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

August 2015

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

Second Annual Report to Congress

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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RPG
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Children's Bureau

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EXECUTIVE SUMMARY

The strong correlation between substance use disorders and child maltreatment has harmful consequences for children and presents serious challenges for organizations trying to assist them. An estimated 50 to 80 percent of child welfare cases involve a parent who misuses substances (Niccols et al., 2012; U.S. Department of Health and Human Services 1999). Further, children involved with child welfare who have parents with substance use disorders are more likely than other children in the child welfare system to experience subsequent referrals to child protective services (Connell, Bergeron, Katz, Saunders, & Tebes, 2007), have longer stays in foster care (Vanderploeg et al., 2007), and are more likely to reenter foster care (Brook & McDonald, 2009).

Although staff in both child welfare and substance abuse treatment systems generally endorse the need for simultaneously addressing substance use and child welfare issues (Drabble, 2007), the systems are not always well equipped to do so. The need for collaboration and coordination is clear, but the best way to move forward is not.

Since 2006, Congress has authorized competitive grants to address problems resulting from a family's involvement in the child welfare system due to a parent with a substance use disorder. The Child and Family Services Improvement Act of 2006 (P.L. 109-288) provided funding over a five-year period to implement regional partnerships among child welfare, substance abuse treatment, and related organizations 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 methamphetamine or other 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 and funded the first round of grants.[1]

The Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) reauthorized the RPG program and extended funding through 2016. With the funding, HHS offered new competitive grants up to $1 million per year for five years (ACF, 2012a).[2] On September 28, 2012, the Children's Bureau awarded RPG funding under the grant program to 17 partnerships in 15 states (Table 1).

HHS will provide Congress with information on the five-year 2012 RPG program, through annual reports. The first report to Congress (HHS, 2014) focused on the award and initial implementation of the RPG2 program—those grants that the Children's Bureau awarded in 2012 following reauthorization. The purpose of this second report to Congress is to describe progress in the early implementation of the 2012 RPG projects. The main source of data for this report is the semiannual progress reports that grantees submitted in October 2013 and April 2014 (each covering their activities for the prior 6 months).

[1] Information on program implementation and grantee performance for the 2007 RPG program—which funded awards over a five-year period–is available in three reports to Congress (HHS May 2010, December 2012, and March 2014), available at [http://www.ncsacw.samhsa.gov/technical/rpg-i.aspx].

[2] HHS also offered existing grantees new grants of $500,000 per year for up to two years (ACF 2012c) to extend their programs. This report does not discuss those grants.

Table 1. Grantees

Grantee	State
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

*Also received RPG grant awards under the 2006 authorization

A. Supporting the grantees

While HHS makes the grants to the RPG partnerships, it also provides other important supports to fulfill the intent and requirements of the RPG authorizing legislation. Specifically, HHS provided technical assistance (TA) and training to RPG grantees through two federal contractors. During this reporting period, HHS also completed development of infrastructure needed to obtain evaluation and performance indicator data from grantees.

1. TA and training

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 for 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.

Most of the formal requests grantees made during this reporting period were for program TA. The 17 RPG grantees made a total of 63 requests 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 abuse treatment, and services agencies to expand their understanding of all three systems; planning to sustain the RPG projects after the grant program ends; and addressing underlying values among partners. Grantees also sought assistance to improve their ability to engage and retain clients and establish peer support programs for RPG participants, and to implement evidence-based practices or interventions. Special attention was

given to engaging and retaining clients in RPG—an ongoing challenge given the nature of the target populations served through RPG.

In addition to the program TA requests to NCSACW, Mathematica received 14 requests to provide TA on evaluation-related topics during the second year of the 2012 RPG program. In total, 8 of the 17 grantees (or RPG federal project officers on behalf of grantees) requested evaluation-related TA. Half the TA requests related to questions about data collection plans, which reflected the fact that most grantees were preparing to collect evaluation data. Mathematica also created a "help desk" system in March 2014, to quickly address questions on individual data collection instruments and processes. The help desk received 69 inquiries through June 2014.

Along with one-on-one assistance, both contractors provided additional TA and training through webinars or at in-person seminars and discussions for RPG grantees and evaluators that were held in conjunction with the 19th annual National Conference on Child Abuse and Neglect in April, 2014.

2. Milestones reached

In addition to providing TA to grantees through their contractors, HHS, reached a number of milestones during the second year of the 2012 RPG program. Highlights of 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 (P.L. No. 96-511, 94 Stat. 2812, codified at 44 U.S.C. § 3501-3521). Finally, HHS completed web-based data collection systems grantees will use 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.

B. Partnerships

The RPG program was designed to support and enhance collaborative relationships between agencies to provide integrated services to families involved in both the child welfare and the substance abuse treatment systems. 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 services providers. Yet families' needs often overlap the different systems and thus require that agencies collaborate to address them. To apply for RPG funding, grantees formed partnerships they will continue to develop and work with throughout the grant period.

As of April 2014, grantees reported having between 5 and 30 partners, with an average of 13. In an effort to meet the needs of families, eight sites added new partners to their RPG partnerships during the year—six grantees added 1 to 3 partners, one added 6, and one added 11. Several sites made targeted efforts to include members of the legal community (such as attorneys, judges, court administrators, and guardians ad litem) in their RPG projects. The public school system, community service boards, and child welfare agencies in rural areas were other

targeted partners in some jurisdictions. In all, eight RPG grantees brought 26 new partners into their collaboratives over the past year.

During the second year of the 2012 RPG program, grantees continued their efforts to develop, strengthen, and expand their partnerships and establish procedures and structures for collaboration. RPG grantees and their partners worked to clearly define fundamental components of their collaborations and their overall governance structures. Identifying and working through differences across partner agencies in underlying values and guiding principles was one important goal for several grantees. In conjunction with strengthening relationships, the grantees and their partners continued to develop and clarify mechanisms for coordination, such as data use agreements or data-sharing procedures. Grantees mapped the flow of clients through their RPG projects and also mapped local resources available to children and families in their service areas. Grantees and their partners worked creatively to improve collaboration and to address challenges. Thus, most grantees and their partners were able to successfully initiate RPG project operations during Year 2 and begin serving families in need.

C. Programs

Grantees and their partnerships were at different stages when the RPG2 grants began in October 2012. Some were continuing existing programs funded in the first round of RPG grants made in 2007, while others were receiving RPG grants for the first time and hence establishing new programs. Grantees progressed toward initiating enrollment at different rates, and during the reporting period 11 grantees made changes to the evidence-based programs and practices (EBPs) or services they planned to offer participants in response to changing circumstances or better understanding of client needs. Overall, grantees made substantial progress implementing their programs. By April 2014 16 of the 17 grantees had begun enrollment. The number of people 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.

1. Addressing trauma

In response to scientific findings that continue to emerge about the long-term neurological, behavioral, relational, and other impacts of maltreatment on children, HHS has urged states and child welfare systems to do more to attend to children's behavioral, emotional, and social functioning. One component of this process is addressing the impact of trauma resulting from maltreatment or other adverse experiences, and its effect on the overall functioning of children and youth. A national sample of over 2,220 children in child welfare found that over 70 percent met criteria for having been exposed to trauma (Greeson et al., 2011).

RPG grantees were addressing 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 (SAMHSA n.d.(a)). Ten grantees implemented EBPs specifically designed to address child and/or adult trauma.

2. Contextual factors

Not only their own efforts but also external factors affected grantees' progress implementing their RPG projects. Fourteen grantees in 12 states described contextual factors that affected their RPG projects (Table IV.3).[3] Three main types of factors were cited: (1) factors related to child welfare (reported by 11 grantees in 10 states); (2) factors related to substance use, or policies affecting substance use treatment or individuals with substance use disorders (reported by 7 grantees); and (3) fiscal or economic factors at the federal or state levels (reported by 7 grantees). Five grantees in four states also mentioned in their semiannual progress reports that health care reform or elements of the Affordable Care Act influenced their work.

D. Evaluation

To address the goals and requirements of the legislation, and to contribute knowledge to the fields of child welfare and substance abuse treatment programming, HHS required local and cross-site RPG evaluations. Specifically, grantees must evaluate their RPG projects, using rigorous designs when possible and high quality measures. These local evaluations then contribute data to the national cross-site evaluation.

During the past year, grantees and local evaluators worked with HHS to finalize research designs and begin local evaluations. The process included identifying appropriate comparison groups, when possible; establishing partnerships and agreements with other agencies; and acquiring data collection instruments for the cross-site evaluation. Grantee teams made progress on all fronts, but encountered some challenges as well—such as reaching and enrolling their target populations, establishing appropriate comparison groups to test the effectiveness of their RPG projects, and forming productive partnerships between grantees and evaluators.

1. Status of local evaluations

In the past year, grantees and local evaluators have, in most cases, finalized their designs and begun executing them. This has required substantial planning, including obtaining approval for the designs and planning the logistics of data collection. As with any evaluation, the teams have experienced successes and challenges. HHS required that grantees seek and obtain Institutional Review Board (IRB) approval for their designs. IRBs review the design to ensure appropriate protections are in place for human subjects, including fully informed consent and the protection of confidentiality. As of April 2014, 15 grantees had obtained IRB approval for the local evaluations, and others had applied for approval. By that time, of the 19 local evaluations (two grantees are conducting two 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.

2. Data sharing

Using administrative data in an evaluation capitalizes on information collected primarily for other purposes. Administrative data may be more complete and accurate than self-reported data,

[3] Grantees were asked to "describe any significant contextual conditions, events, or community changes that took place during the reporting period which have already had or will likely have an impact on your project or the outcomes you are measuring for your target population." They were also asked whether their RPG project "experienced any significant challenges during the reporting period as a result of the current fiscal environment."

for example, if the information is sensitive or covers a long period of time over which an individual might forget some pertinent information. It may also be less costly to collect than other forms of data. Accordingly, federal agencies such as OMB and the Government Accountability Office encourage government agencies to use administrative data in creative ways to explore relevant results (Burwell et al., 2013; U.S. Government Accountability Office, 2013). Specific to the field of child welfare, the ACF strongly urges child welfare agencies to share data with discretionary grant projects funded by the Children's Bureau, or related federally funded initiatives (ACYF-CB-IM-13-02, 2013).

For the RPG evaluations, grantees were encouraged to obtain administrative data on child welfare in order to measure outcomes for their local evaluations, and to measure child safety and permanency for the cross-site evaluation. In addition to child welfare data, grantees were asked to obtain data on substance abuse treatment to measure adult recovery from substance use dependence for the cross-site evaluation. In some cases, the RPG grantees themselves were state agencies responsible for child welfare or state agencies responsible for publicly funded substance abuse treatment programs, and thus had the data in house. Otherwise, so that they could obtain administrative data of either or both types, grantees were encouraged to develop data-sharing agreements or memoranda of understanding with state or county agencies to obtain the data.

Many of the state agencies were willing partners that were working with grantees and local evaluators to share administrative data on families served by RPG. At least in the initial stages, grantees were generally more successful establishing agreements with child welfare agencies, likely in part because of past experience working together. However, as of March 2014, five of the grantees did not have agreements to obtain child welfare data, and nine did not have agreements for substance abuse treatment data. State agencies may be reluctant to share information if they do not have established relationships with the requesting organizations. Such agencies also have competing demands and often find it difficult to marshal the resources for data requests. The experience of the 2012 RPG grantees has also shown that the expected data are not always available or accessible. In some cases, these challenges undermine or prevent the use of administrative data for evaluation purposes.

E. Looking ahead

HHS received OMB clearance for the cross-site evaluation in March 2013. HHS then began providing data collection materials to the grantees, and initiated training on the data collection systems being developed for grantees to submit implementation and outcome data. Most grantees have launched data collection and other evaluation activities and in the next reporting period will be submitting data to the cross-site evaluation. In the coming year, HHS will also field two surveys for the cross-site evaluation.

1. Submission and collection of data for the cross-site evaluation

To facilitate the implementation study component of the RPG cross-site evaluation, HHS developed a web-based data collection system during Year 2. The "enrollment and services log" (ESL) component of the system was launched in early June of 2014. Grantee staff use the ESL to provide:

- Demographic information about RPG case members at enrollment.[4]
- Enrollment and exit dates for each case that enrolls in the RPG project.
- Enrollment and exit dates for all EBPs that are offered as part of the RPG project.
- Information on each service delivery contact for any of the 10 focal EBPs implemented by the grantee.

The cross-site evaluation outcomes study provides an opportunity to describe the changes that occur in children, adults, and families who participate in the 17 RPG projects. The outcomes study will use primary data and administrative data collected or obtained by the grantees and their evaluators. Beginning in October 2014, grantees submitted data from standardized instruments and administrative sources twice each year to the Outcome and Impact Study Information System (OAISIS), a second component of the RPG online data collection system.

In addition to obtaining data from grantees, between April and June of 2015 Mathematica conducted two surveys as part of the cross-site evaluation partner and implementation studies—one of RPG grantees and their partners, and another of direct service staff working with RPG participants.

2. Funding a third round of RPG grants

On January 9, 2014, HHS published a grants forecast announcing its intention to provide additional targeted RPG competitive grant funds. HHS anticipated making four grants ranging from $500,000 to $600,000 per year for five years. The newly funded partnerships would be subject to the requirements of the Child and Family Services Improvement and Innovation Act of 2011 that re-authorized RPG. They would also 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, and EBPs that are also trauma-informed and targeted to the identified population.
- To conduct an evaluation sufficiently rigorous to contribute to the evidence base on service delivery and outcomes associated with the project's chosen interventions.

In April 2014, HHS released a funding opportunity announcement for the grants (ACF, 2014), which will become 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. The new partnerships will be expected to participate to the extent practicable in the national RPG cross-site evaluation, including the implementation, partnership, and outcomes studies, as well as an impact study if appropriate given the design of their local evaluations. Future reports to Congress will provide information on the 2015 cohort of grantees.

[4] For the cross-site evaluation, an RPG case is the group of people who present themselves to enroll in an RPG program. A case may be a family or household in which some members are biologically related and some are not.

