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

June 2018

2014 Regional Partnership Grants Cohort 3 Report:
RPG3 Participants at Baseline

MATHEMATICA Policy Research

Children's Bureau

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2014 Regional Partnership Grants Cohort 3 Report: RPG3 Participants at Baseline

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Regional Partnership Grants
and Cross-Site Evaluation

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I. INTRODUCTION

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

- **First round of grants (RPG1).** The Child and Family Services Improvement Act of 2006 (Pub. L. 109-288) authorized and appropriated $145 million over five years for the first round of RPG funding. HHS made two- to five-year grants to 53 partnerships in 29 states in 2007. In 2012, HHS also offered existing grantees new grants of $500,000 per year for up to two years to extend their programs.
- **Second round of grants (RPG2).** The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) reauthorized the RPG program and appropriated $100 million of funding for new grants. In September 2012, the Children's Bureau awarded new grants to 17 organizations in 15 states. HHS contracted with Mathematica Policy Research to conduct a cross-site evaluation and provide technical assistance (TA) to help grantees conduct their own local evaluations.[1] A subset of grantees participated in a cross-site impact evaluation.
- **Third round of grants (RPG3).** In September 2014, a subset of the funds from The Child and Family Services Improvement and Innovation Act of 2011 (Pub. L. 112-34) became available to support additional grantees. The Children's Bureau awarded another round of five-year grants to four organizations in four states. Similar to RPG2, these new grantees also participate in the cross-site evaluation that was underway for the 2012 grants, including the implementation, partnership, and outcomes studies, and receive evaluation- and program-related TA from Mathematica.[2]

This is an interim report to the Children's Bureau on RPG3.

A. RPG3 grantees

Among the four RPG3 grantees (Table I.1), one is a university, and three are local service providers. The partners in each site have worked together to design the RPG program, identify families to participate, provide services, and design and implement local evaluations. A subset of the RPG3 grantees is also participating in the cross-site impact evaluation.

[1] Mathematica provides these services under contract number HHSP233201250024A, "RPG National Cross-Site Evaluation and Evaluation-Related Technical Assistance."

[2] Participation in the RPG cross-site evaluation and provision of evaluation-related TA for RPG3 grantees is supported through contract number HHSP23320095642WC_HHSP23337058T, "Evaluation-Related Technical Assistance and Data Collection Support for Regional Partnership Grant Program Round Three Sites."

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

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

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

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

As the grant required, each partnership includes the state or county child welfare agency, either as the primary grantee or as a partner. In addition to child welfare agencies, the most common members of RPG3 partnerships are substance abuse treatment agencies and providers, and nonprofit or private child welfare services providers. Two of the grantees identified existing community collaborations or partnerships focused on child welfare as part of their RPG3 partnerships; two partnered with the developer of their primary evidence-based program or practice model (EBP), and one identified the family court as an RPG partner.

B. Purpose and organization of this report

This is the third year of program implementation for the RPG3 grantees. The purpose of this interim report to the Children's Bureau is to describe (1) the implementation progress of RPG3 projects, (2) the baseline characteristics of RPG3 participants, and (3) participant enrollment in programs and services. In prior years, Mathematica presented RPG3 findings in a separate chapter of annual reports to Congress produced as part of the RPG2 cross-site evaluation and TA contract. However, this year is the final RPG2 report to Congress and, as such, must meet special requirements in the legislation—making the inclusion of a separate RPG3 chapter less appropriate. The Children's Bureau requested this interim report rather than deferring information on implementation progress, baseline characteristics, and service enrollment for a full year. Mathematica might integrate key findings from this report into an RPG3 report to Congress produced in summer 2018, if requested by the Children's Bureau.

The report uses data from three main sources:

- **Semiannual progress reports.** Grantees must report semiannually on their spending and progress during the term of their grants. Their reports provide information on grantees' enrollment, their planned interventions, target populations, and successes and challenges. This report draws on reports submitted in April 2016 and April 2017.
- **Enrollment and services data.** To document participant characteristics and their enrollment in EBPs, grantees provide data on enrollment of and services provided to RPG families/cases. Data include demographic information on family members, dates of entry into and exit from the RPG program and each EBP, and information on each service delivery contact for a subset of EBPs implemented by grantees. This report includes data on RPG3 families and individuals enrolled through February 2017.
- **Outcome data.** To measure participant outcomes at program entry, grantees use self-administered instruments collected from RPG adults. These standardized instruments collect information on child well-being, adult and family functioning, and adult substance use. Grantees also obtain administrative data on a common set of child welfare and substance use disorder treatment elements. This report includes data on the characteristics measured at baseline, or program entry, for RPG3 participants enrolled through February 2017.

This report is organized as follows:

- Chapter II describes the RPG3 grantees and their descriptions of enrollment via the semiannual progress reports, and their implementation progress, successes, and challenges. It reports on evaluation-related TA provided to grantees.[3]
- Chapter III describes the families enrolled in RPG3 as part of the cross-site evaluation through February 2017, including the occurrence of child maltreatment and out-of-home placement in the year before RPG3 enrollment.
- Chapter IV discusses child and adult well-being and adult functioning at program entry.
- Chapter V describes participant enrollment in programs and services, including identifying the EBPs offered and showing the number of families enrolled in EBPs.

For information on the design of the RPG cross-site evaluation, evaluation data and measures, implementation progress and baseline characteristics for RPG2 participants, and early implementation of RPG3, the reader can look into the reports identified in Table I.2.

[3] RPG grantees also receive program-related TA. As part of its contract to manage the National Center on Substance Abuse and Child Welfare, supported through an intra-agency agreement between the Substance Abuse and Mental Health Services Administration and ACYF, the Center for Children and Family Futures provides program-related TA to the grantees.

Table I.2. Prior RPG cross-site evaluation reports

Report title	Report topic(s)	Citation
Regional Partnership Grant Program Cross-Site Evaluation Design Report	Design of the RPG cross-site evaluation (evaluation components, research questions, data sources, and data collection plan)	Strong et al. 2014
2012 and 2014 Regional Partnership Grants to Increase the Well-Being of and to Improve the Permanency Outcomes for Children Affected by Substance Abuse: Third Annual Report to Congress	The funding of RPG3 and a description of the RPG3 projects. Also describes RPG2 grantees at baseline, and their enrollment into RPG projects and EBPs	HHS 2016
2012 and 2014 Regional Partnership Grants to Increase the Well-Being of and to Improve the Permanency Outcomes for Children Affected by Substance Abuse: Fourth Annual Report to Congress	Early enrollment in RPG3	HHS forthcoming

II. IMPLEMENTATION PROGRESS

In this chapter, we describe the RPG3 grantees in more detail. We first provide information on enrollment in the four RPG3 programs from HHS award in 2014 through spring 2017 and describe the grantees and their projects, based on grantee semiannual progress reports.

To more fully understand grantee progress, we then provide a portrait of each grantee's implementation progress. Social programs, even ones that research shows to be effective, will fail their clients if they are never implemented as intended (Mead 2016). Increasing the quality of implementation increases the chances that an EBP will achieve its intended outcomes. Wandersman et al. (2016) noted that it is important to look not only at the quality of implementation, but also at interventions in the settings (context) in which they are implemented. This chapter describes the challenges grantees have faced in implementation, key successes as they addressed challenges, and critical contextual issues. It concludes with a description of the TA provided to support grantees' evaluations.

A. RPG3 grantees and their projects

The four RPG3 grantees bring diverse perspectives to this work; they represent different types of organizations, and each has a unique target population and program focus selected to align with local needs (Table II.1). Two grantees are local providers of child and family services, one is a university, and one is a medical center. Three grantees received $600,000 annually and one received $564,914, with increasing percentages of required grantee matching funds over time. One of the four grantees had also received RPG funding in 2007, but none was a 2012 RPG2 grantee.

Table II.1. RPG3 grantees, organization type, funding level, and description of target population and program focus

Grantee organization and state	Organization type	Federal grant amount	Planned target population and program focus
Our Kids of Miami-Dade/ Monroe, Inc., Florida	Provider of child and family services	$600,000	Through the Miami-Dade IMPACT Project, Our Kids and its partners provide a suite of services to families with children from birth through age 11 who are referred through the child protective investigation process for diversion or prevention. Services include (1) the Multi-Dimensional Family Therapy – Family Recovery (MDFT-FR; formerly known as the Engaging Moms/Parenting Program), which provides additional support for engagement in substance use disorder treatment, family therapy interventions, and supports to improve parenting skills; (2) engagement with a peer specialist; (3) intensive family preservation services; and (4) referral to the area's Motivational Support Program, which connects clients to needed substance abuse and mental health treatment services.
University of Kansas Center for Research, Inc., Kansas	Public university	$564,914	Through the Kansas Serves Substance Affected Families (KSSAF) project, the University of Kanas Center for Research and its partners target families with substance use disorders and children up to 47 months old in foster care or at risk of out-of-home placement. Families receive the Strengthening Families Program: Birth to Three (SFP B-3).
Montefiore Medical Center, New York	Medical center, provider of substance use disorder treatment and child and family services	$600,000	Montefiore targets families with substance use disorders and open and indicated child welfare cases where children are at risk for removal. Families participate in the Family Treatment/ Rehabilitation (FT/R) program and receive three program enhancements. The FT/R program (which is funded by the New York child welfare agency) includes such services as clinical assessment of substance abuse, referrals to substance abuse treatment or other services, home visits, and case management. The three enhancements for RPG include Seeking Safety, Incredible Years, and contingency reinforcement.
Volunteers of America – Oregon (VOAOR), Oregon	Provider of child and family services and substance use disorder treatment	$600,000	VOAOR and its partner provide a recovery-oriented system of care for parents in recovery from substance use disorders who are either engaged with or at risk of engagement with child welfare. In eligible families, the adult in recovery has already completed treatment for substance use disorder. Services are provided through VOAOR's Family Recovery Support (FRS) program, a drop-in center that offers access to a range of services. Participants are matched to a certified peer recovery mentor if requested; they may also work with a resource specialist and/or therapist. Each participant develops a recovery support plan that selects services from a menu of options.

Source: Grantees' RPG3 applications, cross-site evaluation grantee liaison records, and other grantee materials.

All four of the grantees have been enrolling participants and actively providing services since 2015. Table II.2 shows enrollment totals reported by each grantee in the April 2016 and April 2017 semiannual progress reports. For the Florida and Kansas partnerships, where services are targeted to whole families, enrollment totals include both adults and children. For New York

and Oregon, where services are targeted to parents only, enrollment totals include only adults.[4] In April 2017, grantees reported enrollments ranging from 29 adults in New York to 408 adults and children in Kansas. Enrollment totals more than doubled over the one-year period for both grantees—from 11 to 29 in New York and 179 to 408 in Kansas.

