Function (BRIEF; Gioia et al., 2000)	This is an indicator of clinically significant impairments in global executive functioning, drawn from the global executive composite summary score. This score captures information using the same clinical scales as the BRIEF-P, with the addition of the (1) initiate, (2) organization of materials, and (3) monitor scales.	Global composite summary score exceeded the clinically significant threshold described in the BRIEF test manual.
Sensory processing	Atypical sensory-processing ability	Infant-Toddler Sensory Profile (ITSP; Dunn, 2002)	This is an indicator of whether a child has scores that suggest sensory-processing difficulties, drawn from the low threshold score, a composite of the low sensory sensitivity and sensation avoiding scales.	Low threshold scores placed them outside the typical range described in the ITSP test manual. This could have been caused by either under-responsiveness or over-responsiveness to stimuli.
Child emotional and behavioral problems	Emotional problems	Child Behavior Checklist Preschool Form (CBCL-PS; Achenbach & Rescorla, 2000; 2001)	This is an indicator of problematic levels of internalizing (inward looking) behaviors, drawn from the internalizing problems scale score. This composite score is made up of four scales: the emotionally reactive, anxious/depressed, somatic complaints, and withdrawn scales.	Internalizing problems scale score exceeded the clinically significant threshold described in the CBCL-PS test manual.
Child emotional and behavioral problems	Emotional problems	Child Behavior Checklist School Age Form (CBCL-SA; Achenbach & Rescorla, 2000; 2001)	This is an indicator of problematic levels of internalizing (inward looking) behaviors, drawn from the internalizing problems scale score. This composite score is made up of three scales: the anxious/depressed, withdrawn/depressed, and somatic complaints scales.	Internalizing problems scale score exceeded the clinically significant threshold described in the CBCL-SA test manual.
Child emotional and behavioral problems	Behavioral problems	CBCL-PS	This is an indicator of problematic levels of externalizing (outward looking) behaviors, drawn from the externalizing problems scale score. This composite score is made up of two scales: the attention problems and aggressive behavior scales.	Externalizing problems scale score exceeded the clinically significant threshold described in the CBCL-PS test manual.
Child emotional and behavioral problems	Behavioral problems	CBCL-SA	This is an indicator of problematic levels of externalizing (outward looking) behaviors, drawn from the externalizing problems scale score. This composite score is made up of two scales: the rule breaking and aggressive behavior scales.	Externalizing problems scale score exceeded the clinically significant threshold described in the CBCL-SA test manual.

Child well-being aspect	Risk indicator	Instrument	Description	Criteria for risk category
Child emotional and behavioral problems	Emotional, behavioral, and other problems	CBCL-PS	This is an indicator of problematic levels of general behavior and emotional and social functioning, drawn from the total problems score. This composite score is made up of the scales in both the internalizing and externalizing behavior scale scores, combined with two additional scales: sleep problems and other problems.	Total problems scale score exceeded the clinically significant threshold described in the CBCL-PS test manual.
Child emotional and behavioral problems	Emotional, behavioral, and other problems	CBCL-SA	This is an indicator of problematic levels of general behavior and emotional and social functioning, drawn from the total problems score. This composite score is made up of the scales in both the internalizing and externalizing behavior scale scores, combined with four additional scales: social problems, thought problems, attention problems, and other problems.	Total problems scale score exceeded the clinically significant threshold described in the CBCL-SA test manual.
Social and adaptive behavior	Poor social skills	Socialization Subscale, Vineland Adaptive Behavior Scales, Second Edition, Parent-Caregiver Rating Form (Vineland II; Sparrow et al., 2005)	This is an indicator of whether a child has scores that suggest problematic levels of social skills, drawn from the socialization domain score. This score is a summary of information on the interpersonal relationships, play and leisure time, and coping skills subdomains.	The socialization score placed them in the lowest of five adaptive behavior levels as described in the Vineland II test manual.
Trauma symptoms	Post-traumatic Stress Disorder (PTSD) symptoms	Trauma Symptom Checklist for Young Children (TSCYC; Briere et al., 2001)	This is an indicator of whether a child has exhibited PTSD symptoms, drawn from the TSCYC total score. This score captures information from the following scales: (1) post-traumatic stress–intrusion, (2) post-traumatic stress–avoidance, (3) post-traumatic stress–arousal.	Post-traumatic Stress – Total score exceeded PTSD symptom threshold described in TSCYC manual.

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