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I. INTRODUCTION

The strong correlation between substance use disorders and child maltreatment has harmful consequences for children and presents serious challenges for organizations trying to assist them. An estimated 50 to 80 percent of child welfare cases involve a parent who misuses substances (Niccols et al., 2012; U.S. Department of Health and Human Services 1999). Further, children involved with child welfare who have parents with substance use disorders are more likely than other children in the child welfare system to experience subsequent referrals to child protective services (Connell, Bergeron, Katz, Saunders, & Tebes, 2007), have longer stays in foster care (Vanderploeg et al., 2007), and are more likely to reenter foster care (Brook & McDonald, 2009).

Although staff in both child welfare and substance abuse treatment systems generally endorse the need for simultaneously addressing substance use 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 abuse disorders unless they lead to abuse or neglect and is not designed to manage them (Young, Boles, & Otero, 2007). Recovery from a substance use disorder is likely to be prolonged and may include relapses, whereas children need safe and stable environments immediately (U.S. Department of Health and Human Services 1999). 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 can impede collaboration (U.S. Department of Health and Human Services 1999; Marsh & Smith 2011; Semidei, Radel, & Nolan, 2001). The need for collaboration and coordination is clear, but the best way to move forward is not.

A. The Regional Partnership Grant Program

Since 2006, Congress has authorized competitive grants to address problems resulting from a family's involvement in the child welfare system due to a parent with a substance use disorder. The Child and Family Services Improvement Act of 2006 (P.L. 109-288) provided funding over a five-year period to implement regional partnerships among child welfare, substance abuse treatment, and related organizations 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 methamphetamine or other 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 and funded the first round of grants.[5]

The Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) reauthorized the RPG program and extended funding through 2016. With the funding, HHS offered new competitive grants up to $1 million per year for five years (ACF, 2012a).[6] On September 28, 2012, the Children's Bureau awarded RPG funding under the grant program to 17 partnerships in 15 states (Table I.1).

[5] Information on program implementation and grantee performance for the 2007 RPG program is available in three reports to Congress (HHS 2010, 2012, and 2014), available at [http://www.ncsacw.samhsa.gov/technical/rpg-i.aspx].

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

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

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

Source: RPG grant applications.

[a]Recipient of prior RPG grant.

The 2012 "RPG2" funding differs from the original 2007 "RPG1" funding in several ways:[7]

- Removed emphasis on methamphetamine. The legislation reauthorizing the RPG program removed most references to methamphetamine, including the requirement that gave weight to grant applications focused on methamphetamine use.
- **Reports.** HHS must now evaluate and report on the effectiveness of the grants. The reauthorizing legislation required a report on the first round of RPG funding by December 31, 2012, and on 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.

In addition to implementing these changes, HHS made the following updates to the RPG2 grant program:

- Grantees are required to adopt and implement programs and services that are *trauma-informed*. One component of this process is addressing the impact of trauma and its effect on the overall functioning of children and youth.
- HHS required that grantees adopt and implement specific, well-defined program services and activities that were *evidence-based* or *evidence-informed*. Since the first round of RPG funding, federal leaders and policymakers have increasingly emphasized evidence-based and evidence-informed practices in their budgeting and program decisions (Haskins and Baron 2011).
- Reflecting the emphasis on evidence-based practices, HHS established a cross-site evaluation to test innovative approaches and to develop and disseminate knowledge about what works to improve outcomes for affected children and youth. It also required that grantees conduct well-designed outcome evaluations and contribute to the cross-site evaluation.
- To support the expanded evaluation requirements, HHS added evaluation-related technical assistance (TA) to the programmatic TA provided to earlier grantees.

1. What are trauma-informed programs and practices?

In response to scientific findings that continue to emerge about the long-term neurological, behavioral, relational, and other impacts of maltreatment on children, HHS is urging states and child welfare systems to do more to attend to children's behavioral, emotional, and social functioning (Samuels 2012; ACF, 2012b). Most children involved in child welfare have been exposed to some form of trauma, whether from sexual, physical, or emotional abuse; neglect; domestic, school, or community violence; or severe caregiver impairment (Kisiel et al. 2009). Therefore, RPG grantees are required to adopt and implement programs and services that are *trauma-informed*. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities of trauma survivors that traditional service-delivery

[7] For more information, including the reauthorizing legislation and a summary of changes, see [http://www.acf.hhs.gov/sites/default/files/cb/im1106.pdf].

approaches may trigger or exacerbate, so that these services and programs can be more supportive and avoid retraumatizing participants (SAMHSA n.d.(a)).

2. What are "evidence-based" programs and practices?

HHS required that RPG applicants propose specific, well-defined program services and activities that were *evidence-based* or *evidence-informed*. Evidence-based programs or practices are those that evaluation research has shown to be effective (SAMHSA n.d.(b)). The concept of an evidence-based practice first emerged in medicine, where researchers defined it as the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals" (Sackett et al. 1996). In medicine, randomized controlled trials are considered the ideal means to establish that an intervention is effective (Steinberg and Luce 2005). Other fields have adopted the concept of evidence-based practices or programs, although evidence may be more difficult to establish if ethical and practical constraints preclude the use of random assignment evaluation methods (Mattox and Kilburn n.d.). Evidence-informed practices use the best available research and practice knowledge to guide program design and implementation (U.S. Department of Health and Human Services 2011). This informed practice allows for innovation while incorporating the lessons learned from the existing research literature.

Policymakers, funders, program model developers, providers and practitioners, and researchers have in recent years devoted more effort and resources to testing the effectiveness of programs through rigorous evaluations. To help ensure that federal dollars are invested wisely, HHS and other federal agencies have increasingly required applicants for discretionary grants to select programs and practices with evidence supporting their effectiveness as a criterion of receiving funds. To expand knowledge of whether and when interventions are effective, federal funders often require that grantees evaluate their grant-funded programs and participate in well-designed federally sponsored cross-site evaluations.

3. The RPG cross-site evaluation

Consistent with this growing emphasis on evidence and evaluation, the Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34), which reauthorized RPG, required that HHS evaluate the effectiveness of grants awarded under the legislation. In addition, the law mandated that HHS establish indicators to assess the performance of grant recipients. To comply with these requirements, as well as to contribute knowledge to the fields of child welfare and substance abuse treatment programming, HHS requires that RPG grantees conduct evaluations and participate in a national cross-site evaluation, which includes providing data for assessing performance and program effectiveness. In September 2012, HHS awarded a contract to Mathematica Policy Research to assist grantees in designing and conducting rigorous evaluations, and to design and conduct a national cross-site evaluation.

The cross-site evaluation is designed to address the following research questions:

1. Who was involved in each RPG project, and how did the partners work together? To what extent were the grantees and their partners prepared to sustain their projects by the end of the grant period?

2. Who were the target populations of the RPG projects? Did RPG projects reach their intended target populations?
3. Which EBPs did the RPG projects select? How well did they align with RPG projects' target populations and goals?
4. What procedures, infrastructure, and supports were in place to facilitate implementation of the EBPs?
5. How were the EBPs implemented? What services were provided? What were the characteristics of enrolled participants?
6. To what extent were the RPG projects prepared to sustain their EBPs at the end of the grant period?
7. What were the well-being, permanency, and safety outcomes of children, and the recovery outcomes of adults, who received services from the RPG projects?

The questions will be addressed through four main components of the cross-site evaluation:

- **Implementation study**. The RPG cross-site evaluation will examine the process of implementation in the 17 RPG projects, with a focus on factors shown in the research literature to be associated with quality implementation of evidence-based approaches (Fixsen et al. 2013; Meyers et al. 2012). The EBPs selected by grantees are the primary focus of the implementation study. Data for the implementation study are being obtained from (1) grantees' semiannual progress reports, (2) a survey of staff providing selected EBPs to RPG participants, (3) site visits, and (4) a web-based system in which grantees enter participant-level data on RPG enrollment and services.
- **Partnership study.** The cross-site evaluation will provide a description of the partnerships formed by each of the 17 RPG grantees, agencies in the community implementing RPG services, and organizations who have come together to support the RPG program. The partnership study will draw on three main data sources: (1) the semiannual progress reports, (2) surveys of the RPG partners, and (3) site visits.
- **Outcomes study.** The RPG cross-site evaluation will also describe the changes that occur in children and adults who participate in the 17 RPG projects. The outcomes study examines five domains of interest to Congress and HHS: (1) child well-being, (2) permanency, (3) safety, (4) adult recovery, and (5) family functioning/stability. To address these domains, the outcomes study will use primary data and administrative data collected or obtained by the grantees and their evaluators. So that change can be measured over time, grantees are asked to collect data before and after receipt of RPG services, and to submit data at regular intervals to the cross- site evaluation.
- **Impact study.** HHS is interested in assessing the effectiveness of programs proposed by the grantees. To meet this objective, the cross-site evaluation will include an impact study among a subset of grantees with the ability to provide suitable data for such a study. The impact study examines the effect of the interventions by comparing outcomes for people with access to RPG services with those in groups that do not receive the RPG services but may receive a different set of services (business as usual). Grantees included in the cross-site

impact study will provide to the cross-site evaluation outcome data on their comparison groups, as well as on RPG program participants.

4. Program and evaluation TA

Partnerships selected for RPG grant awards receive the significant benefit of federal funding to help address their stated goals, but they also shoulder important responsibilities. To support their efforts, HHS provides TA to the grantees, through two federal contractors. As part of its contract to manage the National Center for Substance Abuse and Child Welfare (NCSACW, which is funded by ACYF and the Substance Abuse and Mental Health Services Administration, SAMHSA), 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.

For both program and evaluation TA, the approach is structured but flexible. Each grantee has a designated program management liaison (PML), assigned by NCSACW, and a cross-site evaluation liaison (CSL), assigned by Mathematica. These liaisons provide program- and evaluation-related TA, respectively. Programmatic issues can affect an evaluation, for example, if services change or participation is low. Thus the liaisons work together with grantees to provide integrated support. Both contractors also coordinate their efforts and work closely with HHS to ensure a united, cohesive, and cost-effective effort.

B. The 2012 grantees

RPG funding supports interagency collaborations and program integration designed to increase the well-being, improve the permanency, and enhance the safety of children who are in, or at risk of, out-of-home placements as a result of a parent's or caretaker's substance use disorder. In 2011, Congress authorized $20 million annually for the RPG program. In response to the grant announcement released April 16, 2012, HHS received over 70 applications for RPG funding, and awarded 17 grants in 15 states.

Grant amounts ranged from $500,000 to $1 million annually, with increasing percentages of required grantee matching funds. Ten of the grantees also received earlier RPG funding; the other seven are new to the RPG program. Grantees are mainly state agencies or local service providers (Table I.2):

- Six grantees are state agencies: four are child welfare or substance abuse services agencies, and one is a judicial branch. In one state, the state child welfare and substance abuse services agency jointly received the grant.
- One grantee is a county child welfare agency.
- Nine grantees are organizations that provide services to individuals and families: three are substance abuse treatment providers, three are health or mental health services providers, and three provide child welfare or other child and family services.
- The final grantee is a university research foundation.

Table I.2. Grantees and planned target population and program focus

State	Grantee Organization	Organization type	RPG1 grantee*	Federal grant amount	Planned target population and program focus
California	Center Point, Inc.	Substance abuse treatment agency/ provider	Yes	$500,000	Center Point will provide substance abuse treatment and complementary services to women with diagnosable substance use disorders and their children aged 0–5 who are in or at risk of an out-of-home placement. Pregnant women will also be eligible. The program will include residential substance abuse treatment, on-site parenting/family-strengthening services, Head Start and other child development services, employment preparedness services, and case management. Participants will also receive post-discharge home visits.
Georgia	Georgia State University Research Foundation, Inc.	State university	No	$790,452	The grantee and its partners will provide evidence-based parenting and trauma services to adult criminal drug court clients and their children. In addition to "standard" drug court services—such as abuse treatment, random drug screenings, and graduated sanctions and incentives—participants will receive adult and child trauma treatment and parenting/family strengthening services, all of which are delivered in an integrated manner.
Iowa	Judicial Branch, State of Iowa	State judicial agency	Yes	$500,000	Iowa's Judicial Branch will pilot a new service-delivery and care-coordination system for families in one of the state's family treatment courts. The program will serve families with children aged 0–12 in which parents have substance use disorders and children are in or at risk of placement in foster care. Participating families will receive parenting/family strengthening services, and family members are also assessed for trauma and referred to trauma treatment as needed.
Iowa	Northwest Iowa Mental Health Center/Seasons Center	Community mental health service provider	No	$500,000	Seasons Center offers trauma treatment programs to families with children aged 0–18 who are in or at risk of an out-of-home placement as a result of a caregiver's substance use disorder and who have experienced trauma. Participating families will receive one of four programs that aim to help parents and children recover from trauma and strengthen their bonds.

Table I.2 (*continued*)

State	Grantee Organization	Organization type	RPG1 grantee*	Federal grant amount	Planned target population and program focus
Illinois	Children's Research Triangle	Child and family services provider	Yes	$999,799	The grantee will operate the Project Thrive program, which provides customized, comprehensive well-being services for children who are in out-of-home care due to substance use disorders in their families and who also screen positive for trauma or mental health issues. Participating children will receive services from SOS Children's Villages, an alternative foster care system, and are assigned to a family support specialist who links them and their families to a customized package of coordinated, integrated services, as well as a case manager. An integrated team of clinicians delivers services, which may include trauma treatment, parenting/family-strengthening services, or child-caregiver therapy. In addition, program group foster parents may be able to participate in support groups and other group activities.
Kentucky	Kentucky Department for Community Based Services	State child welfare agency	Yes	$500,000	Through the Sobriety Treatment and Recovery Teams (START) program, the grantee will provide in-home support and access to wraparound services to families with children aged 0–5 that are at risk of an out-of-home placement due primarily to a parent's substance use disorder. Participating families will receive case management from a START worker—a specially trained child protective services worker—and additional support from a family mentor, a specialist in peer support for long-term addiction recovery. START workers and mentors visit families in their homes to deliver substance abuse treatment, child-caregiver therapy, parent training, and trauma treatment.
Massachusetts	Commonwealth of Massachusetts	State child welfare agency and state substance abuse services agency received grant jointly	Yes	$750,000	The grantee's RPG-funded program, the Family Recovery Project Southeast, will provide coordinated, in-home substance abuse treatment, parenting/family-strengthening services, trauma treatment, and case management services. The program will serve families whose children have been removed or are at imminent risk of removal from the home, and in which parents have substance use disorders but have been difficult to engage in treatment. Participating families will receive weekly or more frequent visits from a family recovery specialist who provides services, coordinates with the child welfare case manager, and helps the family transition to community-based services.