Table II.2. Enrollment reported by grantees in April 2016 and April 2017

	April 2016		April 2017	
Grantee and state	Enrollment	Percentage of children	Enrollment	Percentage of children
Our Kids of Miami-Dade/ Monroe, Inc., Florida	90	68	113	70
University of Kansas Center for Research, Inc., Kansas	179	46	408	47
Montefiore Medical Center, New York	11	n.a.	29	n.a.
Volunteers of America – Oregon, Oregon	117	n.a.	199	n.a.
Total	397		749	

Source: April 2016 and April 2017 semiannual progress reports

n.a. = not applicable. The New York and Oregon programs directly serve adults (not children).

B. Implementation progress, successes, and challenges for each grantee

Since services began, each grantee has had to address challenges related to staff turnover and develop strategies for improving enrollment to meet its planned target. In the face of these challenges, grantees have implemented new strategies or made changes that ultimately lay the foundation for important successes. Looking ahead, all grantees will have to focus on improving enrollment to both meet service targets and successfully evaluate the impact of their program.

1. Florida—the Miami-Dade IMPACT Project

The IMPACT Project serves families in Miami-Dade County who are referred through the child protective investigation process for diversion or prevention. The IMPACT Project began serving families in August 2015. As of April 2017, it had enrolled 33 families (including 34 adults and 79 children). Of these 33 families, 15 had successfully completed the program, 14 were still involved in the program, and 4 had dropped out.

When the child protective investigation process identifies a family in need of services, the grantee—Our Kids—receives the referral. If Our Kids determines that the family is eligible for RPG services, the family is assigned to the partner agency that provides RPG services. From 2016 to 2017, the grantee successfully transitioned provision of the RPG program—Multi-Dimensional Family Therapy – Family Recovery (MDFT-FR)—to a new partner. The change was critical because the prior partner agency had experienced challenges with staff turnover and

[4] In subsequent chapters, we will us an alternate definition of *case* for the purposes of the cross-site evaluation (notably, one that does include children).

difficulty hiring new therapists to provide RPG services. Although this transition created challenges, the process of developing and implementing solutions led to several successes.

- **Substance use treatment provider offering family preservation services.** The new RPG partner providing MDFT-FR is a substance use disorder treatment provider. According to the grantee, this is the first time in Miami-Dade County that a substance use disorder treatment provider is directly providing family preservation services, per the local RPG project's plan.
- **Hiring and training for implementation.** When RPG services shifted to a new partner, it had to hire and train new therapists. Because the provider had no experience providing child welfare services to families, the therapists needed extensive training in providing MDFT-FR and in all areas of child welfare. By October 2016, the new partner was fully staffed; it currently operates with four trained therapists, one of whom is a lead therapist and co-trainer with the MDFT-FR developer. The grantee and MDFT-FR developer have adapted the trainings to better align with the needs of this new cohort of therapists.
- **Greater capacity to serve clients.** With four therapists, the IMPACT Project has the capacity to take on more cases at any one time than it did during any previous period in the grant. The IMPACT Project enrolled more families from April to September 2017 than it did in any previous six-month period since the grant began in October 2014.
- **Implementation with fidelity.** Since the start of the RPG grant, the MDFT-FR developer has worked closely with the grantee to train and supervise therapists implementing the model and to ensure fidelity to the model. The grantee planned for the developer's involvement to decline as the capacity of program staff increased. The grantee and developer agree they are nearing the point where developer involvement will no longer be necessary.
- **Reduced wait times.** The previous partner for RPG services provided family support and education services and was therefore well connected to child-specific services in the community. The new partner does not have these same connections and has struggled to access services for children in a timely manner. With its focus on developing new partnerships in this area, the grantee is now seeing that families are receiving needed services for children without long wait times.
- **Interventionists meeting the many needs of clients.** Implementing the RPG grant program has produced peer specialists trained in both recovery support and child welfare issues in the local area. Before this grant, peers had certification in mental health services and substance abuse treatment, but none had expertise in child welfare. In addition, due to the RPG program's success in increasing interest among peers with child welfare experience, the local community has developed two additional peer programs with this focus.
- **Strong local evaluation.** This grantee is implementing a rigorous, random-assignment evaluation. When it changed partners for RPG services, it had to update its evaluation procedures. The evaluation and program staff worked together to successfully update the random assignment process in a way that maintained the rigor of the evaluation and met all requirements related to providing family preservation services. The lead evaluator partners closely with the lead program staff, an arrangement that allows for formative feedback based on what she learns in her qualitative data collection. In addition, the evaluation team is very

responsive to the program's changes and has been addressing them as part of the evaluation to provide additional lessons learned.

The grantee continues to face one primary challenge: enrollment is lower than its original target. There are three main reasons for this. First, staff turnover at the prior RPG partner meant that it could not serve as many families as planned at any one time. Second, when RPG services moved to the new partner, the IMPACT Project stopped taking new cases for about five months to accommodate all necessary transition activities (for example, establishing a contract with the new service provider, hiring and training MDFT-FR therapists). Third, referrals from child protective investigations are not as frequent as originally anticipated, due to a change in practice at the state level. Around the time the IMPACT Project began enrolling families, the state changed the safety practice model. Based on the grantee's experience, this has created uncertainty in the community (including among child protective investigators who provide referrals for the IMPACT Project) about who can be referred for family preservation services, when they can be referred, and whether families need certified case management in addition to or in lieu of family preservation services. This has reduced the number of eligible families and referrals for the IMPACT Project (and for family preservation services throughout the state). The reduction was so significant that in March 2017, the secretary of the Department of Children and Families released a memo to clarify safety procedures and support referrals for services.

The grantee is hopeful that enrollment will continue to increase. Because the new partner is now fully staffed, challenges associated with enrollment stemming from the first two issues (staff turnover and a temporary stop in services) are likely to decrease. To address the third issue—referrals—the grantee is reaching out to the community, including to child protective investigators. The grantee also communicates regularly with the Department of Children and Families' administration and other community partners to ensure their involvement in addressing this issue.

2. Kansas—Kansas Serves Substance Affected Families (KSSAF)

The KSSAF project implements Strengthening Families Program: Birth to Three (SFP B-3) among families with substance use disorders who have children up to 47 months old in foster care or at risk of out-of-home placement. The KSSAF project began enrolling families in August 2015. As of April 2017, it had enrolled 143 families including 214 adults and 194 children, and 85 families had successfully completed the program. Of the remaining families, 42 were still involved in the program and 16 had dropped out.

The KSSAF project serves families in six locations across Kansas. Each SFP B-3 cycle lasts 16 weeks, and the program typically operates at four locations at any one time. Local partners from one of two privatized child welfare agencies in the state of Kansas provide the services. The grantee—the University of Kansas—works closely with agency staff in each site to identify eligible families and implement SFP B-3 trainings for its staff. The grantee consistently uses available data to plan and then evaluate program improvements. The grantee is also responsive to both the needs of staff providing services and to input from partners. With this approach, the KSSAF project has achieved several implementation successes and is quick to develop solutions in response to challenges.

- **Adapting the intervention for young children.** When KSSAF began implementing SFP B-3, this version of the curriculum—which targets families with infants and toddlers—had not yet been in wide use. The grantee has worked closely with the implementation specialist since SFP B-3 implementation began to assist as needed for working with this young population. For example, the grantee determined that the optimal group size for this version of SFP B-3 is smaller than it would be for the version focused on families with slightly older children. The grantee and partners have also created a supplemental document with age-appropriate examples to improve the developmental appropriateness of the curriculum for the birth to age three population. When the project began, the grantee developed a team website on which documents supporting implementation were available to the project's implementation team. The grantee has maintained this website, regularly updating materials as new resources become available and as decisions emerge on adjusting the approach to implementation.
- **Building intervention sustainability through frequent training.** To support the project's sustainability and avoid issues created by staff turnover, the grantee holds SFP B-3 trainings every year. Trainings are open to staff at the agencies that provide SFP B-3 for RPG as well as for other members of the local communities (for example, to volunteers who support implementation through local partnerships in each site, staff at community-based agencies that provide other services to families with young children). To help it decide when and where to hold trainings, the grantee tracks capacity for delivering SFP B-3 in each site (numbers trained, turnover among those who have been trained).
- **Implementation with fidelity.** The SFP B-3 implementation specialist closely monitors fidelity of local implementation to the program model, and the team assesses parent satisfaction in each cycle. Since services began, the team has received positive evaluations in both areas. The grantee shares findings from its fidelity and satisfaction monitoring with the project steering committee and implementation team members as part of discussions about ongoing program improvements.
- **High rates of program completion.** According to the SFP B-3 implementation specialist, program completion rates (81 percent across the first five cycles) are high. The grantee actively works with the agencies implementing SFP B-3 to avoid dropout. For example, the grantee developed guidelines for the agencies that clearly outline how to handle make-up sessions when a family misses a session. The grantee and agency staff also regularly communicate to strategize about specific cases as issues arise.
- **Strong local evaluation.** This grantee is implementing a rigorous, random-assignment evaluation. Families are randomly assigned to RPG services or a comparison group that receives the typical/usual services provided in Kansas. However, in the rural sites, filling the SFP B-3 cycle to capacity can be challenging, which makes random assignment less feasible. The project's steering committee—which includes key partners from across the state—preferred that more families receive SFP B-3, in particular, when there is sufficient capacity. Working closely with the steering committee, the grantee developed a solution for this problem that enabled the grantee to maintain its rigorous evaluation. Specifically, it now uses unequal randomization ratios; with this approach to random assignment, more families are assigned to RPG services than to comparison services. Over time, the grantee has shifted to using this approach in all six sites (rather than just in the rural sites). This has helped the

grantee meet its original service goals for its RPG program. In addition, it recently revisited the randomization procedures to make the process more efficient, which provides agency staff with more time for recruitment.

- **Evaluation dissemination.** The grantee has begun sharing early results from its local outcome evaluation with its steering committee and implementation team. Both groups value this information, and the grantee is hopeful that continuing this sharing will support buy-in and engagement of partners in sustainability efforts.

Moving forward, the grantee will continue to focus on both capacity for implementing SFP B-3 in each site and encouraging high enrollment and completion rates. Although the grantee has successfully addressed enrollment issues over time, it expects that site-specific challenges will continue.