Table I.2 (*continued*)

State	Grantee Organization	Organization type	RPG1 grantee*	Federal grant amount	Planned target population and program focus
Maine	Families and Children Together	Child welfare services provider	No	$797,405	The Penquis Regional Linking Project, the program funded by RPG, will provide case management and service linkages to rural families with children aged 0–5 who are in or at risk of an out-of-home placement and who face issues related to caregiver substance use disorders. Expectant mothers will also be eligible. Participating families will be assigned to a "navigator" who will assess their needs and refer them to parenting/family-strengthening services and/or substance use disorder screening services as appropriate. Navigators will also help families build formal and informal supports and work to reduce barriers to accessing services. In addition, families will have access to financial assistance for transportation and child care, and in Year 2, FACT will implement a peer mentoring program.
Missouri	Alternative Opportunities, Inc.	Substance abuse treatment agency/ provider	No	$984,310	The grantee will provide the Services, Needs, Abilities, and Preferences (SNAP) approach—which includes case management and customized services—to families with parental substance use disorders and children aged 0–21 who are in or at risk of an out-of-home placement. Participating families will take part in family group conferencing and receive specialized case management, recovery coaches, and a customized plan of parenting/family strengthening services, trauma treatment, and substance abuse treatment. In addition, they will receive access and referrals to health care, transportation, and housing and child care support.
Montana	The Center for Children and Families	Child and family services provider	Yes	$500,000	The Center will offer Family Treatment Matters—a comprehensive outpatient substance abuse treatment and family services program—to families with children aged 0–12 who are in or at risk of an out-of-home placement due to a parent's substance use disorder. Participating families will receive a combination of substance abuse treatment—which is provided in three phases that progressively decrease in intensity—parenting/family strengthening services, life skills development for adults, and child development services. A caseworker will provide assistance with ancillary services as needed, such as neuropsychological evaluations or therapeutic groups. In addition, the grantee has adapted its services specifically to address the needs of Native American populations.

Table I.2 (*continued*)

State	Grantee Organization	Organization type	RPG1 grantee*	Federal grant amount	Planned target population and program focus
Nevada	State of Nevada Division of Child and Family Services	State child welfare agency	Yes	$593,110	In collaboration with partners, the grantee will provide the Dependency Mothers Drug Court program: enhanced on-site services for low-income women receiving substance abuse treatment in a residential facility and their children aged 0–8 who are in or at risk of an out-of-home placement. Participating families will receive residential substance abuse treatment in a modified therapeutic community, with children under age 8 able to join their mothers in the facility after a 30-day adjustment period. Families will have access to peer mentoring and substance abuse counseling. In addition, the enhanced services consist of treatment supervision and collaborative case management monitored by the court, as well as on-site counseling/mental health, parenting/family-strengthening services, vocational services, assessments and referrals for children, and transitional services after leaving the facility.
Ohio	Summit County Children Services	County child welfare agency	No	$500,000	Summit County Children Services will provide a program called the Summit County Collaborative on Trauma, Alcohol & Other Drug, & Resiliency-building Services for Children & Families (STARS) to families that have child welfare cases with court involvement. Families will receive an in-home alcohol-and-other-drugs assessment and will be assigned to a STARS coordinator who will coordinate child welfare and substance abuse treatment services, and to a public health outreach worker who will provide ongoing phone contact and help with service coordination. In addition, families will have access to a recovery coach; receive parent/ family-strengthening services; and receive trauma treatment for children, youth mentoring/tutoring, and transportation assistance, as needed.

Table I.2 (*continued*)

State	Grantee Organization	Organization type	RPG1 grantee*	Federal grant amount	Planned target population and program focus
Oklahoma	Oklahoma Department of Mental Health and Substance Abuse Services	State substance abuse agency	Yes	$650,000	Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS) will provide two distinct interventions, both of which serve families affected by parental substance use disorders with children who are in or at risk of an out-of-home placement. The programs are distinct, and will serve different families: One intervention is the Strengthening Families Program, a highly structured family skills training program that includes components for parents, children, and both together. The other intervention is Solution-Focused Brief Therapy, a "strengths-based" counseling intervention to support recovery from substance use disorders. The project will also use the UNCOPE, a universal substance use disorder assessment, as part of the state's family functioning assessment
Pennsylvania	Health Federation of Philadelphia, Inc.	Community health services provider	No	$600,000	The grantee has integrated Child Parent Psychotherapy into an existing suite of services available through its Achieving Reunification Center. The Center offers families case management, adult and child mental health services, substance abuse treatment, parenting/family-strengthening services, employment services, housing assistance, psycho-educational groups, and on-site child care. Child Parent Psychotherapy, the additional service, is a therapeutic treatment focused on the child-caregiver relationship that incorporates trauma treatment and includes supervised visits between parents and children in out-of-home placements. The intervention will serve families in which parents have substance use disorders and children aged 0–5 have been placed outside the home.

Table I.2 (*continued*)

State	Grantee Organization	Organization type	RPG1 grantee*	Federal grant amount	Planned target population and program focus
Tennessee	Helen Ross McNabb Center	Substance abuse treatment agency/ provider	Yes	$1 million	The grantee will provide a program called New Beginnings for Children, Women and Families, which offers early intervention and wraparound services to substance-addicted parents and their children aged 0–18. Many children served will be at risk of an out-of-home placement. Parents will receive residential, intensive outpatient, or in-home substance abuse treatment, and their families will have access to comprehensive family assessment, parenting/family-strengthening services, trauma treatment, housing/help finding housing, and integrated health care. Children aged 0–12 may live on the premises with their parents while they undergo substance abuse treatment.
Tennessee	Tennessee Department of Mental Health and Substance Abuse Services	State substance abuse agency	Yes	$1 million	The grantee will provide Therapeutic Intervention, Education, and Skills (TIES)—a suite of coordinated services—to families with children aged 0–17 who are in or at risk of an out-of-home placement due to a parent or caretaker's substance use disorder. TIES consists of in-home Intensive Family Preservation Services (based on Homebuilders, a family-strengthening/case management model), followed by trauma treatment, as needed.
Virginia	Rockingham Memorial Hospital	Community health services provider	No	$592,733	The grantee will provide substance abuse and complementary services to mothers with substance use disorders and their children who are in or at risk of an out-of-home placement. Families will receive an individualized program of services from substance use disorder specialists. In addition to substance abuse treatment, these services may include parenting/family-strengthening services; trauma treatment; and referrals to additional substance abuse treatment. Families may also be assigned a home visitor to provide parent training.

Source: Grantees' RPG applications and semiannual progress reports for September 2012–March 2013.

**RPG1 Grantee* means the grantee had received a 2007 RPG grant.

Because the grants were intended to improve collaboration between the substance abuse treatment and child welfare systems, they required that grantees set up partnerships between these two systems and other related agencies. The partners have worked together to design the RPG program, identify families to participate, provide services, and promote systemic change.

The first year of the 2012 RPG grants was devoted mainly to establishing the regional partnerships, finalizing program plans and local evaluation designs, and preparing for the cross-site evaluation. During the second year, grantees began implementing their projects. With their partners, grantees began providing a variety of services to children and their caregivers in their identified target groups. These services included, for example, case management, residential and outpatient substance abuse treatment, parenting and 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 abuse treatment programs or are involved in adult criminal or family drug treatment courts. They may also serve families in which parents are at risk of substance use dependence. In addition, grantees take differing approaches to service provision. Some provide a focused suite of services to all participants; others offer a range of interventions and customize the services each family receives.

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 (U.S. Department of Health and Human Services, 2014) focused on the award and initial implementation of the RPG2 program following reauthorization. Highlights of the report include:

- **Technical assistance.** HHS funded two contractors for program and evaluation TA, respectively. NCSACW, the program-related TA provider, responded to numerous requests from grantees on such topics as strategies to cross-train staff on child welfare and substance abuse treatment and sustainability after the grant program ends. To provide evaluation TA and design the cross-site evaluation, HHS funded Mathematica and its subcontractor Walter R. McDonald & Associates. The contractor also 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 had monthly calls with grantees and met in person at two meetings.
- **RPG partnerships and programs.** As required by the RPG funding, all grantees partnered with state 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 other agencies—from 4 to 29—including state and county agencies; courts; and private, nonprofit, and faith-based organizations. Grantees offered more than 50 EBPs.

- **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. The 17 grantees proposed 19 local evaluations (two grantees planned two separate evaluations). 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 a cross-site evaluation that included (1) a study of the structure and functioning of the RPG **partnerships;** (2) a study of the **implementation** of RPG projects, including what EBPs grantees offered and families used; (3) a study of child and family outcomes; and (4) among grantees with rigorous or promising designs, a study of the **effects** of RPG.

2. Second report to Congress

The purpose of this second report to Congress is to describe progress in the early implementation of the 2012 RPG projects. The main source of data for this report is the semiannual progress reports that grantees submitted in October 2013 and April 2014 (each covering their activities for the prior 6 months).

Federal discretionary grantees are required to report semiannually on their spending and progress during the term of their grants. These progress reports include information on grantees' planned interventions, target populations and eligibility criteria, expected program outcomes, and changes or planned adaptations of their projects. Grantees also report on factors that affect their activities, such as changes in public policies and fiscal or economic conditions, and describe their planned activities for the next reporting period. In addition to the semiannual progress reports, the report draws on the information that HHS tracks on the quantity and types of program and evaluation TA that is provided to grantees and local evaluators.

The report thus focuses on activities from April 2013 through March, 2014. This period is referred to as "the reporting period" or "year 2" throughout this report. The 17 RPG grant projects are referred to as "grantees" or "partnerships."

This report is organized as follows:

- Chapter II (Supporting RPG) describes how HHS supported the grantees and local evaluators during the year. It summarizes the TA on program and evaluation issues that was provided.
- Chapter III (Partnerships) describes the size and members of RPG partnerships, including changes from the prior report. It discusses their activities to establish governance and build collaboration, and the challenges they experienced.
- Chapter IV (Programs) provides information on the early implementation of RPG programs and services. It describes changes some grantees made to their initial program plans and reports on enrollment to date. The chapter describes how grantees are addressing child and

adult trauma through implementation of trauma-informed EBPs and efforts to build awareness and capacity to address trauma. Finally, it summarizes factors that influenced implementation, as reported by grantees.

- Chapter V (Evaluation) provides information on grantee evaluations. RPG grantees are required to evaluate their projects, and to participate in the RPG cross-site evaluation, which includes providing data for performance and evaluation measures. Since the first report to Congress, most grantees finalized their evaluation plans and began implementing them. The design of the cross-site evaluation was finalized, and grantees began providing data once HHS received OMB clearance.
- Chapter VI (Looking Ahead) describes next steps and priorities for the coming year, including new data collection, an upcoming third round of RPG grants to begin in FY 2014, and the planned content of future reports to Congress.

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II. SUPPORTING THE GRANTEES

While HHS makes the grants to the RPG partnerships, it also provides other important supports to fulfill the intent and requirements of the RPG authorizing legislation. During the reporting period, HHS, by providing TA and training through two federal contractors, helped grantees implement their partnerships, programs, and local evaluations. The contractors provided coordinated one-on-one assistance through monthly calls held with each grantee, site visits, and other communications, and held group training webinars and activities. HHS also developed the infrastructure needed to obtain performance indicators and cross-site evaluation data from grantees, and received OMB approval for data collection. This chapter describes these activities.

A. Technical assistance and training

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. The program-related TA is designed to help grantees work successfully with their partners and implement their programs, including EBPs, with fidelity, and maintain a high standard of operations. The evaluation TA is intended to assist grantees and their local evaluators in developing and conducting a high quality, rigorous evaluation to the extent possible, and in participating in the cross-site evaluation.

For both programmatic and evaluation TA, the approach is structured but flexible. Each grantee has a designated PML and CSL, who provide program- and evaluation-related TA, respectively. Programmatic issues can affect an evaluation, and vice versa. For example, if program services change or enrollment is low, then data collection and evaluation plans may have to adapt. Therefore, the liaisons work together with grantees to provide integrated support.

Both PMLs and CSLs participated in monthly calls with grantees, local evaluators, and the federal project officers assigned to the grantee. All parties could request topics for the call agendas, and topics tended to reflect the program and evaluation status of the grantee. Early in the reporting period, calls were still focused on program and evaluation plans. Then, as grantees began enrolling people into their programs and evaluations and then collecting evaluation data, the discussions also evolved to implementation of programs and evaluations, and the strength of their cross-system partnerships. Liaisons also conduct TA site visits so they can provide in-person support or assistance to grantees and their staff and partners.

In addition to scheduled calls and site visits, grantees and local evaluators can submit requests for assistance. Grantees can submit questions directly to their liaisons and can also make requests through a help desk via a dedicated email or toll-free phone number. Webinars provide group TA and training, such as on data collection or the implementation of EBPs.

1. Program TA

Most of the formal requests grantees made during the year were for program TA. The Center for Children and Family Futures (CCFF) provides program-related TA to the grantees through NCSACW, which CCFF operates with funding from HHS. The 17 RPG grantees made a total of 63 requests for program assistance between May 1, 2013, and April 30, 2014. Common requests were for help in (1) developing strategies to cross-train staff in child welfare, substance abuse

treatment, and services agencies to expand their understanding of all three systems; (2) planning to sustain the RPG projects after the grant program ends; and (3) addressing underlying values among partners (Table II.1). Grantees also sought assistance to improve their ability to engage and retain clients and establish peer support programs for RPG participants, and to implement evidence-based practices or interventions. NCSACW also received TA requests from grantees asking for general resources about substance use disorders, medication assisted treatment, drug testing, and specific substances such as "bath salts."[8]

To fully assess grantees' potential needs for assistance in building their partnerships and implementing projects, NCSACW staff scheduled two- to three-day site visits with every RPG grantee, beginning in July 2013. At the conclusion of each visit, site visit teams prepare written reports to, and develop TA plans for, each grantee.

Table II.1. Program-related TA topics

Topic area	Response
Cross-systems training and staff development	Assisted with development of plans to cross-train staff in child welfare and substance abuse treatment, and to train service agencies to facilitate coordinated case management; provided TA to help grantees understand substance abuse treatment data collected for the Treatment Episode Data Set, and trauma-informed practices.
Budget and sustainability	Helped grantees create plans to sustain the RPG partnerships and projects after federal RPG grant funds end.
Underlying values	Responded to multiple requests for assistance in administering the Collaborative Values Inventory (CVI) to project partners. (CVI is a survey designed to identify shared and divergent values related to serving families.)
Engagement and retention	Discussed strategies to strengthen family engagement and retention in services, including working with children and fathers.
Peer support groups	Provided TA around the establishment or implementation of Peer/Parent Mentor Models and Aftercare programs.
Evidence-based practices	Assisted sites with addressing factors that influence successful implementation of EBPs; planned a 4-part webinar series focused on the implementation of EBPs used by multiple RPG grantees, and completed one of the webinars, with the rest to be held in the next year.

Source: National Center for Substance Abuse and Child Welfare.

Much of the program TA provided during this period focused on assisting the sites in identifying and addressing partnership program implementation and challenges described in chapters III and IV. During site visits NCSACW conducted between May and November 2013, the PMLs facilitated a review of the partnership structure, the planned sources of referrals for RPG participants and their pathways into and through the RPG program, the array of services

[8] The term *bath salts* refers to several "designer" drugs whose white powder or crystals resemble legal bathing products such as Epsom salts. These drugs are commonly smuggled and sold under the guise of being bath salts.

provided to RPG participants, and how those participants experience the programs and services. This process was intended to help determine whether any key partners were missing or not adequately involved in RPG, clarify RPG target populations, ensure appropriate referrals to RPG, and determine whether the selected EBPs were a good match for their target families. Special attention was also given to engaging and retaining clients in RPG—an ongoing challenge given the nature of the target populations served through RPG, and contextual issues in some states such as the types of substance use issues they face (for instance, prescription drug abuse vs. heroin addiction). PMLs and CSLs regularly discussed enrollments, terminations, drop-outs, and completions during monthly calls with each grantee, to identify potential problems early-on.

During the year, PMLs also worked with each grantee to develop individualized plans for program TA. These plans reflect information from earlier site visits and the ongoing communications with the grantees, such as during the monthly calls. The TA plan is viewed as a "living" document that serves as a guide for strategies to improve the execution of the RPG program and thus support desired outcomes. Some grantees also use the TA plans as an organizing framework or work plan for project management activities. Development of the plans included working with the grantee and the federal project officers (FPOs) to prioritize tasks, and clarifying the partners' mutual responsibilities and timelines for carrying out the tasks identified to strengthen implementation of each RPG project.

2. Evaluation TA

Mathematica Policy Research, the contractor conducting the RPG cross-site evaluation, also provided evaluation TA to the grantees. Mathematica received 14 requests to provide TA on evaluation-related topics during the second year of the 2012 RPG program (Table II.2). Requests were made by the grantees, the local evaluators, or the FPOs, frequently as follow-up to an issue raised during a monthly call. In total, 8 of the 17 grantees (or federal project officers on behalf of grantees) requested evaluation-related TA. Half the TA requests related to questions about data collection plans, reflecting the fact that most grantees were preparing to collect evaluation data.

Table II.2. Requests for evaluation-related TA

	Number
Total number of requests	14
Number of grantees (or federal project officers on behalf of grantees) that made requests	8
Topics addressed in requests	
Data collection	7
Administrative data	2
Authorship	1
Consent process	1
Replacing evaluator	1
Outcome domains and measures	1
Random assignment	1

Source: Mathematica Policy Research RPG Technical Assistance Tracking System.

In addition to requesting formal TA, grantees had many questions on individual data collection instruments and processes, and on the planned operation of web-based systems to be provided for grantees to enter or upload data for use in the cross-site evaluation. To simplify the

request process and ensure timely and consistent feedback, Mathematica developed an RPG "help desk" through which grantees could submit questions via email or a toll-free, monitored telephone number. These inquiries are also tracked. From March 2014, when the new system was implemented, through June 2014, the RPG help desk received 69 inquiries on 9 topics (Table II.3).

Table II.3. RPG help desk inquiries

	Number
Standardized instruments	22
Use of web-based data collection system for implementation data	15
Use of paper forms for implementation data	13
Administrative data	5
General data collection	4
Use of web-based data collection system for outcome data	4
Appropriate reporter for standardized instruments	3
Use of both data collection systems	2
Obtaining Institutional Review Board approval	1
Total	**69**

Source: Mathematica Policy Research RPG Technical Assistance Tracking System.

Besides responding to formal requests for TA, HHS and contractor staff maintained contact with grantees and their local evaluators through regular calls,[9] during which grantees provided updates on plans and implementation of their projects, and federal and contractor staff responded to programmatic and evaluation-related questions or issues. From October 2013 through June 2014, CSLs participated in 128 calls, including 92 with grantees and 36 with FPOs and PMLs to plan for the calls with grantees or to discuss grantee-related issues.

3. Group TA and training

Along with one-on-one assistance, both contractors provided additional TA and training through webinars. Grantees, their local evaluators, HHS staff, and other RPG stakeholders were invited to participate. HHS also held in-person seminars and discussions for RPG grantees and evaluators in conjunction with the 19th annual National Conference on Child Abuse and Neglect.

To support implementation, NCSACW began a webinar series targeting practices and programs being used by the RPG sites and studied in the cross-site evaluation. The purpose of the webinars was to establish a learning community among grantees, assist grantees with successful implementation, provide a forum for learning and sharing experiences about factors that might affect successful implementation, promote fidelity to the program models chosen by grantees, and consider data necessary to measure outcomes and impacts. Two webinars during the reporting period were intended to help agencies become trauma informed, and to help them

[9] Calls were intended to be monthly, but because of scheduling conflicts, they sometimes had to be held less often.

implement a program designed to address trauma. Additional program-related webinars will be held in future years.

In line with their responsibility to help grantees participate in the cross-site evaluation, Mathematica trained them on data collection through several webinars held during the period. In August 2013, a training manual was released and a webinar held on how to administer standardized instruments selected for use in the cross-site evaluation. Later webinars provided information on child welfare and substance abuse treatment data elements and sources, use of the planned web-based data collection systems, and collection of follow-up data. In all, six evaluation-related webinars were held.

To further build peer learning opportunities, HHS organized seminars and discussion groups for RPG grantees and evaluators at an RPG annual meeting. The meeting was held in conjunction with the 19th annual National Conference on Child Abuse and Neglect in New Orleans, in April 2014.[10] The RPG meeting included sessions on topics such as improving response rates for data collection, using evaluation data for program improvement, and implementing interventions such as the use of recovery coaches or peer mentors.

B. Milestones reached

In addition to providing TA to grantees through its contractors, HHS reached a number of milestones during the second year of the 2012 RPG program. These laid the foundation for fulfilling legislative requirements to collect performance data and evaluate the effectiveness of the grants. Highlights of HHS's accomplishments include the following:

Finalized design of the cross-site evaluation. A major task of the first year was designing the RPG cross-site evaluation, which included selecting outcomes, developing or selecting data collection instruments, and designing the partnership, implementation, outcomes, and impact studies as described in Chapter I. The design was finalized in September 2013 and the design report (Strong et al. 2014) was released in May 2014.

Obtained data collection instruments for grantees. As part of the cross-site evaluation design process, HHS selected 10 existing data collection instruments for grantees to use in measuring RPG outcomes in five domains, as described in Chapter V.[11] Selection of the instruments was based on criteria such as evidence of strong psychometric properties, prior use with similar populations, appropriateness for families and children from diverse cultural, racial, ethnic, and linguistic backgrounds, and ease in administration (could be used by grantees after minimal training). Some of the selected instruments were in the public domain and thus freely available for use, but others required payment of licenses or fees to publishers based on the number of administrations. To encourage grantees to use these instruments and to defray their costs, HHS requested that the cross-site evaluation contractor obtain licenses for copyrighted

[10] The conference has been held biennially since 1976. Sponsored by the Office of Child Abuse and Neglect within the Children's Bureau, the conference serves as the nation's leading training and TA event for practitioners, policymakers, advocates, and researchers working in the area of child maltreatment.

[11] Four of the instruments had two alternative versions depending on the age of the respondent or the subject of the items in the instrument, for a total of 10 instruments and 14 versions.

instruments on behalf of the RPG grantees. In fall 2013, the contractor obtained the necessary license and administration agreements from the relevant instrument developers and publishers. Through data use agreements executed between grantees and the contractor, grantees then received permission to use the instruments, including English and Spanish versions. The contractor translated several instruments that lacked existing translations into Spanish, thus ensuring that all the instruments were available to grantees in both languages. Once the data use agreements were signed, the contractor sent all the relevant licensed instruments to each grantee.

Received Office of Management and Budget (OMB) clearance. Along with finalizing the cross-site evaluation design and selecting or developing data collection instruments, HHS began and completed the process of seeking clearance for data collection under the Paperwork Reduction Act of 1995 (P.L. No. 96-511, 94 Stat. 2812, codified at 44 U.S.C. § 3501-3521). The process began with submission of a 60-day notice of the planned information collection to the Federal Register on August 16, 2013. It was published on September 19, 2013 and invited public comment on the planned information collection. No comments were received. The 30-day notice appeared in the Federal Register on December 3, 2013; it announced submission of the information request for OMB review and invited comments. All materials were submitted to OMB by December 20, 2013. HHS received OMB approval on March 18, 2014 (0970-0444; expires March 31, 2017).

Completed preparations for web-based data collection. For the cross-site implementation study, the grantees will provide enrollment and services data for RPG participants. For the outcome and implementation studies, grantees will submit data on their participants' characteristics and outcomes using the instruments described above along with administrative child welfare, foster care, and substance abuse treatment records. As planned, HHS supported the development of a web-based data collection system that grantees could use to provide the data, having two components tailored for each type of data. Grantees will enter implementation data on an ongoing basis using one component of the system. This "enrollment and services log" will also enable the grantees to download the data they have entered at any time for their own use. Grantees will upload outcome data twice a year using another component of the system that is designed to accept data in two alternative formats and to validate incoming data. The system was fully designed, and when OMB clearance was received, final development was initiated. Use of the system was scheduled to begin in June 2014, with the first upload of outcome data scheduled for October 2014. Meanwhile, HHS provided paper and electronic forms and instruments so that grantees could collect and store data after OMB clearance was received until the data collection system was launched.

III. RPG PARTNERSHIPS

The RPG program was designed to support and enhance collaborative relationships between agencies to provide integrated services to families involved in both the child welfare and the substance abuse treatment systems. 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 services providers. Yet families' needs often overlap the different systems and thus require that agencies collaborate to address them. This chapter describes the partnership arrangements grantees developed, as well as progress the RPG partnerships made on collaboration, including developing shared values and outcomes.

A. Number and types of RPG partners

Grantees were expected to create a collaborative infrastructure capable of building the region's capacity for addressing the needs of families involved in the child welfare and substance abuse treatment systems. To apply for RPG funding, grantees formed partnerships that they continued to develop during the second year of the program. The number and types of organizations belonging to each RPG partnership vary, depending on the nature of each RPG project. However, legislative requirements for the grant program have led to some commonalities across grantees. As part of their application, eligible applicants had to include in its partnership the state child welfare agency responsible for the administration of the state's plan under Title IV-B or IV-E of the Social Security Act. In addition, partnerships were to include at least one of the following parties:

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

1. Number of partners

As of April 2014, grantees reported having between 5 and 30 partners (Table III.1), with an average of 13. In an effort to meet the needs of families, eight sites added new partners to their RPG partnerships during the year—six grantees added 1 to 3 partners, one added 6, and one added 11. Several sites made targeted efforts to include members of the legal community (such

as attorneys, judges, court administrators, and guardians ad litem) in their RPG projects. The public school system, community service boards, and child welfare agencies in rural areas were other targeted partners in some jurisdictions. In all, eight RPG grantees brought 26 new partners into their collaboratives during the past year.

Table III.1. Total number of RPG partners as of April 2014

Grantee	Number of partners
Families and Children Together, Maine[a]	30[b]
Commonwealth of Massachusetts[a]	28[b]
Center Point, Inc., California	23[b]
State of Nevada Division of Child and Family Services	23[b]
Alternative Opportunities, Inc., Missouri[a]	19
Helen Ross McNabb Center, Tennessee	14
The Center for Children and Families, Montana[a]	13
Rockingham Memorial Hospital, Virginia	11
Judicial Branch, State of Iowa	10
Summit County Children Services, Ohio	9
Kentucky Department for Community Based Services[a]	8
Georgia State University Research Foundation	7
Tennessee Department of Mental Health and Substance Abuse Services[a]	7
Oklahoma Department of Mental Health and Substance Abuse Services[a]	6
Children's Research Triangle, Illinois	5
Health Federation of Philadelphia, Inc., Pennsylvania[a]	5
Northwest Iowa Mental Health Center/Seasons Center	5

Source: Grantees' semi-annual progress reports for September 2012–April 2014 and RPG grant applications.

[a]Added more partners since the first report to Congress.

[b]Several grantees have a large number of partners, for various reasons. Maine has many referral sources. Massachusetts includes multiple mental/behavioral health services and substance abuse treatment providers across the state. Several of California's partners serve in advisory capacities, in addition to partners that play operational roles such as providing referrals. Nevada offers a range of services, including financial assistance for pregnant and parenting clients, financial assistance for child care costs, a developmental play gym for low-income families, and adult education and GED prep.