3. New York—a regional partnership for New York City to improve child welfare outcomes among families with substance use disorders

Montefiore Medical Center implements Family Treatment/ Rehabilitation (FT/R) and the three program enhancements (Incredible Years, Seeking Safety, and contingency reinforcement) among families with (1) substance use disorders and (2) open and indicated child welfare cases where children are at risk for removal (but have not been removed). Montefiore began enrolling families in July 2015. As of April 2017, it had enrolled 29 cases (individual adults). As of April 2017, 8 adults had successfully completed the program. Of the remaining adults, 16 were still involved in the program and 5 had dropped out.

Montefiore provides all services. Families are referred to Montefiore's FT/R program by the New York child welfare agency. (FT/R is funded by New York's child welfare agency and implemented by contracted agencies across the city.) Once referred to FT/R, staff determine whether the family is eligible for RPG. If a family is eligible, an adult from the family is then recruited for and enrolls in substance abuse treatment in Montefiore's outpatient program and the three program enhancements. One Montefiore staff person implements the three program enhancements on-site at the substance abuse treatment program. Key successes and challenges stem from issues related to staffing and enrollment.

- **Achieving recruitment goals.** The grantee aims to recruit 20 adults per year, and as of September 2017 it had met that goal. However, when implementation first began, enrollment was slower than planned. During the first two years of providing services, the grantee implemented two strategies to address this problem. First, the team revisited and then simplified enrollment procedures. It determined that adults encountered too many steps when trying to enroll, which limited enrollment. The grantee combined some of these steps to remove barriers to enrollment. Second, it worked closely with the child welfare agency to ensure the flow of adults to its FT/R program was sufficient for meeting RPG service goals. The grantee continues to use this simpler enrollment procedure, and it has maintained its close partnership with the child welfare agency.
- **Adapting program implementation to accommodate client availability.** The grantee had originally planned to implement Incredible Years and Seeking Safety in small groups. Because the program is (intentionally) small, the number of clients available to implement

these enhancements in a group format is usually insufficient. Therefore, the grantee has been flexible in its approach, providing Incredible Years and Seeking Safety either one on one or in small groups depending on program enrollment.

- **Filling a gap in service provision following staff turnover.** In July 2017, the RPG staff person who provided the three program enhancements left Montefiore. The project director ensured continuity in services by providing the three enhancements herself while the grantee was searching for and hiring a new RPG staff person.
- **Identifying a matched comparison group.** This grantee is using a quasi-experimental, matched comparison group design to evaluate the impact of the program. To do so, it must reach outside of the RPG program's referral source to identify and recruit a matched comparison group. It has closely monitored the progress of this recruitment throughout the grant. When it was concerned about not meeting the enrollment target for the comparison group, the grantee reached out extensively to identify other recruitment opportunities. Because of this outreach, it is now close to meeting the targeted number of comparison group cases; it has recruited 152 of the targeted 200 cases. In addition, the grantee is considering how it can use local data to support sustainability planning.

In sum, the grantee will continue to monitor recruitment and implementation this year, and will focus in particular on moving forward with its local evaluation efforts.

4. Oregon—Family Recovery Support (FRS)

Unlike the other RPG3 projects, this grantee, Volunteers of America – Oregon (VOAOR), targets individuals who have already completed substance use treatment (they are in recovery from a substance use disorder); participants are from families who are engaged with or at risk of engagement with child welfare. VOAOR began enrolling cases in February 2015. As of April 2017, it had enrolled 199 cases (individual adults). As of April 2017, 12 adults had successfully completed the program. Of the remaining adults, 119 were still involved in the program and 68 had dropped out.

The grantee provides services in Multnomah County, Oregon, through a partnership between VOAOR and the Miracles Club, another local organization supporting those in recovery. Grantee and partner staff reach out extensively in the community to ensure individuals are aware of the program. All services take place through VOAOR's FRS drop-in center. Key challenges this grantee faces stem from both staff turnover and efforts to integrate a more structured program (RPG services) into the drop-in center model (which is quite fluid). Key successes stem from efforts to better understand the population accessing FRS services and targeting RPG services in the context of the drop-in center.

- **Filling staff vacancies in response to turnover.** RPG services are provided by peer mentors, therapists, and a resource specialist who work out of VOAOR's FRS drop-in center. Over the course of the grant, each of these positions turned over at least once. As of September 2017, the program was once again fully staffed, with members of the staff trained in the key EBPs and practices offered to clients. Even while addressing issues of staff turnover, the grantee continued outreach and enrollment efforts and provided the full range of planned services.

- **Monitoring sample recruitment and service flow.** The grantee reviewed its cases to understand the flow of clients into the program and to determine whether it could further target its recruiting. When planning this program (before the grant began), the grantee developed enrollment targets and procedures based on its experience with individuals who typically dropped in to the FRS program each month to engage in at least one service. This group included families who were likely still using substances, who might be homeless, or who may have other barriers that created instability in their families. These families are part of the target demographic for the FRS drop-in center and were likely receiving at least one service such as assistance accessing treatment and housing. However, they are generally not stable enough to participate fully in the RPG program (and if they were still using substances would not be part of the target population). RPG services require a higher level of engagement; adults develop recovery support plans with a staff member, and the expectation is that they will remain engaged in the program to complete the services and meet the goals in that plan. Based on its case reviews, the grantee determined that many adults who were officially enrolled in the RPG program on their first visit were not returning to the program for further services.
- **Revising enrollment procedures to better match individuals with programming.** Using the lessons learned from its case reviews, the grantee has developed new enrollment procedures to better identify those who are ready for services that are at the level of the RPG program. Previously, any individual who expressed interest in the program was enrolled on his or her first visit to the FRS drop-in center. Under the new enrollment procedures, individuals are enrolled on the first visit only if they convey a clear willingness and capacity to engage in the program. For other cases, enrollment does not occur until at least a second visit. For those cases who are not yet ready to enroll, the grantee identifies them as part of its "pre-enrollment" pool; connects them to any services needed immediately (for example, referrals to access treatment); and establishes plans to follow up at a later time. In addition, the grantee is reviewing the background information collected on both pre-enrollees and full enrollees so it can continue to accurately target services and improve enrollment procedures.
- **Conducting outreach to boost recruitment.** Both FRS and Miracles Club staff have engaged in extensive outreach efforts to inform community members about the program. They target both program staff (for example, caseworkers in substance abuse treatment programs or in child welfare offices) and individuals receiving services. In planning the RPG program, the grantee noted that few services targeted African American families, specifically. Therefore, outreach to African American families in the service area remains a priority.
- **Responding to real-world evaluation issues.** This grantee is using a quasi-experimental, matched comparison group design to evaluate the impact of the program. Enrollment in both the treatment and comparison groups is lower than expected. Treatment group enrollment is lower than targeted for two reasons. First, the program has enrolled fewer adults than planned, and this has a direct impact on the numbers referred to the evaluation. Second, adults are recruited for the evaluation only if they permit staff to share their contact information with the evaluation team; due in part to turnover, program staff may not have been consistent in asking adults about their interest in participating in the evaluation. The evaluation team is working closely with the program to address this issue. Enrollment in the comparison group is lower than targeted because the planned sources for comparison group

members have not dedicated the time needed to the evaluation. The evaluation team is currently reaching out to additional sources for comparison group members.

Given the lessons learned from recruitment and enrollment procedures, the grantee will prioritize this activity in the coming year to ensure that the appropriate population is receiving services and that the evaluation can credibly test the program's effectiveness.

5. Summary and key themes

Since the start of implementation, each grantee has had several successes related to providing services. Three of the four grantees have consistently served clients since their program began operating. The fourth, Florida, worked hard to successfully shift services to a new partner when the previous partner unexpectedly stopped providing services; since moving to the new partner, it has more capacity for providing RPG services than in any prior period of the grant. Throughout implementation, the grantees have focused on meeting staff training needs, working with partners to support the success of their program, and carrying out their rigorous evaluations as designed.

For all four grantees, the primary challenges they have faced relate to staff turnover and maintaining target enrollment levels. Three of the four grantees (Florida, New York, and Oregon) have had to replace all of their frontline staff. (One of the grantees, New York, has only one frontline staff person.) Although turnover inevitably created challenges, all of the grantees successfully replaced and trained those staff in their RPG approach. With regard to enrollment, all of the grantees proactively worked to increase their enrollment, but the focus of their efforts has differed across grantees. In Florida, the team is reaching out extensively to increase referrals. In Kansas, the grantee enhanced relatively strong program enrollment by adjusting its evaluation design (to assign more families to RPG services). In New York and Oregon, grantees have revisited enrollment procedures to strengthen the flow of clients into the RPG program.

Looking ahead, all grantees will have to stay focused on improving enrollment to both meet service targets and complete impact evaluations of their program. As they increase their focus on sustainability efforts in the coming months, outreach to partners will be critical. To support those efforts, the cross-site evaluation team will work with grantees to help them consider ways they can use their local data to inform service provision and tell the stories of their efforts.

C. TA provided

The RPG3 teams use a range of evaluation approaches and have varying needs for support and assistance. As a result, it is critical for the cross-site evaluation to systematically monitor TA provided by the cross-site liaison (CSL), the front-line resource for each grantee to access the RPG team, and other members of the broader RPG team. In this section, we summarize the TA provided based on three types of tickets that we monitor regularly:

1. TA request tickets to track specific TA requested by the grantee or evaluator from the CSL (Table II.3)
2. Call tickets to monitor monthly and other TA calls with grantees and evaluators (Table II.4)

3. Data collection help desk tickets to track grantee-requested support through the RPG Help Desk phone line or email regarding use of the cross-site evaluation data collection instruments and processes (Table II.5)

In the following tables, we summarize both the number of TA tickets and the focus of those TA interactions. Of the 12 individual TA requests made to date, grantees most often requested support with data collection and random assignment issues (Table II.3). Notably, however, all of these requests occurred during the earlier phases of the grant; no new TA requests occurred this year.

Table II.3. RPG3 TA request tickets opened through September 2017

	Number of requests (current year)[a]	Number of requests (cumulative total)[b]
Number of TA requests received	0	12
Topics of TA requests		
Data collection	0	5
Institutional review board	0	2
Random assignment	0	3
Analytic methods	0	1
Outcomes	0	1

[a] Requests received from October 2016 to September 2017.

[b] Requests received from February 2013 to September 2017.

Of the 175 call tickets received to date, the vast majority (111) have been for ongoing meetings between grantees, evaluators, and their CSL, program management liaison (PML), and federal project officer (FPO) (Table II.4). In about one-third or more of the 175 calls, discussions addressed implementation; intake, consent, and enrollment processes; staff issues; random assignment; and grantee-collected data. These topics have also been the most frequent sources of discussion in the current year.