2. Types of partners and roles

All 17 RPG partnerships include representation from child welfare and substance abuse treatment agencies and organizations. All the partnerships go beyond the two-partner minimum required by the legislation, and encompass a diverse array of services designed to meet the multiple needs of the children and families participating in the RPG projects. Partnership compositions vary by site based on regional or community needs, but the majority of the RPG projects include representation from the following sectors:

- Mental health agencies and providers
- Community-based organizations that provide child and family services

- Courts and court-related agencies
- Criminal justice and legal systems
- Education and early childhood education organizations
- Child and adult health services agencies or providers
- State and local employment agencies; employment/vocational service providers
- Housing agencies and service providers
- Maternal and other public health providers

Additional service providers and organizations are unique to individual projects or represented in fewer RPG partnerships, depending on their specific circumstances, target populations, and planned EBPs. They include:

- Tribal entities
- Dental service providers
- Parenting education service providers
- Faith-based organizations, including churches
- Home visiting agencies
- Family income support providers
- Domestic violence service providers
- Foundations
- Community development districts

Partner agencies play various roles in the RPG projects. Some are referral or recruitment sources for RPG participants. Others provide RPG-related services by operating one or more EBPs, by providing case management or substance abuse treatment, or by supplying housing, transportation, child care, or other support services. Several grantees are coordinating their projects with family treatment drug courts in their communities, or providing selected or additional services to individuals with court cases and/or their children. Other partners may provide additional funds to the RPG grantee or other partners.

B. Activities of the partnerships

During Year 2, grantees continued to develop, strengthen, and expand their partnerships and establish procedures and structures for collaboration. Grantees addressed challenges to collaborative implementation of their RPG projects, such as a lack of agreement on shared mission, goals, and values. Partnerships needed to clearly define expectations for cross-system collaboration, as well as guiding principles for how they would work together and share accountability and data. Some grantees needed to engage agencies or service system that had not been brought into the partnership initially. For most grantees, strengthening the relationships

between child welfare, substance abuse treatment systems, and the courts was fundamental in establishing effective partnerships.

1. Establishing relationships

RPG grantees and their partners worked to clearly define fundamental components of their collaborations and their overall governance structures. This required establishing and operationalizing roles and responsibilities of the partner agencies. Nearly all grantees set up steering or advisory committees to oversee and guide the partnerships, along with implementation teams to plan for, and coordinate, the EBPs and services to be provided as part of their RPG projects. State-level grantees sometimes established advisory committees at the state level and steering committees within the individual community or communities where RPG projects were taking place. Some grantees set up other subcommittees with specialized tasks, such as (1) communications (keeping partners informed or providing information about the program to various audiences), (2) cross-training of staff (such as, informing child welfare workers, substance abuse treatment staff, and court officials and staff about each other's systems and perspectives on family needs), and (3) evaluation planning and implementation. Some grantees held meetings with the full partnerships each year or more often.

Through their committees or as a whole body, RPG partnerships also worked to agree on project goals. They reviewed, refined, and revised their RPG project logic models to ensure agreement on (1) planned project inputs such as resources and EBPs; (2) desired participant outcomes such as improvements in safety and well-being for children; (3) selected outcome data and measures they would collect; and (4) the characteristics and numbers of families to be served.

Identifying and working through differences across partner agencies in underlying values and guiding principles was one important goal for several grantees. As one way to better align their members, five grantees administered the Collaborative Values Inventory (CVI) to all partners by April 2014, and three additional grantees were planning to administer it.[12] The intent of the questionnaire is to assist community members and professional staff in developing common principles for their work together (Young et al., 2007). The CVI was administered to the 2007 RPG partnerships both as a diagnostic tool and as a measure of performance indicators related to the alignment of the partnerships. NCSACW makes the instrument freely available, and grantees were either familiar with it from their participation in the 2007 grants or used it on the advice of NCSACW staff.

2. Planning to coordinate services

In conjunction with strengthening relationships, the grantees and their partners continued to develop and clarify mechanisms for coordination. For example, grantees worked to determine what kinds of information RPG partners would need on RPG participants in order to better coordinate services for them. They identified and developed mechanisms, such as data use

[12] The Collaborative Values Inventory can be accessed on Children and Family Futures website [http://www.cffutures.org/resources/policy-tools].

agreements or data-sharing procedures, for exchanging information about client characteristics, as well as information on their enrollment and participation in specific programs.

Grantees also began to plan and document the "flow" of clients through the service systems and agencies represented by the RPG partnership. For example, some grantees began to gather data to conduct drop-off analyses. (A *drop-off analysis* is a method used to determine how many families do not connect for services, such as when they are referred between child welfare and provider agencies—and why.) The drop-off analysis can inform partnerships where more efforts are needed to improve follow-through or access. Some grantees also undertook *resource mapping* (a tool used to plot the location and distribution of community assets, such as service providers) and finalized flow-charts showing target population and service delivery pathways. Communities use mapping to understand the distribution of services and to better align resources to meet the needs of community members or RPG participants.

C. Successes and challenges

Collaboration has a myriad of benefits, such as potentially expanding the number and type of clients served, offering a broader array of services than a single agency can provide, and integrating services—but it can also be challenging. Agencies have different cultures, staffing arrangements, and competing demands. The RPG2 grantees had many successes with their partners, including the start of services, increases in referrals, and improving coordination. They also noted a number of issues, to include:

Communication and engagement. This was the challenge grantees cited most frequently in working with their partners. Grantees sometimes felt that partners were less engaged in the collaboration than was ideal. Similarly, some grantees felt that it was difficult to schedule times for calls or in-person meetings with partners. Staff in each agency have their own demands and goals; coordination may be an additional responsibility. One grantee noted that coordinating cases was difficult because staff had competing demands on their time.

Conflicting perspectives. Even if agencies serve the same clients, they may have different perceptions of the client and visions for success. For example, one grantee found that agency staff sometimes disagreed on clients' progress. In one case, grantee staff did not want to discharge a client until she had saved more money, but a partner agency thought she was ready to be released. Another agency identified staff disagreements on whether the goal for a parent with a substance use disorder was abstinence or harm reduction. This meant that the agencies likely approached changes differently and would not necessarily agree on a successful outcome.

Sharing information. Because of concerns about confidentiality, agencies are not always able to share information about clients freely. This can inhibit communication as well as prevent service integration and goal planning, because staff cannot fully disclose what they know about a family. Staff were sometimes uncomfortable withholding information from partner agencies. They were also not always aware of other agencies' rules and so were uncertain what type of information partners might have been withholding. Grantees worked—both internally and with partner agencies—to ensure that staff were trained in the information sharing processes, confidentiality regulations, and procedures for obtaining informed consent. Grantees and their partners also developed and/or finalized data-sharing agreements and memorandums of

understanding, and established protocols for information sharing at the case level to facilitate coordinated joint case management.

History. Many grantees' agencies and their partners are well established and may have interacted and collaborated in the past. Depending on whether prior relationships were positive or negative, this shared history might have facilitated or inhibited collaboration. One grantee, for example, noted that child protective services and behavioral health treatment systems in their region had a legacy of clashes fueled by "lack of communication leading to assumptions about the other system's motivations, long memories about the other's [past] mistakes…, lack of resources for services resulting in blame…, high stress and pressure in both systems causing unpleasant interactions, and high turnover so that constructive relationships have to be built over and over" (April 2014 semiannual progress reports).

Despite these challenges, grantees and their partners worked creatively to improve collaboration, such as by developing communication protocols and brainstorming ways to increase stakeholder engagement. As will be discussed in the next chapter, most grantees and their partners were able to successfully initiate RPG project operations and begin serving families in need.

IV. PROGRAMS

Grantees and their partnerships were at different stages when the RPG2 grants began in October 2012. Ten of the grantees had also received grants during the first round of RPG funding in 2007 and were continuing their existing partnerships and projects or updating them, while the remaining seven grantees were receiving RPG grants for the first time (Table I.1). In addition, grantees progressed toward initiating enrollment at different rates. Grantees had to work through issues to ensure that the selected EBPs and services met the needs of families and staff. Although the grantees reported numerous successes in beginning program operations, many also made changes between October 2013 and April 2014 in their planned services. Eleven grantees reported at least one change to their planned EBPs, services, or both.

This chapter provides information on the early implementation of RPG programs and services. It describes changes some grantees made to their initial program plans to better tailor their services as they learned more about families' needs and existing services provided by partners. It reports the number of adults and children enrolled in RPG by the end of the reporting period. The chapter describes how grantees are addressing child and adult trauma through implementation of trauma-informed EBPs and efforts to build awareness and capacity to address trauma. Finally, it summarizes external factors that influenced implementation, as reported by grantees.

A. Implementation status

Grantees designed their RPG projects to strengthen families; respond to child or adult trauma; provide child, caregiver, and family therapy or counseling; treat substance use disorders; or integrate substance abuse treatment into family drug courts. All the RPG projects make at least one, and as many as 12, evidence-based or evidence-informed programs or practices (EBPs) available to their participants. Grantees themselves may be providing one or more EBPs, or partner agencies may provide them instead of, or in addition to, the grantee.

In addition to EBPs, grantees and their partners planned to provide an array of services and supports to RPG participants. The mix and number of planned services also varied across grantees and included services such as housing, child care, transportation, and educational/support groups on parenting, nutrition, and intimate partner violence. Some RPG projects make use of navigators, case managers, or recovery coaches to engage and support participants and help coordinate the programs and services they receive.

1. Changes in planned EBPs and services

Though grantees and their partners may have given considerable thought to the selection of their EBPs, since the first Report to Congress (HHS, 2014), 11 grantees have made changes to the EBPs or services they planned to offer participants. Seven grantees made changes in their RPG programs or services by October 2013. Three of the seven made additional changes between October 2013 and April 2014, as did four other grantees. Grantees requested and received any necessary approvals from HHS for the changes they made.

These changes stemmed mainly from efforts to better tailor their RPG projects to meet the needs of participants. Other factors included implementation delays, high program costs, and the receipt of new funding to support additional programs. For example:

- One partnership began using two additional EBPs to meet a broader range of needs for the adults and children they served.
- When a grantee working with a family drug treatment court found that the court already provided programs very similar to one of the planned EBPs, the grantee dropped the EBP to avoid overburdening participants.
- A partnership replaced one EBP with another they deemed to be a better fit for the women being served in their RPG project.
- Several partnerships added components or protocols to a selected EBP to better meet the needs of families being served in RPG—such as a protocol developed specifically for adult drug users with a history of trauma.
- Initially one grantee was trying to choose which of two EBPs to offer; after conducting focus groups with their partners and with community members, they chose the EPB with a strong focus on recovery from substance use disorders.
- A grantee discontinued an EBP to avoid the high cost of ongoing staff training and program support required, and to focus on offering a single EBP rather than multiple ones.
- An RPG grantee agency received a new grant from the U.S. Department of Justice to operate a family recovery court in which some of their RPG project participants will enroll.

2. Enrollment

Grantees have made substantial progress implementing their programs. Program implementation successes reported by grantees between 2013 and 2014 included training staff providing the planned services and EBPs; expanding services, such as offering a new home visiting component to help families transition from residential to outpatient services or bringing services to underserved areas; increasing referrals from partners into a grantee's RPG program as well as providing opportunities for additional services to which grantees can refer their clients; and engaging families. The first report to Congress noted that by April 2013, seven of the grantees had begun enrolling participants. By September 2013, the end of the full first year of the 2012 RPG grants, 15 of the 17 projects had enrolled participants, and by April 1, 2014, just one grantee had not yet begun enrollment.[13] The number of people enrolled at each site by then ranged from 35 to just over 700. Six grantees had enrolled 100 or fewer adults and children; five had enrolled between 101 and 200, and five had enrolled more than 200 (Table IV.1).

[13] That grantee was awaiting execution of data-sharing agreements with the child welfare and behavioral health departments, and began enrollment later that April.

Table IV.1. Cumulative enrollment in RPG by site

Grantee and state	Reported in October 2013		Reported in April 2014	
	Total number of people enrolled	Percentage of total enrollment who are children	Total number of people enrolled	Percentage of total enrollment who are children
Center Point, Inc., California	33	45	79	57
Georgia State University Research Foundation, Inc.	4	75	35	9
Judicial Branch, State of Iowa	61	54	124	62
Northwest Iowa Mental Health Center/Seasons Center[a]	206	100	395	100
Children's Research Triangle, Illinois	132	85	161	85
Kentucky Department for Community Based Services	29	55	93	60
Commonwealth of Massachusetts	72	65	147	64
Families and Children Together, Maine	180	63	388	55
Alternative Opportunities, Inc., Missouri	169	68	267	67
The Center for Children and Families, Montana	28	61	48	63
State of Nevada Division of Child and Family Services	48	35	58	34
Summit County Children Services, Ohio	123	59	117	44
Oklahoma Department of Mental Health and Substance Abuse Services	0	NA	35	57
Health Federation of Philadelphia, Inc.[b]	0	NA	0	n/a
Helen Ross McNabb Center, Tennessee	502	67	711	66
Tennessee Department of Mental Health and Substance Abuse Services	65	58	176	57
Rockingham Memorial Hospital, Virginia	227	39	531	57
Total	**1,879**	**65**	**3,365**	**65**

Source: October 2013 and April 2014 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 have counted all program enrollment on the basis of the number of children enrolled in their services.

[b]The Health Federation of Philadelphia began enrollment in April 2014, after concluding partnership and data-sharing agreements with child welfare and behavioral health departments in their service area.

NA = not applicable.

Along with successes, several grantees noted challenges with implementing their programs, which sometimes required modifications to the way services were offered. For example, one grantee experienced high dropout rates from an EBP, which the grantee addressed by moving the EBP to later in the program, when families might be more stable. Another found it difficult to offer a planned EBP that required ongoing training, because they were also experiencing high staff turnover and consequently did not always have at least one staff person who was fully trained on the EBP. In another site, a state agency expressed concern that focusing on the family relationships as part of the RPG program distracted parents from meeting goals of employment and finding stable housing.

3. Engagement and retention

To improve outcomes for children and adults, RPG grantees and their partners had to first successfully engage families in their RPG projects, then retain them in services long enough to receive a sufficient exposure to one or more EBPs. During the year, grantees used feedback from participants and partner agencies along with data on referrals and enrollment to identify problems, such as fewer referrals than expected, low enrollment, or high drop-out rates, and then developed strategies to address barriers to engagement and retention.

For example, people referred to RPG projects need to be a good fit for the program, and enrollees must meet eligibility criteria. Throughout this reporting period, the majority of grantees needed to define or clarify some aspect of their eligibility criteria or referral processes for agencies making referrals to RPG and or for contracted providers. One area of focus was referrals to substance abuse treatment programs. Once a person agrees to accept treatment for a substance use disorder, it is essential to begin treatment immediately, before the person's circumstances or intentions change. Delayed access to treatment, due to slow referral processes or the lack of treatment slots, was a barrier some grantees experienced and needed to address.