Table II.4. RPG3 call tickets received through September 2017

	Number of requests (current year)[a]	Number of requests (cumulative total)[b]
Call type		
Regularly scheduled teleconference with grantee, CSL, PML, and FPO[c]	28	111
Check-in with CSL, PML, and FPO to discuss grantee-related issues[d]	16	35
Provision of TA requested by FPO	0	9
Discussion of RPG programmatic issues (initiated by PML)	0	9
Evaluation focused (requested by grantee)	0	5
Evaluation focused (initiated by CSL)	0	3
Site visit	0	3
Main topics discussed		
Implementation	37	121
Intake, study consent, or enrollment processes	21	71
Staff	31	69
Random assignment	18	64
Grantee-collected data	22	56
Treatment and comparison group formation	18	55
Administrative data	7	54
Sample size	25	47
Institutional review board	11	44
Tracking sample members	11	28
Systems-level or collaboration outcomes	6	26
Fidelity	6	23
Sample attrition	10	21
Outcomes	4	18
Baseline equivalence	0	9
Consent	1	4
Analysis methods/technical questions	0	1
Crossovers/contamination	0	1

[a] Requests received from October 2016 to September 2017.

[b] Requests received from February 2013 to September 2017.

[c] Regularly scheduled calls typically addressed evaluation- and program-related topics.

[d] Calls could include multiple topics.

Finally, the data collection help desk has received 153 tickets requesting support in the cross-site evaluation (Table II.5). Most of those tickets have focused on the enrollment and services log (ESL) system, which tracks information about evaluation participants and implementation of their EBPs. This has been the most common topic for requests in the current evaluation year as well.

Table II.5. Help desk tickets received during the cross-site evaluation through September 2017

	Number of requests (current year)[a]	Number of requests (cumulative total)[b]
Number of help desk requests received	47	153
Topics of help desk requests		
ESL	29	83
OAISIS	12	31
Standardized instruments	4	27
Administrative data	2	11
All systems	0	1
Institutional review board	0	0

[a] Requests received from October 2016 to September 2017.

[b] Requests received from February 2014 to September 2017.

OAISIS = Outcome and Impact Study Information System.

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III. RPG CASES, CHILDREN, AND ADULTS AT ENROLLMENT

As noted in Chapter II, the specific groups the four RPG3 grantees targeted differed substantially, from grantees targeting adults only to grantees serving families with young children in foster care. This chapter describes RPG3 enrollees at program entry, using more detailed information on families collected as part of the cross-site evaluation. Using the enrollment and baseline outcome data for adults and children enrolled in RPG3 by February 2017, we first describe the makeup of RPG cases (that is, the combination of children and adults who enter RPG as an intact "family" unit).[5] Given that background on demographics of children and adults, we report on the number of focal children who experienced maltreatment or were removed from their home in the year before enrollment in RPG.[6]

The information presented in this chapter uses a different source of data from that used in Chapter II. Here, we rely on enrollment data provided by the grantees through the ESL data collection system of the cross-site evaluation, as well as administrative data collected by the grantee and submitted to the cross-site evaluation team (data submitted through March 2017). As a result, the samples differ somewhat from the enrollments the grantees reported in their semiannual progress reports, presented in Chapter II.

A. RPG enrollment

RPG grantees continue to enroll at-risk families into their programs since the last report in April 2016. From July 2015 to February 2017, grantees in RPG3 enrolled 230 cases into the cross-site evaluation, ranging from 20 to 143 cases by grantee. These cases include 637 adults and children (Table III.1), increasing by 38 percent from April 2016 to February 2017.

Table III.1. Cumulative enrollment in RPG3, by grantee

RPG3 grantee and state	Total number of cases enrolled	Total adults and children enrolled	Percentage of total enrollment who are children
Our Kids of Miami-Dade, Florida	20	62	65
University of Kansas Center for Research, Kansas	143	415	47
Montefiore Medical Center, New York	29	61	53
Volunteers of America Oregon, Oregon	38	99	62
Total	230	637	52

Source: RPG3 ESL data from July 24, 2015, to February 28, 2017.

Note: Enrollment numbers reported in this table are through February 28, 2017, the cutoff date for the ESL data submission, whereas those reported in Table II.2 are based on grantees' semiannual progress report through March 2017.

[5] We refer the cases as "families" in other chapters of this report.

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

Total enrollment in RPG projects ranged from 61 people (Montefiore Medical Center, New York) to 415 people (University of Kansas Center for Research, Kansas). By February 2017, 52 percent of all RPG3 enrollees were children (ranging from 47 percent for Kansas enrollees to 65 percent for Florida enrollees).

B. RPG cases

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

Because RPG addresses the needs of children at risk due to potential or actual substance use by an adult close to them, by definition each RPG case includes at least two members: one adult and one child (even if grantees' projects do not provide services for children).[7] In other respects, the composition of cases varies. There is no cap on the number of individuals who may be in a single case, and members might be biologically related or not.

Among the 230 cases enrolled in RPG3, a majority included only two or three members and, more often than not, case members were biologically related to each other:

- **Among the cases, nearly half (46 percent) included only two members—one adult and one child, 23 percent included a single adult and multiple children, and another 31 percent included multiple adults and child(ren)** (Table III.2). Only 5 percent of RPG3 cases included more than four people. Although many cases included only one child (who is then by default the focal child), 31 percent of cases included at least one child in addition to the focal child—usually a biological sibling. Approximately one-third (31 percent) of cases included more than one adult.
- **Almost all RPG3 cases (99 percent) included a parent or parents and their biological children and, overall, 89 percent of cases included no other members.** When cases did include other members (11 percent), those members were grandparents, stepparents or parents' partners, adoptive parents, or other relatives.

[7] Oregon and New York do not provide direct services to children through their RPG projects. However, they do enroll children for evaluation purposes (for example, to understand how child outcomes change over time).

Table III.2. RPG3 case composition

Case composition	Number or percentage
Total number of individuals	637
Total number of adults	308
Total number of children	329
Percentage of cases with more than one child	31
Percentage of cases with more than one adult	31
Profile of cases	
Percentage of cases with single adult and single child	46
Percentage of cases with single adult and multiple children	23
Percentage of cases with multiple adult and child(ren)	31
Percentage of cases that included biological parents and their children	99
Percentage of cases that included only biological parents and their children	89
Total number of cases	230

Source: RPG3 ESL data from July 24, 2015, to February 28, 2017.

C. Characteristics of children at enrollment

By February 2017, RPG3 grantees had enrolled 329 children. Although cases could include multiple children, grantees collected cross-site evaluation data on only one focal child in each case, selected according to a rule established by each grantee. This enabled the evaluation to obtain detailed information on maltreatment, out-of-home placements, and child well-being outcomes in each RPG case without placing excessive burdens on grantees or families to provide this information on all children enrolled. Case members' relationships were also defined in terms of each person's relationship to the focal child. Because of the importance of the focal child in the cross-site evaluation, we describe the demographics for 230 focal children and the broader population of children served in RPG3 cases separately.

RPG3 grantees served relatively young children. On average, focal children in RPG3 cases were 2.5 years old (Table III.3). Eighty-one percent were younger than 5, including 34 percent who were younger than 1 year old. This largely reflects one RPG3 grantee, Kansas, whose enrollment represented 65 percent of the sample analyzed and whose program focused on very young children. The broader population of children included in RPG3 cases—3.2 years old, on average—tended to be older than focal children. This difference in age might be because grantees were more likely to define the focal child as the youngest child in a case.

Selecting a focal child

If more than one child was part of an RPG case, grantees selected one as the focal child, on whom they would collect more detailed data. Because RPG projects offered different services and served different populations, each grantee was in the best position to define which child within a case would be of greatest interest to the cross-site evaluation. Therefore, each grantee defined its own rule for selecting the focal child. Some grantees selected the youngest child in the case. Other grantees chose rules based on the specific target population for their programs. For example, one grantee whose intervention was designed for children around age 4 to 5 defined the focal child as the child closest to age 4; if two children were equally close to age 4, the grantee selected the older of the two.

Table III.3. Demographic characteristics of focal and all children in RPG3 cases

	Percentage, unless otherwise noted	
Characteristic	**Focal children**	**All children**
Average age at enrollment into RPG[a]	2.5	3.2
Age at enrollment, by category		
Younger than 1[b]	34	29
1 to 4	47	48
5 to 8	10	11
9 or older	8	12
Gender		
Female	48	50
Male	52	51
Race[c]		
White only	57	54
Black or African American only	18	22
American Indian or Alaska Native, Asian, or Native Hawaiian or Pacific Islander only	3	3
More than one race	22	22
Ethnicity[d]		
Hispanic	24	23
Non-Hispanic	76	77
Primary language spoken at home		
English	98	99
Spanish	1	1
Other	1	1
Residence		
Private residence[e]	39	45
Foster parent's residence	48	42
Foster/group home	6	6
Treatment facility, shelter, or correctional facility	7	7
Other residence	0	1
Sample size	208–230	295–329

Source: RPG3 ESL data from July 24, 2015, to February 28, 2017.

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

[a] This calculation does not include children not yet born by the time of RPG enrollment.

[b] This category includes those children who were not yet born by the time of RPG enrollment.

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

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

[e] Children whose residences were in this category most often lived with their biological, step, or adoptive parent, or with a relative other than their parent (such as a grandparent or aunt/uncle).

The majority of children served were non-Hispanic white. More than half (57 percent) of focal children were white, 18 percent were African American, and 22 percent were multiracial; approximately one-quarter of focal children (24 percent) were Hispanic. These rates are similar to the racial and ethnic composition of the broader population of children in RPG3. Almost all

focal children (98 percent) as well as all children in RPG3 (99 percent) were from English-speaking households.

Finally, approximately 54 percent of focal children lived in a foster parent's home, kinship care provider's home, or group home when they were enrolled in RPG3 (Table III.3).[8] In addition, only 33 percent of parents had care of the focal child at the time of program enrollment (Table III.4). Focal children who were in the care of biological parents at program entry mostly lived in the primary residence of an adult case member (79 percent), whereas those who were not in the care of biological parents mostly lived a foster parent's home, kinship care provider's home, or group home (80 percent).

Table III.4. Incidence of focal children in the care of biological parent at RPG3 entry

	Focal child is in the care of biological parent at entry[b]	
Primary residence of focal child is…	Yes (N = 76)	No (N = 153)
Private residence[a]	79	19
Foster parent's residence	0	71
Foster/group home	0	9
Treatment facility, shelter, or correctional facility	20	1
Other residence	1	0

Source: RPG3 ESL data from July 24, 2015, to February 28, 2017.

Note: One-third (33 percent) of focal children were in the care of biological parent at program entry. Because of rounding, category percentages may add to slightly more or less than 100 percent. The sample size for each statistic was the number of focal children with nonmissing data on primary residence.

[a] Children whose residences were in this category most often lived with their biological, step, or adoptive parent, or with a relative other than their parent (like a grandparent or aunt/uncle).

[b] Total in these columns excludes one focal child, for whom data in this category were unknown.

D. Characteristics of biological parents

Among RPG3 cases, the overwhelming majority (228 of 230, or 99 percent) included a biological parent, with demographics that mirrored the child population described earlier. In cases with two biological parents, grantees collected cross-site evaluation data from the parent

[8] This figure may undercount the number who were in foster or kinship care because some children who were in informal, voluntary, or formal kinship foster care were not described as living in a foster parent's home. Some children reported as living in an "other" residence may live with a kinship care provider, but the records did not include enough information to determine the nature of their living situation. *Informal kinship care* refers to arrangements made by the parents and other family members without any involvement from either the child welfare system or the juvenile court system. *Voluntary kinship care* refers to situations in which the children live with relatives and the child welfare system is involved, but the state does not take legal custody. *Formal kinship care* refers to cases in which the children are placed in the legal custody of the state by a judge, and the child welfare system then places the children with grandparents or other kin (HHS 2009).

who was defined as the focal child's caregiver.[9] Most biological parents were female (85 percent), with an average age of 30 (Table III.5). Approximately two-thirds (66 percent) of parents were white, 19 percent were African American, and 13 percent were multiracial; more than three-quarters were non-Hispanic. Almost all (97 percent) were English speaking.

RPG3 adults had a mix of education experiences. Although 37 percent of RPG3 parents had less than a high school education, 33 percent had a high school diploma or GED, and 31 percent had at least some postsecondary education.

Many biological parents enrolled in RPG3 faced financial hardship. Two-thirds (67 percent) had earned less than $10,000 in the year preceding enrollment, one-quarter (24 percent) reported having no source of income in the previous year, and 57 percent reported being unemployed.

A majority of biological parents (62 percent) were single, divorced, separated, or widowed at the time they enrolled in RPG3. The rest reported being married or living with a partner, most of whom were the focal child's other biological parent. Fifteen percent of parents lived in an institutional setting at enrollment, usually a treatment center for substance use disorder, but in some cases a shelter or correctional facility.

Table III.5. Demographic characteristics of biological parents in RPG3 cases

Characteristic	Percentage, unless otherwise noted
Average age at enrollment into RPG	30
Gender	
Female	85
Male	15
Race[a]	
White only	66
Black or African American only	19
American Indian or Alaska Native, Asian, or Native Hawaiian or Pacific Islander only	3
More than one race	13
Ethnicity[b]	
Hispanic	21
Non-Hispanic	79
Primary language spoken at home	
English	97
Spanish	3
Other	0
Lived in an institutional setting or homeless at enrollment (*n* = 228)	15
Highest level of education	
Less than high school	37
High school diploma/GED	33
Some postsecondary education[c]	30

[9] Grantees requested these data from the person who was the focal child's caregiver from the child's family of origin—defined as the family in which the focal child grew up or usually resided.

Characteristic	Percentage, unless otherwise noted
Bachelor's degree or higher	1
Income in past 12 months	
$0–$9,999	67
$10,000–$19,000	19
$19,001–$24,999	8
$25,000 or higher	5
Income source[d]	
Wage or salary	39
Public assistance	23
Retirement or pension	0
Disability	13
Other	7
None	24
Employment status	
Full-time employment	19
Part-time employment	13
Self-employed	3
Unemployed	57
Not in the labor force	8
Relationship status	
Single, divorced, separated, or widowed	62
Married to or cohabiting with focal child's biological parent	27
Married to or cohabiting with other individual	12
Sample size	210–228

Source: RPG3 ESL data from July 24, 2015, to February 28, 2017.

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

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

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

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

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

E. Maltreatment of focal children before RPG enrollment

In authorizing RPG, Congress intended to improve the safety of children who experienced, or were at risk of experiencing, maltreatment due to a parent or caretaker's substance use disorder or other substance-related problem. Data obtained by grantees from their state or county child welfare agencies help show the extent to which RPG projects enrolled children with reported maltreatment or other previous involvement in the child welfare system.

1. Maltreatment

A total of 54 focal children, or 23 percent, had at least one report of maltreatment in the year before RPG entry (Table III.6). This ranged from a low of 5 percent in Oregon to a high of 100 percent in Florida). Of these 54 children, 31 had a substantiated report of maltreatment and 30

had an unsubstantiated report.[10] We include both unsubstantiated and substantiated reports because children with both types of maltreatment records are at similar risk for poor child well-being outcomes (Casanueva et al. 2012), and because a report of maltreatment is considered the beginning of family involvement in the child welfare system (Child Welfare Information Gateway 2013). These rates of maltreatment are markedly higher than the national incidence of maltreatment. In 2015, the national prevalence rate of maltreatment was approximately 4 percent (HHS 2017).

Table III.6. Percentage and number of focal children with substantiated and unsubstantiated reports of maltreatment in the year before entering RPG

Type of maltreatment	Focal children experiencing event (percentage)	Focal children experiencing event (number)[a]
Reported maltreatment (abuse, neglect, or other)	23	54
Substantiated maltreatment	13	31
Unsubstantiated maltreatment	13	30
Reported abuse	5	12
Reported neglect	11	26
Other maltreatment	17	38

Source: Administrative data collected from state or county child welfare agencies, submitted through April 2017.

Note: The percentages reported are relative to 230 focal children who were enrolled in the study as of April 2017.

[a] Children may have had multiple instances of maltreatment and, therefore, may show up in multiple rows in this table.

2. Abuse and neglect

The distribution of abuse and neglect for RPG3 children is comparable to national averages. Among focal children in RPG, reports of neglect were more common than abuse, with 26 instances of neglect and 12 instances of abuse (including physical, psychological, sexual, and other abuse). Stated another way, neglect was more than twice as common as abuse among the RPG sample. Nationally in 2015, among individuals who experienced maltreatment, 74 percent of victims experienced neglect, 17 percent experienced physical abuse, and 8 percent experienced sexual abuse (HHS 2017).

Maltreatment is typically categorized as either abuse or neglect. However, there is a third category of maltreatment that is occasionally captured in child welfare databases: other maltreatment. This represents instances of maltreatment that are not easily categorized as abuse or neglect. Examples vary by state, and include situations such as threats of abuse or neglect rather than actual abuse or neglect, or the presence of illegal drugs in a child's body (HHS 2017). Among the RPG3 sample, this type of maltreatment was the most prevalent—38 individuals (17 percent of the target sample) had an instance of other maltreatment. Nearly every child with an instance of other maltreatment also had an episode of either abuse or neglect, suggesting that

[10] A child can have both substantiated and unsubstantiated cases of maltreatment, and in these data, seven children had both unsubstantiated and substantiated maltreatment episodes during this period.

among these states, this term may have served as a placeholder to provide more detail on the report of maltreatment.

F. Out-of-home placements for focal children

It is not always the case that children who are referred to the child welfare system will be removed from their homes. In many cases, the family receives support and services intended to help maintain a safe and stable household for all children. However, if the risk to a child is considered too great for a child to remain in the home or diversion or other alternatives are unavailable or inappropriate, then the child could be removed and placed in an out-of-home setting. We collected information about the number of children removed from the home, the settings where these children were placed after removal, and the number of children ultimately reunited with their family or otherwise achieving a permanent placement during the period observed.[11] As with the child maltreatment data presented earlier, we focus on the year before entry into the RPG program.

1. Children experiencing removals from home

The majority of children the RPG3 grantees served have experienced a removal. A total of 139, or 60 percent of children were removed from the home during the year before RPG enrollment (Table III.7). This statistic is mainly a result of the large number of removals observed in Kansas (95 percent), whereas removal rates were only 8 percent in Oregon and zero percent in both New York and Florida.

The number of children entering foster care nationwide can provide a rough comparison point to the number of children removed from the home among the RPG sample. A total of 269,509 children entered foster care in federal fiscal year 2015, which represents 0.4 percent of children in the United States during this period (HHS 2016, 2017).[12] Thus, children in the RPG sample are being removed from their home at higher rates than in the United States as a whole.

Table III.7. Removals occurring in the year before RPG enrollment

Removal or placement	Percentage of focal children experiencing event	Number of focal children experiencing event
Removed from home (n = 230)	60	139
Reunited with family (n = 139)[a]	20	28
Placed in permanent setting (n = 139)	22	30

Source: Administrative data collected from state or county child welfare agencies, submitted through April 2017.

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

[11] Defined as either experiencing reunification, adoption, or guardianship.

[12] Estimate calculated from number of children entering foster care in 2015 (268,509) by the total estimated number of children in the United States in 2015 (74,382,502) (HHS 2016).

2. Children achieving a permanent placement or reunification with family, among those removed

Of the 139 children removed from their home in the year before RPG enrollment, 28 (20 percent) were reunified with their family of origin (Table III.7) during the period observed. A total of 30 children were placed in a permanent setting following that initial removal (the additional 2 children were adopted).

3. Types of placement settings

Following a removal from the home, RPG3 children were placed into one or more alternate settings. A total of 184 placements occurred among those who had been removed from the home (Table III.8; 35 children had more than one placement during the observation period). Of these 184 placements, the vast majority (96 percent) were with a foster family: roughly 61 percent of the total were placed with a non-relative foster family, and 35 percent with a relative. Foster homes are the most prevalent placement setting for children in foster care nationwide. Of children in foster care on September 30, 2015, 45 percent were in a non-relative foster family home, and 30 percent were in a relative foster family home (HHS 2016).

Table III.8. Placement settings observed in the year before enrollment

Placement setting	Percentage of placement events	Number of placements
Foster family home (relative)	35	64
Foster family home (non-relative)	61	112
Other[a]	4	8
Total	100	184

Source: Administrative data collected from state or county child welfare agencies, submitted through April 2017.