Lack of attendance by parents or caregivers in family treatment meetings or other RPG services was another barrier grantees often confronted. Some grantees needed to clearly define program participation expectations such as the duration, intensity, and array of services they were implementing. Being clear with program staff and families about the criteria for participation and completion may enable families to make informed decisions to participate. Providing clear information such as the length of time a person must maintain continuous sobriety in order to be discharged from treatment programs or the minimum number of sessions a person must attend in order to complete family strengthening or other programs may enhance his or her willingness and ability to remain in the program. It may also help open up discussions about personal challenges and barriers such as non-standard work hours or a lack of stable housing that make participation difficult but might be addressed once staff are aware of the needs.

Finally, some grantees needed to better align the delivery and duration of EBPs with substance abuse treatment services to minimize conflicts RPG participants experienced. For example, the duration of some parenting interventions was longer than a parent was typically engaged with the child welfare system or in substance abuse treatment, meaning that few parents completed the parenting intervention. Thus, grantees needed to consider whether to shorten the parenting EBP or replace it with another program model. Grantees made other changes to make

programs more convenient for participants, such as co-locating substance abuse treatment professionals in child welfare agencies.

B. Addressing trauma

Traditionally, the goal of the child welfare system has been to ensure safety and achieve permanency for children receiving child welfare services. In recent years, the child welfare system has made strides in these two areas by promoting the importance of family connections and relationships and collaborating with other child-serving systems. However, in response to scientific findings that continue to emerge about the long-term neurological, behavioral, relational, and other impacts of maltreatment on children, HHS is urging states and child welfare systems to do more to attend to children's behavioral, emotional, and social functioning (Samuels, 2012; ACF, 2012b). One component of this process is addressing the impact of trauma and its effect on the overall functioning of children and youth. The experience of trauma is not limited to children, however. For example, most women in substance abuse treatment have experienced trauma as children or adults (Covington, 2010). Therefore RPG grantees are required to adopt and implement programs and services that are *trauma-informed*.

The National Institute of Mental Health (2005) defines *child trauma* as "the emotionally painful or distressful experience of an event that results in lasting mental and physical effects." Most children involved in child welfare have been exposed to some form of trauma, whether from sexual, physical, or emotional abuse; from neglect; from domestic, school, or community violence; or from severe caregiver impairment (Kisiel, Fehrenbach, Small, & Lyons, 2009). For example, a study that analyzed more than 14,000 clinical assessments from child welfare in Illinois found that one in four children exhibited trauma symptoms (Griffin, Kisiel, McClelland, Stolback, & Holzberg, 2012). A national sample of over 2,220 children in child welfare found that over 70 percent met criteria for having been exposed to trauma (Greeson et al., 2011).

Maltreatment is distinct from other types of trauma because it is interpersonal in nature. A caregiver who is supposed to be a secure base—the source of attachment, safety, and security—is also the source of hurt and harm. This creates a confused and ineffective attachment and serves as the model for other significant attachments (Bloom, 1999). Chronic interpersonal trauma or complex trauma can result in difficulties regulating emotional responses, accurately interpreting the cues and communications of others, managing intense moods (particularly rage and anxiety), regulating arousal states (resulting in dissociation), and accurately forming perceptions of self and others (Terr, 1991). The impacts of these effects have been shown to ripple across a child's lifespan, limiting a child's chances to succeed in school, work, and relationships.

RPG grantees are addressing trauma through the programs they offer participants and by encouraging trauma-informed practices by providers and RPG partners. Trauma-informed services are provided just to parents in some sites and to both parents and children in others. Ten grantees are offering one or more of eight EPBs designed to address child or adult trauma; one of these grantees is also planning to implement an emerging practice that addresses trauma (Table IV.2). Seven of the 10 grantees are implementing Trauma-Focused Cognitive Behavioral Therapy to directly address the impact of trauma on children from ages 3 to 18 years. Six of the grantees have integrated the Seeking Safety program in their substance abuse treatment programs. Five grantees are utilizing either Child-Parent Psychotherapy or Parent and Child

Interactive Therapy to strengthen parent-child relationships and the parenting capacity of caretakers. By April 2014, these 10 grantees had enrolled a total of 1,306 adults or children in their RPG projects. Future reports will describe the level of enrollment in each EBP—including those intended to address trauma.[14]

Table IV.2. Trauma-focused EBPs or practices being implemented in RPG

Program or practice	Description	Number of RPG grantees offering
Trauma Focused Cognitive Behavior Therapy (TF-CBT)	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. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents or guardians, with conjoint parent-child sessions increasingly incorporated over the course of treatment. The treatment can be used by a variety of mental health professionals including clinical social workers, professional counselors, psychologists, psychiatrists, or clinical counselors.	7
Seeking Safety	Seeking Safety is a manualized treatment for female adolescents and adults with a history of trauma and substance abuse.[a] The treatment was designed for flexible use: group or individual format, and a variety of settings, such as in outpatient, inpatient, or residential treatment programs. It has been implemented in programs for substance abuse, mental health, domestic violence, homelessness, women and children, and veterans and in correctional, medical, and school settings. There is flexibility in treatment delivery. The number and duration of sessions and the sequence of topics is flexible, depending on participant needs.	6
Child-Parent Psychotherapy (CPP)	CPP is a model of child and family therapy designed to help young children regain their sense of safety and attachment—and improve their cognitive, behavioral, and social functioning—after experiencing trauma, by strengthening the parent-child relationship. CPP is 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). The treatment also engages parents. The type of trauma experienced and the child's age or developmental status determine the structure of CPP sessions.	4
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. The treatment is delivered over 29 75-minute sessions that emphasize the development of coping skills and social support. The intervention is provided by clinicians from a variety of disciplines and programs such as mental health settings, substance abuse settings, correctional settings, domestic violence programs, or homelessness programs. TREM groups have been implemented in a wide range of agencies, including residential and nonresidential substance abuse and mental health programs, correctional institutions, health clinics, and welfare-to-work programs, among others.	3

[14] After OMB clearance was received for the cross-site evaluation in March 2014. Mathematica began collecting implementation data once the web-based data collection system was launched on June 10, 2014.

Program or practice	Description	Number of RPG grantees offering
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.[b] It is a flexible framework rather than a protocol-based intervention.[c] The model may include individual and group therapy for children, education for caregivers, parent-child sessions, and parent workshops delivered by clinicians. The number of sessions, frequency, and duration all vary depending on client needs. ARC principles have been applied in a range of settings, including outpatient clinics, residential treatment centers, schools, and day programs.	1
Lifespan Integration[d]	Lifespan Integration therapy can be used to help clients overcome the effects of early trauma and neglect. When administering this form of therapy, a clinician will guide a client to draw on a memory from each year of his or her life. Each individual memory is then examined to determine the relationship it has with present-day symptoms. This often also allows the client to gain insight into particular patterns or behaviors he or she has sustained throughout the lifetime.	1
Parent and Child Interactive Therapy (PCIT)	In PCIT, therapists coach parents during interaction with their children, as a way to teach parenting skills. The treatment 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. It can be conducted with parents, foster parents, or other caretakers. Licensed mental health providers can implement PCIT, usually in community agencies or outpatient clinics.	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. The program consists of a course of individual therapy designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety. Treatment is individualized and is conducted by social workers, psychologists, psychiatrists, and other therapists trained to use the PE manual, which specifies the agenda and treatment procedures for each session. The duration of treatment can be shortened or lengthened depending on the needs of the client and his or her rate of progress.	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 to19 who may still be living with ongoing stress and are experiencing problems in several areas of functioning. The intervention is delivered over 16 one-hour group sessions. Groups have been provided in a variety of settings, including outpatient clinics, schools, group homes, boarding schools, residential treatment centers and facilities, juvenile justice centers, and foster care programs.	1

[a]"Manualized" treatments have been designed with exact steps, so that every participant receives relatively the same treatment.

[b]*Complex trauma* refers to exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure.

[c]A *protocol* is a set of rules for treatment that would limit flexibility.

[d]Lifespan Integration has not been included in any of the evidence reviews that were examined to classify programs selected by RPG grantees as "evidence-based" or "evidence-informed." Therefore it is not considered an "EBP" for purposes of this report, but rather a "practice."

In addition to providing trauma-focused EBPs, grantees also worked in conjunction with their partners to improve the awareness of trauma throughout their organizations and develop strategies to address trauma. For example, one grantee implemented trauma-informed charting, a practice of keeping client records with sensitivity to any trauma experiences or subsequent issues of the client—and excluding information that could be harmful or damaging to the client if the confidentiality of the records became compromised. Another hosted a regional conference on trauma, and others developed guidelines for working with children and youth who may have

experienced trauma. NCSACW staff provided some grantees with a survey designed to assess trauma-focus and awareness within organizations (Institute for Health and Recovery, 2012).

C. State and local context

In addition to their own efforts, external factors also affected grantees' progress implementing their RPG projects. Fourteen grantees in 12 states described contextual factors that affected their RPG projects (Table IV.3).[15] Three main types of factors were cited: (1) factors related to child welfare (reported by 11 grantees in 10 states); (2) factors related to substance use, or policies affecting substance use treatment or individuals with substance use disorders (reported by 7 grantees in 7 states); and (3) fiscal or economic factors at the federal or state levels (reported by 7 grantees in 7 states). Five grantees in four states also mentioned that health care reform or elements of the Affordable Care Act influenced their work.

Table IV.3. External factors affecting RPG projects, as reported by grantees

Factors	Number reporting	Specific factors cited by grantees (and number that cited the factor)
Child welfare (11 grantees)		
Changes in child welfare practices or structure	6 grantees	Increased emphasis on, or new implementation of, differential response (3) Implementation of a safety management system model (1) Moratorium on providing financial support for kinship care (1) New requirement to provide mental health screening for children in open child welfare cases (1) Contracting out-of child-welfare services (1)
Change or turmoil at state child welfare agency	5 grantees	Agency restructuring (1) Changes in leadership (2) Multiple changes in staff (1) Terminations of staff for improper practices, and agency was operating under consent decree (1)
Injury or death of child	2 grantees	Child not in child protective services (1) Incident related to parental substance use (1)
Changes in child welfare cases	1 grantee	Increase in child welfare caseloads, and greater prevalence of co-occurring problems such as domestic violence and poor mental health

[15] Grantees were asked to "describe any significant contextual conditions, events, or community changes that took place during the reporting period which have already had or will likely have an impact on your project or the outcomes you are measuring for your target population." They were also asked whether their RPG project "experienced any significant challenges during the reporting period as a result of the current fiscal environment."

Factors	Number reporting	Specific factors cited by grantees (and number that cited the factor)
Substance use, treatment, or policies (7 grantees)		
Changes in substance abuse treatment practice or policy	5 grantees	Required recertification of substance abuse treatment providers to receive Medicaid payments (1) Change to crisis stabilization instead of 30-day residential approach (1) Change in recovery coach model, and advocacy by some groups to allow Medicaid billing for peer recovery coaches (1) Denial of TANF assistance to people convicted of a drug felony until they complete drug treatment; denial of food stamps to people convicted of a drug felony; requirement for law enforcement personnel to ask people being arrested for a drug offense whether they receive public assistance and, if so, to notify the legislature (1) Provision of substance abuse treatment to pregnant women with substance use disorders and criminalization of substance use by a woman while pregnant unless she enters substance use treatment (1)
High rates or increases in substance use	4 grantees	Increased use of marijuana following medical marijuana legislation and increased fatalities from opioid overdose (1) More births of drug-exposed babies (1) Methamphetamine labs becoming more common; more children injured or killed in "drug environments," and high rates of abuse of prescription drugs (1) Increase in drug use (1)
Fiscal, economic, financial (7 grantees)		
State or federal budget cuts or shortfalls	4 grantees[a]	Reductions in RPG grant or other federal funds due to sequestration (3) State budget cuts or shortfalls (4)
Fiscal easing or improvement	4 grantees[a]	Prior funding cuts rescinded (1) New federal funds available (1) Additional funding for behavioral health (2 grantees) or child and family services (1 grantee)
State economy	2 grantees	High unemployment rates
Health care reform (5 grantees)		
Affordable Care Act/health reform	5 grantees	Medicaid reimbursement for behavioral health treatment (4) Establishment of health exchange (1) Rejection of health exchange (1)

Source: October 2013 and April 2014 RPG semiannual progress reports filed by grantees.

[a]Two grantees reported their states or programs were being affected by both fiscal easing and budget cuts/shortfalls.

TANF = Temporary Assistance for Needy Families.

Child welfare. Eleven RPG projects were affected by several factors related to child welfare, including changes to child welfare practices, changes or turmoil within the child welfare agency, or child injuries or deaths. For example, three grantees reported that their state or county child welfare departments were newly implementing differential response, or placing an increasing emphasis on it. "Differential response" is a child protective services (CPS) practice that allows for more than one method of initial response to reports of child abuse and neglect (Child Welfare Information Gateway, 2008). One state was adapting the "safety management

system" model, which is used by businesses to manage safety in the workplace, for use by CPS to assess, document, and manage risks to children in child welfare cases.

Two regional partnerships experienced critical child welfare incidents involving parental substance abuse. This resulted in increased awareness of and interest in this issue in these jurisdictions. In one state, the media have been actively involved in bringing to light issues about the child welfare department's handling of cases, which has led to changes in the department's practices related to the release of child welfare records. Incidents in another state prompted a statewide review of all child welfare cases involving young children, and the child welfare department is considering how to formulate a comprehensive, system-wide approach to address the situations of these families, as well as to address the needs of staff who work with families having complex, multiple needs.

Substance use. Seven grantees reported that changes in practices or policies related to substance abuse treatment, or patterns of substance use in their states, influenced the implementation of their RPG projects. In one state, substance abuse treatment providers that had been certified to receive payments through the state's Medicaid program (including the grantee) were required to be recertified. Another state was implementing a new "crisis-stabilization" approach for mandating treatment.[16] A third state was modifying the current model it was using to provide addiction recovery coaches—which the state defined as "non-clinical people who help remove personal and environmental struggles to recovery, guide the recovering person to the recovery community, and serve as mentors in the management of personal and family recovery." Advocates there were also urging the state to allow Medicaid reimbursement for peer recovery coaching services.