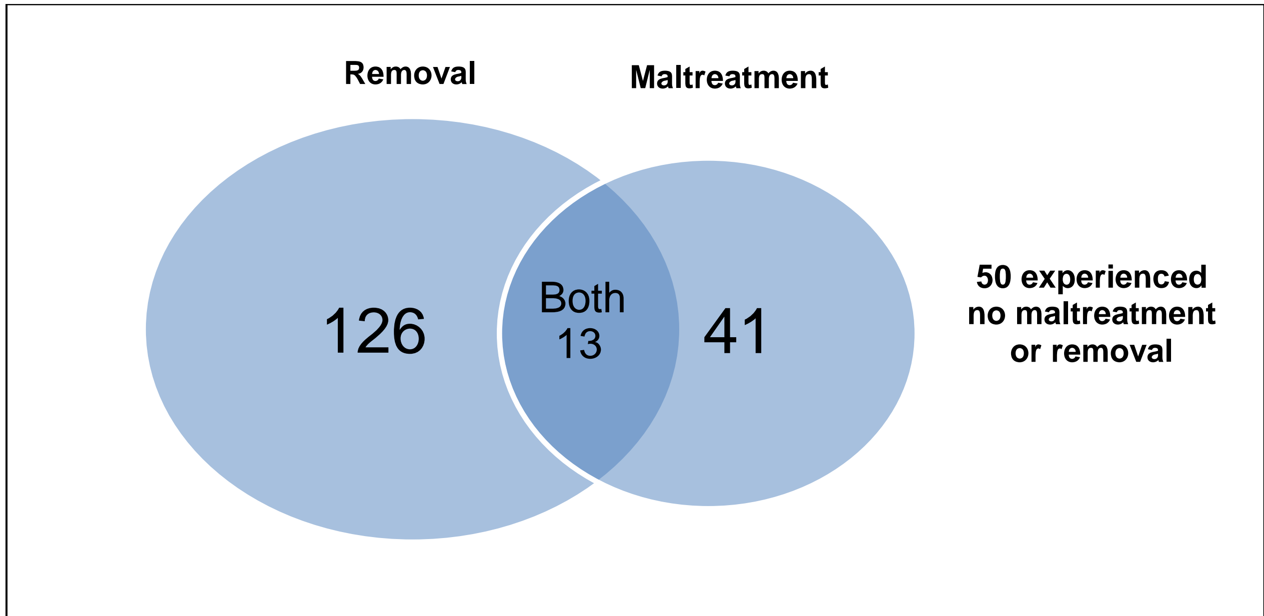
[a] This category includes children placed in pre-adoptive home settings, trial-home visits, and children who were recorded as runaways.

G. Intersection of maltreatment and removals

RPG3 grantees are serving a population that is at risk of either maltreatment, removal, or both—namely, a population with involvement in the child welfare system. Notably, only 50 of 230 focal children (22 percent) did *not* experience either a removal or a report of maltreatment (Figure III.1). That is, more than 78 percent of children in RPG3 had experienced either maltreatment, a removal, or both during the year before RPG. This rate is higher than that of children in RPG2, where 62 percent of children had involvement in the child welfare system.

Removal from the home typically occurs subsequent to a report of child maltreatment. However, among focal children served by RPG3 grantees, the incidence of removals is higher than the incidence of maltreatment reports (60 percent removed, but only 23 percent experiencing reported maltreatment). Only 13 of 230 children in the sample experienced *both* a maltreatment and a removal in the year before enrollment. The likely explanation is that maltreatment events occurred more than one year before RPG enrollment, and the removals observed as part of the RPG study were a result of these earlier maltreatment reports.

Figure III.1. Number of children experiencing removals, maltreatment, both, or neither in the year before RPG enrollment (n = 230)



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IV. WELL-BEING OF ADULTS AND CHILDREN IN RPG AT PROGRAM ENTRY

Parents and other adult caregivers play a critical role in the development of the children for whom they are responsible. It is their role to ensure the health, safety, nurturing, and guidance necessary for children to grow and develop into adults. Parental substance abuse is a known risk factor for child maltreatment and child welfare involvement (Institute of Medicine and National Research Council 2013). In addition, different types of substances or different levels of severity of substance use may have differential effects on child safety (Testa and Smith 2009). Moreover, adult substance use disorder does not exist in isolation. Commonly, substance use disorder, mental health problems, and limitations with parenting skills and attitudes co-exist and negatively reinforce each other. The RPG cross-site evaluation therefore measures substance use and selected characteristics of caregivers receiving RPG services.

The previous chapter described the prevalence of child involvement in the child welfare system due to maltreatment and or removal from the home. Children's experience of maltreatment has been found to be associated with diminished academic and cognitive performance (Crozier and Barth 2005; Jaffee and Maikoich-Fong 2011; Mills et al. 2011); poor social-emotional and behavioral adjustment (English et al. 2005; Font and Berger 2015); and increased risky behaviors and depression (Arata et al. 2005). RPG grantees are expected to focus not only on ensuring the safety and permanency of children, but also on improving their well-being. Therefore, the cross-site evaluation measures and reports on child well-being outcomes.

This chapter describes the adults' and children's well-being at baseline (measured when they entered RPG).[13] We first present information on adult characteristics, including substance use severity and problems related to substance use and participation in treatment for substance use disorder before RPG enrollment, mental health, and parenting attitudes among adults identified as primary caregivers of the child followed for the cross-site evaluation.[14] We then present information on child well-being outcomes for the focal children within each family. Future reports will examine how all of these outcomes change during participation in RPG, by comparing these measures at program entry and program exit.

A. Adult substance use and well-being at RPG entry

Adult substance use is a known risk factor for child maltreatment and involvement in the child welfare system (HHS 2014). However, adult substance use does not exist in isolation. Commonly, substance use, mental health problems, and limitations with parenting skills and attitudes co-exist and negatively reinforce each other. As such, the cross-site evaluation measures each of these broad constructs.

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[13] We provided some baseline information in an earlier report to Congress; however, that information was based only on the 65 cases/families enrolled by RPG3 grantees as of February 2016.

[14] In most families (96 percent), substance use and participation in treatment are also measured for the primary caregiver of the focal child in the evaluation. In the remaining 4 percent of families, the primary caregiver was not receiving services for substance use disorder, and in these situations, data on substance use and treatment were collected from a separate adult in the family who was receiving these services.

1. Adult substance use and participation in treatment

Among adults entering RPG3, drug use was more common than alcohol use. The proportion of adults with drug use profiles that were classified as high severity was higher than the proportion of adults with high-severity alcohol use, according to the cross-site evaluation criteria.[15] Table IV.1 shows alcohol and drug use among adults from the four RPG3 grantees at baseline. On a scale of zero to one, with zero representing the lowest severity rating and one the highest, the mean composite score for drug use was 0.08 (ranging from 0.06 in Kansas to 0.13 in Oregon). This score is comparable with the average observed among a national sample of individuals in treatment settings for substance use disorder, as described by McLellan et al. (2006)—this national sample could be a comparable target population for the RPG program. The RPG3 mean score for alcohol use was 0.03 (ranging from 0.02 in Florida to 0.09 in Oregon), which is markedly lower than the national mean of 0.22.

Only 3 percent of adults were categorized as having high-severity alcohol use, but 21 percent were in the high-severity category for drug use, and 23 percent of adults were considered in the high-severity grouping for either drugs, alcohol, or both. Oregon had the highest percentage of adults with either high-severity drug or alcohol use (33 percent) and Kansas had the lowest percentage (18 percent).

Table IV.1. Drug or alcohol use among adults before RPG enrollment, and percentage in high-severity category

Baseline scale	RPG3 mean (SD)	National mean (SD)[a]	Adults in high-severity category[b] (percentage)
Drug use	0.08 (0.12)	0.10 (0.13)	21
Alcohol use	0.03 (0.07)	0.22 (0.25)	3
Use of drugs or alcohol or both	NR	NR	23
Sample size	214–215		

Source: Grantee baseline administration of the Addiction Severity Index, Self-Report Form, including data submitted to the cross-site evaluation through April 2017.

Note: Sample sizes vary by measure due to instrument or item nonresponse.

[a] As reported in McClellan et al. (2006), which focused on a nationwide sample of individuals in treatment settings for substance use disorder.

[b] Calculation of the percentage of adults in the high-severity category is relative to the number with complete data for a given type of substance use.

SD = standard deviation; NR = not reported.

Marijuana was the most common substance adults enrolled in RPG reported using in the past month. Nineteen percent reported using cannabis/marijuana—a larger percentage than for any other substance (Table IV.2). Marijuana is the most commonly used drug across the United States, and its use has increased the most relative to other drugs in the recent past (National Institute on Drug Abuse 2015). Amphetamines, prescription opiates, and cocaine were the next

[15] RPG3 adults were considered high-severity drug or alcohol users if their mean score on the Addiction Severity Index for each substance was above the national mean—that is, their scores for drug or alcohol use were above the average for individuals in the national sample of adults in substance abuse treatment settings.

most-used substances, with 5 to 8 percent of adults reporting recent use. Sedatives, methadone, heroin, and hallucinogens were all less common, with approximately 3 percent of the RPG3 adults reporting recent use.

Use of these most frequently used drugs in the past 30 days was more prevalent among RPG3 adults than among the general population of adults. Among a national sample of respondents age 26 and older in the 2016 National Survey on Drug Use and Health, 7 percent reported using marijuana; 2 percent reported misusing psychotherapeutics (includes prescription pain relievers, tranquilizers, stimulants, and sedatives); and less than 1 percent reported using each cocaine, heroin, hallucinogens, and methamphetamine in the past month (Substance Abuse and Mental Health Services Administration 2017).

Table IV.2. Substances adults used within 30 days before RPG enrollment

Substance	Percentage of all adults reporting use	Percentage of adults in high-severity category
Cannabis (marijuana, hashish, pot)	19	55
Amphetamine (Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, methamphetamine, ice crystal)	8	35
Prescription opiates (morphine; Dilaudid (hydromorphone); Demerol (meperidine); Percocet (oxycodone + acetaminophen); Darvon (propoxyphene); Talwin; codeine; Tylenol 2,3,4 syrups, Robitussin, fentanyl)	6	20
Cocaine (cocaine crystal, free-base cocaine, “crack” or “rock”)	5	18
Sedatives, hypnotics, and tranquilizers (Valium, Xanax, Librium, Ativan, Serax, Quaaludes, Tranxene, Dalmane, Halcion, Miltown)	3	14
Methadone	3	10
Heroin	2	8
Hallucinogens (LSD [acid], mescaline, mushrooms [psilocybin], peyote, Green, PCP [phencyclidine], Angel Dust, Ecstasy)	1	4
Sample size	217	49

Source: Grantee baseline administration of the Addiction Severity Index, Self-Report Form, including data submitted to the cross-site evaluation through April 2017.

Not surprisingly, the high-severity users were more likely than all RPG3 adults collectively to use one or more of these drugs in the past 30 days. Forty-nine adults had this classification. For the most part, the types of drugs they used most frequently were the same as those the overall sample of RPG3 adults used. However, among the high-severity group, the prevalence rates of drug use were markedly higher than in the overall sample. The majority (55 percent) of adults with high-severity drug use had used cannabis in the past 30 days, and other popular substances included amphetamines (35 percent), prescription opiates (20 percent) and cocaine (18 percent).

a. Problems related to substance use

Substance use has potentially adverse effects to all aspects of life for primary caregivers. To illustrate how high-severity substance use adversely impacts adult life, we compared the adults classified as high-severity substance users with low-severity substance users in our sample.

Employment, legal, physical health, mental health, and relationship status for adults in the high-severity category was worse than that for low-severity substance users in the sample. In addition, adults in the high-severity category fared worse in these areas than did a national sample of adults enrolled in substance use disorder treatment programs (Table IV.3). For our measures, higher scores indicate greater problems. For example, adults in the high-severity group had more employment problems (such as fewer days at work) and legal problems (such as currently awaiting charges, a trial, or sentencing). They also reported more severe medical problems (such as more days experiencing medical problems); psychiatric problems (such as experiencing depression, anxiety, or hallucinations); and family/social relationship problems (such as more conflicts with friends or family).

Table IV.3. Comparison of functioning in five key life areas between adults in high-severity substance use category and other adults in the sample

	Adults in high-severity category	All other adults in the sample (low-severity users)	
ASI-SR scale	Mean (SD)	Mean (SD)	National mean (SD)[a]
Employment	0.74 (0.26)	0.64 (0.30)	0.65 (0.32)
Legal	0.24 (0.36)	0.17 (0.29)	0.18 (0.21)
Medical	0.28 (0.35)	0.12 (0.25)	0.17 (0.30)
Psychiatric	0.37 (0.25)	0.17 (0.20)	0.19 (0.23)
Family/social	0.29 (0.23)	0.14 (0.18)	0.16 (0.21)
Sample size	42–49	160–167	

Source: Grantee baseline administration of the ASI-SR, including data submitted to the cross-site evaluation through April 2017.

Notes: This table presents the ASI-SR scales about the key life areas that are commonly affected by substance use disorder. For these scales, higher scores indicate greater problems. The high-severity category includes those identified in Table IV.2 as having high-severity drug use, high-severity alcohol use, or both. See the third report to Congress for more details on the definitions of the risk indicators for high drug and alcohol use.

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

[a] As reported in McClellan et al. (2006), which focused on a nationwide sample of individuals in treatment settings for substance use disorder.

ASI-SR = Addiction Severity Index, Self-Report; SD = standard deviation.

b. Participation in substance use disorder treatment

Thirty-seven percent of RPG3 adults had been in one or more publicly funded treatment programs for substance use disorder during the year before RPG enrollment. This ranged from a low of 29 percent in Kansas to a high of 59 percent in New York. Adults may have participated in privately funded treatment during that period in addition to or instead of publicly funded treatment, which our data would not capture. In comparison, results from the 2016 National Survey on Drug Use and Health (NSDUH) show that 1.5 percent of U.S. adults age 18 or older enrolled in any substance use treatment in the year before the survey. The NSDUH found that only about 2 million of the estimated 20 million adults in need of substance use treatment (10 percent) actually enrolled in and received treatment for substance use disorder. (For both groups, treatment participation might have been limited by a shortage of treatment providers or slots.)

Of the 85 RPG adults who participated in treatment, 13 (15 percent) completed at least one treatment program during the year before RPG enrollment. Some adults may have completed treatment after enrolling in RPG, so this does not imply that the others failed to complete treatment.

2. Mental health

Substance use disorder often co-occurs with mental health problems. For example, experiences of trauma are strongly predictive of subsequent substance abuse problems (National Child Traumatic Stress Network 2008). In addition, findings from literature reviews and national epidemiological studies show that both stress (Sinha 2001) and depression (Grant 1995) either precede or follow substance use. Table IV.4 displays summary measures of adult trauma, parenting stress, and depression.

Table IV.4. Measures of adult mental health at baseline

Baseline scale	Sample size	RPG3 mean (SD)	National mean (SD)	Adults in high-risk category (percentage)	Adults in high-risk category in the national sample (percentage)
Childhood/adult trauma symptoms	217	25.7 (20.5)	NA	NA	NA
Parenting stress	84	72.6 (20.0)	69.0 (15.5)[a]	17	10
Depressive symptoms	182	10.1 (8.5)	4.7[b]	27	6[b]

Source: Grantee baseline administration of standardized instruments, including data submitted to the cross-site evaluation through April 2017.

Note: Grantees assessed childhood/adult trauma symptoms using the Trauma Symptoms Checklist (TSC-40), parenting stress using the Parenting Stress Index-Short Form (PSI-SF), and depressive symptoms using the Center for Epidemiologic Studies Depression Scale (CES-D). For these measures, a higher score represents a worse mental health assessment score for the respondent.

[a] Calculations of national means and standard deviations for the PSI-SF were based on the percentile ranks associated with raw scores in the scoring manual for the normative population (Abidin 1995). *Normative* means that data were obtained from a large, randomly selected representative sample from the wider population.

[b] In a representative sample of low-income parents of children in Head Start in the 2009 cohort of the Family and Child Experiences Survey.

NA = not available (there is no national average with which to compare the RPG3 population); SD = standard deviation.

RPG3 adults assessed at baseline had experienced some symptoms of trauma in the past two months. The average score among RPG3 adults on the Trauma Symptoms Checklist (TSC-40) was 25.7, which is on the lower end of the possible range of scores on this instrument (0 = not experiencing any symptoms of trauma, 120 = experiencing a wide variety of symptoms with regularity). Average scores for grantees ranged from 19.8 (New York) to 31.8 (Florida).

Compared with typical adults nationwide, RPG3 adults have higher levels of stress and depression. The mean score for parenting stress (72.6) was slightly higher than the national mean score (69.0) for this assessment. On the Parenting Stress Index-Short Form (PSI-SF), a score above 90 represents a high-risk level of stress. Seventeen percent of RPG3 adults met this criterion; their scores were higher than the 10 percent at high risk in the general population. The mean score for depressive symptoms (10.1) was higher than the mean score of 4.7 for a representative sample of low-income parents of children in Head Start in the 2009 cohort of the Family and Child Experiences Survey (FACES) (Aikens et al. 2012). Twenty-seven percent of RPG3 adults had severe depressive symptoms as measured by the CES-D, which was higher than the 6 percent reported in FACES.

3. Parenting attitudes

Parents' negative attitudes about parenting and unrealistic expectations for their children can lead to parental frustration and anger, and a potential for child abuse and neglect (Chan 1994; Webster-Stratton 1988).

Thirty-five percent of RPG3 adults expressed at least one parenting attitude that places their child at risk for maltreatment. In four of the five categories of attitudes measured (inappropriate expectations for a child, lack of empathy for a child, oppresses child's independence, and treats child like an adult peer), RPG3 adults' attitudes were worse than those among a national sample of adult parents. Across these four categories, the rate of adults in the RPG3 sample who had attitudes that the Adult-Adolescent Parenting Inventory-2 (AAPI-2) instrument classifies as indicating a potential risk for maltreatment ranged from 18 to 35 percent, higher than the national average (16 percent). On the fifth category, values corporal punishment, the mean for the RPG3 sample (5.4) was slightly lower than the national average, suggesting slightly less risky attitudes; only 12 percent of RPG3 adults scored in this high-risk group (Table IV.5).

Table IV.5. Parenting attitudes at baseline

Parenting attitude	RPG3 mean (SD)	National mean (SD)[a]	Adults in high-risk category (percentage)	Adults in high-risk category in the national sample (percentage)
Inappropriate expectations for child	6.2 (1.7)	5.5 (2)	18	16
Lack of empathy for child	6.6 (2.0)	5.5 (2)	33	16
Oppresses child's independence	6.1 (2.4)	5.5 (2)	35	16
Treats child like an adult peer, not a child	6.1 (2.4)	5.5 (2)	27	16
Values corporal punishment	5.4 (1.9)	5.5 (2)	12	16
Sample size	173			

Source: Grantee baseline administration of the AAPI-2, including data submitted to the cross-site evaluation through April 2017.

Note: Higher scores on the AAPI-2 indicate a greater number of negative parenting attitudes.

[a] National means and standard deviations for the AAPI-2 are presented in the scoring manual for the instrument (Bavolek and Keene 1999).

SD = standard deviation.

B. Child well-being at RPG entry

The picture of child well-being at RPG entry is mixed. At enrollment, RPG3 focal children were, on average, at higher risk than the national samples of children in executive functioning, behavioral problems, and trauma symptoms, but rated better than the general population in socialization skills (Table IV.6). It should be noted that data on child well-being were only available for a small number of children (n = 35–59), primarily from the Miami and Montefiore grantees at the time of this report and may not be representative of all RPG3 children or RPG3 grantees.

Table IV.6. Child well-being at RPG entry

Aspect of child well-being	RPG3 mean (SD)	National mean (SD)	Children in high-risk category (percentage)	Children in high-risk category in the national sample (percentage)
Executive functioning	51.7 (11.2)	50 (10)	14.2	8–10
Emotional problems	52.8 (11.3)	50 (10)	17.6	10
Behavioral problems	52.8 (11.3)	50 (10)	16.7	10
Total problems score	53.7 (12.4)	50 (10)	19.4	10
Socialization	104.6 (18.6)	100 (15)	0	3
Trauma symptoms	53.5 (10.7)	50 (10)	23.7	NA
Sample size	35–59			

Source: Grantee baseline administration of standardized instruments, including data submitted to the cross-site evaluation through April 2017. Miami and Montefiore provided data for all instruments, Oregon provided data for both the trauma symptoms and socialization and trauma symptoms outcomes, and Kansas provided data on the trauma symptoms outcome only.

Notes: The sample sizes vary by measure because caregivers reported on different subsets of children depending on the child's age, and grantees might not administer all the measures. In addition, the sample size variation in this table reflects instrument nonresponse.

Grantees assessed executive functioning using the Behavior Rating Inventory of Executive Function (BRIEF), emotional and behavioral problems using the Child Behavior Checklist (CBCL), socialization skills using the Vineland Adaptive Behavior Scales, and child trauma symptoms using the Trauma Symptom Checklist for Young Children (TSCYC). Higher scores on the Vineland II scale represent higher levels of socialization skills in children; higher scores on the remaining measures in the table represent more negative child outcomes.

NA = not available; SD = standard deviation.