Two states toughened policies related to substance use. In Tennessee, legislation was proposed (and later passed) to criminalize substance use by pregnant women, unless the woman agreed to enter treatment. Oklahoma planned to deny certain public benefits to people convicted of a drug-related felony, at least until they completed substance abuse treatment. That state also began requiring that law enforcement personnel ask people being arrested for a drug offense whether they received public assistance and, if so, to notify the legislature.

Four grantees noted that their states were experiencing high or increasing rates of substance use, or problems related to substance use or dependence. For example, over the past decade, increasing public health, medical, and political attention has been paid to the parallel increases in the prevalence of prescription opioid abuse and the incidence of neonatal abstinence syndrome.[17] Governors in several New England states have responded to the rise in heroin addiction, as well as overdose deaths from prescription painkiller abuse, as a major public health crisis and initiated statewide strategies to address it. For example, in March of 2014, Massachusetts Governor

[16] *Crisis stabilization* is typically a short-term (such as 24-hour) program that offers a "cooling off" period for children, adults, or families in a crisis situation or in an acute phase of a behavioral disorder. For example, it provides short-term placement in a residential behavioral health facility instead of initial assignment to a full 30-day treatment program. Once the crisis or acute stage has passed, appropriate services can then be determined through assessments.

[17] Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who was exposed to addictive opiate drugs while in the mother's womb (U.S. National Library of Medicine, 2014).

Patrick declared a public health emergency in the Commonwealth, noting that the opioid addiction epidemic in his State requires a specific set of actions (*Boston Globe,* March 27, 2014). The Governor included in this announcement a number of steps the state is taking to address the matter, including the dedication of an additional $20 million to increase treatment and recovery services. In some states, the grantees worked with state leaders to examine legislation and policies related to prenatal substance exposure and the availability of appropriate treatment services, including medication assisted treatment.[18] Some RPG grantees also worked to develop protocols for (1) tracking referrals made for such services; (2) training direct staff on the issue; and (3) providing services needed for both mothers and infants, to ensure a consistent approach to addressing prescription opioid abuse and neonatal abstinence syndrome.

Fiscal environment. Seven grantees also mentioned fiscal, economic, or financial factors that influenced their projects—both unfavorably and favorably. Though all year-two RPG grants were reduced by the budget sequestration cuts that went into effect in March 2013, three grantees mentioned that this presented a challenge for their programs. (As a result of the sequestration, grant amounts for the second year of funding were reduced by 2 to 5 percent per grantee). Four grantees cited state budget cuts or shortfalls—but two of them also reported that their states received additional funding for behavioral health, possibly as a result of ACA provisions that expanded coverage for mental health and substance use disorders. Two additional grantees said that prior funding cuts that had affected their work were rescinded or that new federal funds had become available. One grantee said that high unemployment was reducing the ability of their clients who had participated in substance abuse treatment services to find employment that would enable them to transition to independent living.

Health care reform. Changes in Medicaid and other health insurance coverage for behavioral health made as part of health care reform had implications for the work of grantees, and was mentioned as an important contextual factor by five of them. Four of these grantees, two of which are providers of behavioral health services, cited changes in Medicaid reimbursement for behavioral health treatment stemming from the ACA as an influence on their operations and RPG programs. (Specifically, as a component of the ACA, the Mental Health Parity and Addiction Equity Act of 2008 was changed to provide increased coverage for behavioral health. One of these grantees also mentioned the establishment of a health insurance exchange in their state. The fifth grantee cited the rejection of such an exchange by its state.

[18] Medication assisted treatment is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders (http://www.dpt.samhsa.gov/).

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V. EVALUATION

To support informed decision-making and efficient allocation of resources, government agencies are increasingly charged with developing and using research evidence to gauge program effectiveness (Burwell, Muñoz, Holdren, & Kruger, 2013). The Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) requires that HHS evaluate the services and activities funded through RPG. Specifically, HHS must assess the extent to which grantees are successful in (1) addressing the needs of families who have substance use disorders and who have come to the attention of the child welfare system; and (2) achieving the goals of child safety, permanence, and family stability.

To address the goals and requirements of the legislation, and to contribute knowledge to the fields of child welfare and substance abuse treatment programming, HHS is requiring local and cross-site evaluations. Grantees must evaluate their programs, using rigorous designs when possible and high quality measures. The local evaluations then contribute data to the national cross-site evaluation. Combined with data collected directly by the cross-site evaluator through surveys and site visits, these data will be used (1) to examine grantees' performance, including activities to establish partnerships and implement EBPs; (2) to document services received by children and families served by RPG, and their outcomes; and (3) to test the effectiveness of selected programs. This chapter describes grantees' progress to date in implementation of their evaluation plans and discusses one issue of particular interest, given emerging interest in using administrative data for performance indicators and evaluation: the ability of federal grantees to obtain administrative data from relevant agencies.

A. Progress finalizing local evaluations

During the past year, grantees and local evaluators worked with HHS to finalize research designs and begin local evaluations. The process included identifying appropriate comparison groups, when possible; establishing partnerships and agreements with other agencies; and acquiring instruments for the cross-site evaluation. Grantee teams made progress on all fronts, but encountered some challenges as well.

1. Target population

Grantees are charged with serving families who are involved or at risk of involvement with child welfare because of substance use disorders. Grantees must have access to potentially eligible families and be able to verify their eligibility for RPG services. Of the 16 grantees enrolling families in services by April 2014, nine had difficulty at some point reaching the target population and enrolling them in services. Problems included the following:

- Could not reach rural families
- Could not serve monolingual Spanish families because project management was unable to hire staff with appropriate language skills
- Targeted parent who was participating in drug court often did not have custody of child, so the RPG project had difficulty enrolling the child in services

- Could not determine whether families were eligible unless parents consented to assessment for alcohol or drug use, which many refused to do

The last challenge may be the result of different "silos" of treatment. Because child welfare and substance abuse treatment are typically independent services with little interaction, information on both issues is not always readily available. For example, some grantees found that referrals from child welfare agencies did not typically include information on the substance use problem that triggered the referral to RPG. Unless families agreed to an assessment of alcohol or drug use, which many were reluctant to do, grantees could not determine eligibility for its RPG services.

2. Appropriate use of comparison groups

HHS required that every grantee receiving RPG2 funds evaluate its project, preferring evaluation designs with a comparison group so that the outcomes of participants could be compared to those of nonparticipants. Comparison group designs were preferred because, if well designed and implemented, they can identify the likely effect of project services and activities on participant outcomes.[19]

Not all comparison groups, however, are equally effective for determining program results. The comparison group is supposed to represent what would have happened to those in the program had they not participated. Thus all characteristics of the comparison group should be similar to those of the program group at the time they initially enrolled in RPG. Later differences, such as improved child well-being among program participants, can then be attributed to the program. But finding comparison groups similar to a program group is often a challenge in program evaluation.

All 19 local evaluations (two of the 17 grantees are conducting two evaluations of separate projects) have designs that include a comparison group (Table V.1). One grantee is using a comparison group for the local evaluation but is not collecting any of the cross-site measures on the comparison group. Across the 19 evaluations, three ways of forming program and comparison groups have been proposed:

1. Seven of the evaluations include program and comparison groups formed through random assignment, considered a very rigorous design. Because the program and comparison groups are formed by chance, the members should be the same on all measured traits, and in theory, all traits that cannot be measured.
2. Five of the evaluations will use matched program and comparison groups. Primary data will be collected at baseline (before program services) and analyzed to ensure that the groups are similar on key measured characteristics. The design cannot rule out differences in unmeasured characteristics such as motivation for change or other characteristics that might distinguish program and comparison groups, however.

[19] Other evaluation designs, such as pre-post designs that compare participants before and after a program rather than to a separate comparison group, are unable to attribute changes to the program being evaluated separate from other factors that may lead to change.

3. Seven grantees have proposed comparison group designs in which comparison group members will be drawn from administrative records. However, since information on the cases selected for the comparison group is limited to items available in the administrative records, without any additional baseline data, the ability to match the program and comparison groups and ensure their similarity is limited. Such a design may provide suggestive, but limited, information on program effects.

Table V.1. Grantees' planned evaluation designs

State	Grantee organization	Evaluation design
California	Center Point, Inc.	Matched comparison group design (comparison group not yet identified)
Georgia	Georgia State University Research Foundation, Inc.	Comparison group design
Iowa	Judicial Branch, State of Iowa	Comparison group design
Iowa	Northwest Iowa Mental Health Center/ Seasons Center	Randomized controlled trial
Illinois	Children's Research Triangle	Matched comparison group design
Kentucky	Kentucky Department for Community Based Services	Matched comparison group design
Maine	Families and Children Together	Comparison group design
Massachusetts	Commonwealth of Massachusetts	Matched comparison group design
Montana	Alternative Opportunities, Inc.	Matched comparison group design
Missouri	The Center for Children and Families	Randomized controlled trial
Nevada	State of Nevada Division of Child and Family Services	Randomized controlled trial
Ohio	Summit County Children Services	Randomized controlled trial
Oklahoma	Oklahoma Department of Mental Health and Substance Abuse Services	Strengthening Families Program: Comparison group design Solution Focused Brief Therapy: Randomized controlled trial
Pennsylvania	Health Federation of Philadelphia, Inc.	Randomized controlled trial
Tennessee	Helen Ross McNabb Center	Evaluation 1: Comparison group design Evaluation 2: Randomized controlled trial
Tennessee	Tennessee Department of Mental Health and Substance Abuse Services	Comparison group design
Virginia	Rockingham Memorial Hospital	Comparison group design (comparison group not yet identified)

Notes: Matched comparison group designs build the comparison group by matching on key characteristics of evaluation participants. Comparison group designs do not use matching on key characteristics to form the comparison group.

There are 19 designs for 17 grantees because the Oklahoma Department of Mental Health and Substance Abuse Services and the Helen Ross McNabb Center (Tennessee) plan to implement two evaluation designs.

3. Effective partnerships between grantees and evaluators

All grantees are working with an evaluator to assess their project. Most of the grantees are working with independent evaluators, but three are working with in-house evaluation staff. Grantees vary in their arrangements with evaluators in how responsibilities are divided. Some evaluators are responsible for data collection for the outcomes studies, whereas some grantees are collecting data themselves and providing it to their external or internal evaluator.

Although there have been some staffing changes, all grantees but one have maintained the same evaluator. One grantee found that the partnership with the original evaluator was not meeting their needs, and has engaged a new evaluator.

B. Status of local evaluations

In the past year, grantees and local evaluators have, in most cases, finalized their designs and begun executing them. This has required substantial planning, including obtaining approval for the designs and planning the logistics of data collection. As with any evaluation, the teams have experienced successes and challenges.

1. Successes: obtaining approvals and setting parameters

HHS required that grantees seek and obtain Institutional Review Board (IRB) approval for their designs. IRBs review the design to ensure appropriate protections are in place for human subjects, including fully informed consent and the protection of confidentiality. As of April 2014, 15 grantees had obtained IRB approval for the local evaluations, and others had applied for approval.

The grantees and local evaluators must define certain parameters of the evaluation. For example, each grantee team must select a focal child for whom cross-site evaluation data will be collected. (Collecting data on all children in the family may put too much burden on the participating families.) The teams were in the best position to develop the parameters for a focal child because they could identify the child who was expected to be most affected by the intervention, for example, if the intervention focused services on children within certain age ranges. By April 2014, all grantees had developed criteria for consistently selecting a focal child for each family.

HHS also helped grantees think through definitions for program exit, which would trigger follow-up data collection. Grantees and local evaluators had to define the core services of RPG, and definitions of program completion (such as the number of meetings with a case manager or the number of group sessions to be completed for the core services). Because many grantees offered multiple programs to families as part of RPG, careful thought was required to identify the core programs required for completion of RPG participation.

Of the 19 local evaluations (two grantees are conducting two evaluations of separate projects), 13 had begun participating in the cross-site study, including obtaining IRB approval, enrolling families into the cross-site evaluation (Section A discusses enrollment into services, of which a subset may be included in the evaluation), and collecting data for the cross-site evaluation. HHS requires that the grantee and/or local evaluator collect a consistent set of data on

the families in the evaluation sample, such as on participant outcomes and on the services received.

2. Early challenges

Although all grantees have planned an evaluation with a comparison group, several have encountered challenges in the planning or early execution of the design:

- One grantee intends to identify a comparison group but has been unable to do so to date.
- An agreement with a comparison site fell through for one grantee, which has explored alternative arrangements with three other agencies. A spoken agreement was reached with one of the agencies in March.
- One grantee is using a comparison group for the local evaluation but is not collecting any of the cross-site measures on the comparison group, and thus the potential effectiveness of the intervention on those outcomes cannot be determined.
- Three other grantees planned to do a random assignment study, but the design is threatened by low enrollment. One, for example, had planned to begin random assignment once the RPG project neared enrollment capacity. New families would then be randomly assigned to a waiting list and be enrolled as program slots became available, instead of being turned away because the project was oversubscribed. However, the program has been unable to identify enough eligible and consenting families to fill its services near capacity, so random assignment has not begun.

Several grantees have noted challenges with coordinating their local evaluations with the cross-site evaluation. The most common issue was the perceived delays in receiving the final set of cross-site data collection instruments for baseline administration to RPG participants, through the process described in Chapter II. Some grantees also felt that administering the instruments was complex and challenging. The time necessary to administer the full battery of measures is between 1.5 and 2 hours, depending on the age of the focal child. Further, multiple reporters may be needed to cover instruments in all domains of interest to HHS. For example, the child well-being measures should be answered by the primary caregiver because that person is most knowledgeable about the child. But the family functioning domain focuses on the focal child's family of origin. Thus, if the child is in foster care, the foster parent may be asked to report on child well-being, whereas the biological parent may be asked to report on family functioning and stability.

C. Data sharing

Using administrative data in an evaluation capitalizes on information collected primarily for other purposes. For example, administrative data may be more complete and accurate than self-reported data if the information is sensitive or covers a long period of time over which an individual might forget some pertinent information. They also may be less costly to collect than other forms of data. Accordingly, federal agencies such as OMB and the Government Accountability Office encourage government agencies to use administrative data in creative ways to explore relevant results (Burwell et al., 2013; U.S. Government Accountability Office, 2013).