1. Executive functioning

Executive functioning, a set of skills such as impulse inhibition, flexible thinking, and working memory that children can use to regulate their emotions and behaviors, has the potential to be influenced by prenatal substance exposure (Behnke et al. 2013). Moreover, research has shown that caregiver parenting skills influence executive functioning (Masten 2011). Executive functioning can be a strong predictor of children's and adolescents' academic performance (Herbers et al. 2011; Samuels et al. 2016). Children with difficulties in executive functioning are also prone to exhibiting social skill deficits and problem behaviors (Schonfeld et al. 2006).

Children in RPG3 had slightly higher levels of executive dysfunction than did children in the general population. They had more difficulties controlling their impulses, moving freely from one situation or activity to another, controlling emotional responses, and being organized, for example. At RPG entry, children scored a mean of 52 on the Behavior Rating Inventory of Executive Function, whereas the national mean is 50 (Table IV.6). The percentage of children classified as high risk in executive functioning (scores above 65 on this scale) also showed such a pattern when compared with the national sample. About 14 percent of RPG3 children were classified as high risk; in contrast, 8 to 10 percent of children in the national sample were in the high-risk category (Gioia et al. 2000, 2003).

2. Emotional and behavioral problems

As noted above, difficulties in executive functioning could lead to emotional and behavioral problems. In addition, children's emotional and behavioral problems are associated with caregiver substance use (Behnke et al. 2013), caregiver well-being, and parenting stress and skills (Neece et al. 2012).

The levels of emotional and behavioral problems and total problems were higher for children in RPG3 than children in the national sample. The mean scores of emotional (anxiety, depression); behavioral (attention, aggression); and total problems (combination of the two former categories and other problems) for children at RPG entry ranged from 53 to 54, compared with the national mean of 50 (Table IV.6). About 17 to 19 percent of children in RPG3 were categorized as high risk for these problems. In comparison, 10 percent children in the national sample were in the high-risk category (Achenbach and Rescorla 2000, 2001).

3. Socialization skills

Difficulties in executive functioning and problematic emotional behavior could also lead to diminished social and adaptive behaviors, which are defined as "the performance of daily activities required for personal and social sufficiency" (Sparrow et al. 2005, p. 6). Experience of maltreatment is also related to deficits in socialization skills that put children at increased risk for developmental delays, poor relationships with peers, or setbacks in academic performance (Viezel et al. 2014; Becker-Weidman 2009).

However, RPG3 children's socialization skills (interactions with others, use of play and leisure time, and use of coping strategies) fared better than those among the national sample. The mean score for children in RPG3 was 104.6 at program entry, meaningfully higher than the national mean of 100 (higher scores represent higher levels of socialization) (Table IV.6). No children in RPG3 were classified as high risk, whereas about 3 percent of children in the national sample were in the high-risk category. On average, RPG3 children demonstrated better skills to interact with other people, manage themselves, and be independent, compared with children in the general population.

4. Trauma symptoms

Exposure to traumatic events such as maltreatment or abuse can affect multiple domains of children's well-being and might have adverse effects into adulthood (Stoddard 2014). Many traumatized children receiving services ended up in treatment for emotional or behavioral problems caused by exposure to trauma (Cohen et al. 2010). Thus, describing children's trauma symptoms at baseline could help identify risk factors for children receiving RPG services.

On average, caregiver ratings indicated a greater number of trauma symptoms for children ages 3 to 12 in RPG3 than for children in the general population. The mean score for posttraumatic stress was 54 for children at RPG entry, higher than the national mean score of 50 (Table IV.6). About one-quarter (24 percent) of children in RPG3 were classified as high risk with elevated symptoms of posttraumatic stress disorder.

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V. FAMILY ENROLLMENT IN PROGRAMS AND SERVICES

In recent years, federal agencies and policymakers, funders, practitioners, and providers have sought to identify, implement, scale up, and sustain evidence-based interventions. By expanding the use of evidence-based or evidence-informed interventions, stakeholders aim to better allocate scarce resources and ultimately improve the effectiveness of their work (Strong et al. 2014).

To obtain funding, HHS required RPG applicants to propose one or more specific, well-defined program service that was *evidence-based* or *evidence-informed* as part of their projects. Each of the RPG grantees designed an RPG project that offered a set of EBPs and other services such as case management, peer support, or assessments for substance use disorder (Table II.1). Two RPG3 grantees offered one EBP, and the other two offered three EBPs. By February 2017, the four RPG3 grantees had enrolled 200 families in seven of the eight EBPs. By then, most participants had been enrolled in at least one EBP.

Because of the importance RPG placed on use of EBPs, the cross-site evaluation collects data from each grantee on enrollment in RPG and enrollment and participation in EBPs. This chapter describes the EBPs each grantee offers and the number of EBPs in which any participants were enrolled (Section A), the types of EBPs in which participants have been enrolled (Section B), and the length of time participants spent in EBPs (Section C).

A. Number of EBPs in which families enrolled

Most families enrolled in RPG3 had also been enrolled in an EBP by the end of the reporting period. Of the 230 RPG families in RPG3, 200 (87 percent) were enrolled in at least one EBP by that time. Our Kids of Miami-Dade and University of Kansas Center for Research each offered one EBP (Engaging Moms/Parenting Programs and Strengthening Families Program: Birth to Three, respectively). Ninety-five percent and 100 percent of their families, respectively, had been enrolled in the offered EBP. Montefiore Medical Center in New York and Volunteers of America – Oregon (VOAOR) each offered three EBPs, and 90 percent and 32 percent of their families had been enrolled in at least one EBP, respectively. Montefiore encourages all its clients to enroll in all three EBPs. VOAOR offered a full menu of service options to clients and had someone from the program work with each client to develop a personalized service plan. This plan may or may not have included one of the grantee's EBPs, which is the main reason for its low enrollment rate in EBPs. Moreover, this grantee also experienced substantive staff turnover over time, which might have impeded the availability of its EBP facilitators.

B. Types of EBPs in which families enrolled

RPG3 grantees offered three types of EBPs: family strengthening, substance abuse treatment, and response to trauma (Table V.1). Family-strengthening programs were the most common EBPs and were implemented by all four RPG3 grantees. Seventy-eight percent of all families enrolled in such an EBP. Each grantee offered a different family-strengthening EBP, with the cumulative enrollment in the specific EBP ranging from 7 families for VOAOR to 143

families for the University of Kansas (Table V.2). The two other types of EBPs were treatment for substance use disorder and response to trauma:[16]

- **Treatment for substance use disorder.** These EBPs intend to help clients overcome addiction and avoid relapse. Montefiore had enrolled 26 families in two of the substance abuse treatment EBPs it offered (Seeking Safety and contingency reinforcement). VOAOR offered one EBP for treating substance use disorder (Mindfulness Relapse Prevention) but had not enrolled any family in it at the time of reporting (Table V.2) due to difficulty retaining participants, staff turnover, and delays in staff training.
- **Response to trauma.** This type of EBP intends to help clients cope with trauma and develop resilience. VOAOR was the only RPG3 grantee offering this type of EBP, in which it had enrolled six families (Table V.2).

Table V.1. EBP enrollments, by type

EBP type	Number of EBPs of this type being offered by grantees	Number of grantees enrolling families in EBP(s) of this type[a]	Number of cases served by grantees enrolling families in EBP(s) of this type	Number and percentage of all families enrolled in EBP(s) of this type
Family strengthening	4	4	230	179 (78)
Treatment of substance use disorder	3	1	29	26 (11)
Response to trauma	1	1	38	6 (3)

Source: RPG3 ESL data from July 24, 2015, to February 28, 2017.

[a] Calculated as number of grantees offering EBP(s) of that type with at least one family enrolled.

[16] For information on the categorization of these EBPs, see Strong et al. (2014).

Table V.2. EBP offerings and enrollments, by grantee

	Number of cases enrolled in the EBP(s) offered by grantees			
EBP	Our Kids of Miami-Dade, Florida	University of Kansas Center for Research, Kansas	Montefiore Medical Center, New York	Volunteers of America, Oregon, Oregon
Family-strengthening				
Nurturing Parenting Program	-	-	-	7
Strengthening Families Program: Birth to Three	-	143	-	-
Incredible Years Parenting Class	-	-	10	-
Engaging Moms/Parenting Program	19	-	-	-
Treatment for substance use disorder				
Seeking Safety	-	-	21	-
Contingency reinforcement	-	-	26	-
Mindfulness Relapse Prevention	-	-	-	0
Response to trauma				
Beyond Trauma	-	-	-	6
Percentage of families enrolled in at least one EBP	95	100	90	32

Source: RPG3 ESL data from July 24, 2015, to February 28, 2017.

C. Time participating in EBPs

Grantees placed participants into EBPs quickly. On average, enrollment in one or more EBPs occurred 3 days after RPG enrollment. On average, RPG3 cases had been enrolled in EBPs for 102 days by February 28, 2017, ranging from 71 days for cases that were still open at the end of the reporting period to 116 days for cases closed by then (Table V.3).[17] The length of time enrolled in EBPs varied by EBP type, with participants spending longer periods in EBPs for treatment of substance use disorder.

[17] Each family is a case in the RPG program. RPG grantees closed a case after RPG services for that case ended.

Table V.3. Time in EBPs, overall and by EBP type

Enrollment in any EBP	Average number of days[b]		
	Overall	Family strengthening	Treatment for substance use disorder
Time enrolled in EBPs			
All cases	102.1	99.5	171.4
Closed cases	116.0	113.6	252.5
Open cases[a]	70.5	61.2	111.9

Source: RPG ESL data from July 24, 2015, to February 28, 2017.

Note: This table includes cases with any EBP enrollments. Only six cases were enrolled in the EBP for response to trauma and therefore are not reported in this table.

[a] Approximately 31 percent of cases did not have a reported closure date at the end of data collection. Length is calculated using the end date of February 28, 2017.

[b] Calculated as time from RPG enrollment to first EBP enrollment for cases with any EBP enrollment.

D. Next steps for RPG3 cross-site evaluation

This report presents findings based on semiannual progress reports from RPG3 grantees submitted in April 2017, ESL data through February 2017 and standardized instrument and administrative data through April 2017. We may include results presented here in the next RPG3 report to Congress, using additional data collected and submitted by grantees through April 2018. In addition, the next report to Congress will include new findings from data collected through surveys of RPG3 grantee staff and partners, as well as information learned from site visits with RPG3 grantees conducted in late 2017. As such, the next report to Congress will focus on program implementation.

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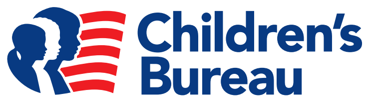

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