Specific to the field of child welfare, the ACF strongly urges child welfare agencies to share data with discretionary grant projects funded by the Children's Bureau, or related federally funded initiatives. An information memorandum on the subject (ACYF-CB-IM-13-02, 2013) notes that the Bureau's grantees must use child welfare data for their local evaluations and any national cross-site evaluation that might also be conducted, in order to properly examine the outcomes and impacts of services provided under the grants. Grantees that cannot access relevant child welfare data for participants in their programs are unable to complete their required evaluations. In the memo, RPG grants are specifically mentioned as one of the federally funded grants in which child welfare agency data play a significant role. While recognizing that child welfare agencies must comply with applicable privacy laws, regulations, and policies, the memo states that sharing such data also benefits the child welfare field overall, by helping:

- To provide the child welfare field with more informed research on child welfare programs and policy
- To provide an increased number of theoretical and empirical studies that rigorously analyze and augment the understanding of federal, state, and tribal child welfare programs
- To provide timely and improved high quality data to assist child welfare agencies and grantees in making informed decisions

For the RPG evaluations, grantees were encouraged to obtain administrative data on child welfare in order to measure outcomes for their local evaluations, and for the child safety and permanency domains of the cross-site evaluation. All grantees selected a focal child for each family on which to obtain child welfare information on such outcomes as referrals, types of allegations, removals, and placements. (Grantees may have requested the same information on additional children they were including in their local evaluations.) In addition to child welfare data, grantees were asked to obtain data on substance abuse treatment for the recovery domain of the cross-site evaluation.

To learn more about substance abuse treatment, HHS also asked grantees to obtain information from state administrative data sources on dates of entry and exit from treatment on a selected adult in the family (either the focal child's primary caregiver or another adult) who was receiving RPG services.

In some cases, the RPG grantees themselves were state agencies responsible for child welfare or state agencies responsible for publicly funded substance abuse treatment programs (Table V.2). Otherwise, so that they could obtain administrative data of either or both types, grantees were encouraged to develop data-sharing agreements or memoranda of understanding with state agencies to clearly delineate responsibilities and expectations. Once the agreements were in place, grantees could submit specific data requests to staff within the relevant state agencies to provide the data.

Table V.2. Grantees that are child welfare or state substance abuse treatment agencies

State	Grantee	Agency type
Kentucky	Kentucky Department for Community Based Services	Child welfare (state)
Ohio	Summit County Children Services	Child welfare (county)
Massachusetts	Commonwealth of Massachusetts	Joint grant to state child welfare and substance abuse treatment agencies (state)
Nevada	Nevada Division of Child and Family Services	Child welfare (state)
Oklahoma	Oklahoma Department of Mental Health and Substance Abuse Services	Substance abuse treatment (state)
Tennessee	Tennessee Department of Mental Health and Substance Abuse Services	Substance abuse treatment (state)

Note: Some grantees are substance abuse treatment providers, but not state agencies that collect treatment data from publicly funded substance abuse treatment providers.

To support grantees in their efforts to obtain data-sharing agreements and to request specific child welfare and substance abuse treatment data elements, the evaluation TA contractor, Mathematica, conducted three main activities:

1. It held webinars describing sources of the administrative data that were needed and ongoing federal data collection systems or efforts for which states already prepare the records that the RPG grantees would request.

2. It provided lists of the specific data elements to be used for cross-site measures of safety, permanency, and recovery, and described how each was typically defined within these existing systems or efforts. It also prepared spreadsheets grantees could use to request data on RPG program and comparison group members.

3. In coordination with its cross-site evaluation subcontractor (Walter R. McDonald & Associates) and staff from NCSACW, it provided one-on-one TA to individual grantees as requested.

1. Support grantees received from state agencies

Almost all grantees and local evaluators began the process of working with state or county agencies. This required establishing agreements with agencies providing the data. To obtain agreements, grantees and their evaluators must identify the appropriate person or persons with whom to discuss their data needs; share the data elements of interest; and agree on logistics, such as the schedule for requests, the format of extracts, and protecting the privacy of individuals. Some of the grantees were the relevant agency for one or both administrative data sources, which greatly facilitated the process.

As of March 2014, eight grantees had agreements in place with both child welfare and substance abuse treatment agencies. Four had agreements with child welfare agencies to obtain

data, but not substance abuse treatment agencies. The remaining five did not have agreements in place with either relevant agency.

Grantees that had also received RPG1 funds were more likely to have secured data-sharing agreements, perhaps because of their previous experience and established contacts with the relevant agencies. Of the eight grantees that had established agreements with both child welfare and substance abuse treatment, six had received RPG1 funds.

Broadly, grantees were able to secure agreement with child welfare agencies faster than with substance abuse treatment agencies. Some of the grantees had the advantage of being the relevant child welfare agency: four were state or county child welfare agencies. In addition, three other grantee lead agencies were providers of child welfare or child and family services, and thus were likely familiar with the relevant agencies and may have had established points of contact.

2. Challenges grantees face from state agencies

Grantees and local evaluators generally faced more challenges working with agencies to obtain substance abuse treatment data. States are required to collect data on treatment for alcohol and substance abuse for agencies receiving public funds and report them to the national Treatment Episode Data Set (TEDS).[20] However, coverage is not always complete. For example, one state, where one of the grantees is located, generally does not provide TEDS data. Another grantee reported that the state agency did not collect all the data needed for the cross-site evaluation.

In addition to coverage limitations, grantees also encountered problems with data sharing and coordination. Other grantees reported that agencies were reluctant to share the data, citing Health Insurance Portability and Accountability Act of 1996 concerns—even though grantees had obtained consent from those in the evaluation sample—or were willing to share the data only with an educational institution. Another grantee learned that each treatment provider assigned clients its own identification number, which neither the grantee nor the state could definitively match to other information, such as a social security number.

Some grantees also experienced difficulties working with agencies to obtain child welfare data. One grantee could not identify an appropriate liaison at the state level, and thus was working to secure agreement with county child welfare agencies. Because the grantee served families from multiple counties, this would require multiple agreements. Other grantees reported that their county or state welfare agencies had a high volume of requests for data. In some cases, agency budgets for sharing data with grantees or others were stretched thin, and grantees were not in a position to make payments to defray the costs of their requests. Sometimes requests from other stakeholders, such as state or local policymakers or federal agencies, took precedence over requests from RPG grantees, which led to long delays in obtaining needed data.

[20] If not licensed through the state substance abuse agency, treatment facilities operated by for-profit agencies, hospitals, and the state correctional system may be excluded from TEDS. TEDS also excludes data for providers operated by the Bureau of Prisons, the Department of Defense, and the Department of Veterans Affairs (for more information on TEDS, see [http://wwwdasis.samhsa.gov/webt/information.htm]).

3. Implications

An increasing emphasis on using administrative data for cost and coverage highlights the importance of being able to work with relevant agencies to obtain data. This is not always a straightforward task: an appropriate liaison must be identified, the agency must be willing to share their data, and the logistics must be agreed upon. Many of the state agencies were willing partners that are working with grantees and local evaluators to share key information on families served by RPG. At least in the initial stages, grantees were generally more successful establishing agreements with child welfare agencies, likely in part because of past experience working together. However, as of March 2014, five of the grantees did not have agreements to obtain child welfare data, and nine did not have agreements for substance abuse treatment data. State agencies may be reluctant to share information if they do not have established relationships with the requesting organizations. Such agencies also have competing demands and often find it difficult to marshal the resources for data requests. The experience of the 2012 RPG grantees has also shown that the expected data are not always available or accessible. In some cases, these challenges undermine or prevent the use of administrative data for evaluation purposes.

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VI. LOOKING AHEAD

Since the beginning of the 2012 RPG grant program, HHS has assessed grantees' program strategies and evaluation plans, provided TA to ensure program success and strengthen the proposed evaluations, and designed and launched a cross-site evaluation. On their part, the grantees have (1) continued or established their regional partnerships; (2) worked with partners to refine and implement their programs, including providing EBPs and addressing trauma; and (3) begun enrollment. During the past reporting period, HHS reached critical milestones needed to obtain data from grantees for reporting performance indicators and completing the cross-site evaluation. Data collection will ramp up in the coming year. HHS also established plans to fund a third cohort of RPG grants beginning in October 2014. This chapter describes these "next steps" in the RPG program, along with the planned content of future reports to Congress.

A. Cross-site evaluation data collection

HHS received OMB clearance for the cross-site evaluation in March 2013. It then began providing data collection materials to the grantees, and initiated training on the data collection systems being developed for grantees to submit implementation and outcome data. Most grantees have launched data collection and other evaluation activities and will be submitting data to the cross-site evaluation in the next reporting period. In the coming year, HHS will also field two surveys for the cross-site evaluation.

1. Submission of implementation and outcome data by grantees

In contrast to the first round of RPG grants, when grantees selected measures to report from a menu of performance indicators, the 2012 grantees will all provide common data and measures. As under the earlier grants, however, HHS chose to establish automated systems through which grantees could provide the data. Use of such systems is intended (1) to ensure data quality and completeness through use of automated validation procedures, and (2) to motivate grantees to organize their own data for analysis and by providing infrastructure they can use to do so—such as spreadsheets and forms tailored to each data requirement. Beginning in the next reporting period, RPG grantees will provide implementation and outcome data for evaluation and reporting through the two web-based data collection systems developed by HHS.

Implementation data. The RPG cross-site evaluation will contribute to building the knowledge base about effective implementation strategies by examining the process of implementation in the 17 RPG projects, with a focus on factors shown in the research literature to be associated with quality implementation. Implementation outputs to be examined include reach into the target population, enrollment levels, dosage and duration of services received by families, content delivered, adherence/fidelity to EBP requirements, and participant responsiveness. To facilitate an assessment of these service delivery outputs, HHS developed a web-based "enrollment and services log" (ESL), launched in early June of 2014. Grantee staff use the ESL to record:

- Demographic information about RPG case members at enrollment.[21]
- Enrollment and exit dates for each case that enrolls in the RPG project.
- Enrollment and exit dates for all EBPs that are offered as part of the RPG project.
- Information on each service delivery contact for any of the 10 focal EBPs implemented by the grantee.

Data will be entered on a continuous basis by grantee staff who enroll adults and children into RPG and by direct services staff (such as caseworkers and therapists) to provide services or facilitate program sessions. While the cross-site evaluation contractor has access to all data, the system is also designed to allow grantees to download their own data at any time, for use in their evaluations or for program management and improvement.

Outcome data. The cross-site evaluation outcomes study provides an opportunity to describe the changes that occur in children, adults, and families who participate in the 17 RPG projects. The outcomes study will use primary data and administrative data collected or obtained by the grantees and their evaluators. Primary data will be based on self-administered standardized instruments that HHS has asked all grantees and their evaluators to give to RPG participants. The administrative data will include a common set of child welfare and substance abuse treatment elements that grantees and their evaluators will obtain from states or providers. The cross-site evaluation will use scores created from the instruments, individual items, or constructed variables to examine outcomes by comparing data at baseline and program exit. Grantees will also use the data in their local evaluations. Beginning in October 2014, grantees were required to submit data from the instruments and administrative sources twice each year to the Outcome and Impact Study Information System (OAISIS), an online data collection system. Unlike the ESL, grantees cannot download their data from OAISIS. However, they can extract data from the tools designed for data submission, and create analysis files for their own use.

2. Partner and staff surveys

Between April and June of 2015, two surveys were conducted as part of the cross-site evaluation partner and implementation studies—one of RPG grantees and their partners, and another of direct service staff working with RPG 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. The survey will collect information about partners' characteristics, their goals for RPG and their relationships within the partnership, and outputs of the partnerships.
- 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

[21] For the cross-site evaluation, an RPG case is the group of people who present themselves to enroll in an RPG program. A case may be a family or household in which some members are biologically related and some are not.

in depth. Those surveyed will include staff who provide direct services to children, adults, and families, such as caseworkers, therapists, and session facilitators, and their supervisors. This group will include staff employed directly by the grantee organization, as well as staff employed by other implementing agencies that are partnering with the grantee. The staff survey will collect information on staff characteristics and attitudes toward implementing EBPs, characteristics of their organizations, supports and supervision they receive, and their experiences implementing the focal EBPs.

B. Funding a third round of RPG grants

The Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) reauthorized the existing RPG program and extended funding through 2016. With the funding, HHS funded the 2012 RPG 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 one of these "extension grants," which came to an end in September 2014. HHS decided to use the authorized funds then remaining for a third cohort of five-year RPG grantees.

On January 9, 2014, HHS published a grants 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 five years. As with the RPG grants funded in 2012, the primary applicant had to be a regional partnership organization of one of 11 parties (Table V1.1) 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. In 2012, the Children's Bureau funded 17 RPGs, which are participating in the RPG national cross-site evaluation.
- To use specific, well-defined, and evidence-based programs that are also trauma-informed and targeted to the identified population.
- To conduct an evaluation sufficiently rigorous to contribute to the evidence base on service delivery and outcomes associated with the project's chosen interventions.

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 will become 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.

Table VI.1. Types of regional partners for 2014 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 abuse 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 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 that is located in a state that is state-supervised and county-administered, the county child welfare agency satisfies this requirement.

C. 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 will depend on the phase of the project and available data. Table V1.2 summarizes the data sources to be used for the future reports.

Table VI.2. Data sources for future annual reports to Congress

	2015	2016	2017
Semiannual progress reports	X	X	X
ESL data collection system (implementation data)	X	X	X
OAISIS data collection system (outcomes data)	X	X	X
Partner survey		X	X
Staff survey		X	X
Site visits			X

- The **2015 report** will use implementation and outcomes data from grantees to provide enrollment, service, and baseline and follow-up outcome measures for participants enrolled and served from the beginning of RPG.
- The **2016 report** will include findings from the surveys of RPG partners, and of staff members providing EBPs being studied in-depth for the cross-site evaluation.
- The **2017 report** will make use of all data sources, including site visits. It will present findings from all four of the cross-site studies, including the impact study. 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.

As required by the legislation, HHS will submit a 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 abuse problems 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.

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