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

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

Ninth Report to Congress

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

ADMINISTRATION FOR CHILDREN & FAMILIES

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RPG Regional Partnership Grants

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ACRONYMS

AAPI-2	Adult Adolescent Parenting Inventory
ACE	Adverse childhood experience
ACF	Administration for Children and Families
ACYF	Administration on Children, Youth, and Families
ASFA	Adoption and Safe Families Act
ASI-SR	Addiction Severity Index, Self-Report Form
CB	Children's Bureau
CBCL	Child Behavior Checklist
CES-D	Center for Epidemiologic Studies Depression Scale
CFF	Center for Children and Family Futures
CPS	Child protective services
CQI	Continuous quality improvement
DBA	Doing business as
FACES	Family and Child Experiences Survey
FASD	Fetal alcohol spectrum disorders
HHS	U.S. Department of Health and Human Services
ITSP	Infant/Toddler Sensory Profile
LCA	Latent class analysis
MI	Motivational Interviewing
MOU	Memorandum of understanding
MOUD	Medications for opioid use disorder
NCSACW	National Center for Substance Abuse and Child Welfare
NICU	Neonatal intensive care unit
RPG	Regional Partnership Grants
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance use disorder
TA	Technical assistance
TSC-40	Trauma Symptoms Checklist-40

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EXECUTIVE SUMMARY

Introduction

Recognizing that parental substance use is a key factor underlying the abuse or neglect of many children, Congress passed the Child and Family Services Improvement Act of 2006 (Pub. L. 109-288). The legislation amended section 437 of the Social Security Act (42 U.S.C. 629g[f]) to authorize the Children's Bureau (CB) in the Administration on Children, Youth and Families (ACYF) —part of the Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services (HHS)—to fund discretionary grants to improve safety, well-being, and permanency outcomes for children at risk of or in out-of-home placement because of their caregiver's substance use.

To fulfill the requirements of the legislation, in 2007 HHS launched the Regional Partnership Grants (RPG) program. Reauthorized in 2011, again by the Bipartisan Budget Act of 2018 (Pub. L. 115-123), and most recently in 2025 (Public Law 118-258), these competitive grants are designed to support regional partnerships among child welfare agencies, substance use treatment organizations, and other social service systems. Since 2007, HHS has made awards to 7 cohorts of projects (referred to in this report as RPG1–RPG7) that have implemented 127 RPG projects. This report focuses on RPG5, RPG6, and RPG7, which included 36 projects:

- RPG5: In 2018, HHS funded 10 RPG projects in 8 states. The original period of performance was three years, but midway through the initial grant period, HHS offered two-year extensions with additional funds (through 2023). Nine of the 10 awardees applied for and received this extension. Half of the projects are led by a previous RPG grant recipient. The most common type of lead organization was behavioral health service providers.
- RPG6: HHS funded eight projects in eight states starting in 2019 and lasting until 2024. Five of the eight awardees had previously received a grant, including one that had received an RPG5 award. As with the RPG5 cohort, behavioral health service providers were the single most common type of lead organization.
- RPG7: In 2022, HHS funded 18 projects in 14 states to run through 2027. Fourteen of the 18 awardees had received prior RPG funding, including five that had received an RPG5 award, three that had received an RPG6 award, and one that had received both an RPG5 and RPG6 award. The most common type of lead agency was behavioral health service providers, followed by family support service providers.

To help assess whether the RPG program operates as intended and meets its desired goals, Congress requires HHS to define and collect data on performance measures from each grant recipient and evaluate the services and activities that are provided with RPG funds. To evaluate the overall program and to satisfy the legislative mandates, HHS contracted with Mathematica and its partner, WRMA Inc., to conduct a RPG cross-site evaluation.

This report summarizes the final findings from the cross-site evaluations for RPG5 and RPG6 and introduces the projects in RPG7.[1] Most of the report focuses on RPG5 and RPG6, as these cohorts had completed activities in 2023 and 2024, respectively.[2] Beginning in 2020 and for most of their periods of performance, RPG5 and RPG6 projects operated during the COVID-19 pandemic, which required them to adapt in many ways. For example, some projects switched to virtual service delivery, and many tried to meet the increased needs of their participants (HHS, 2023). This context is useful to consider when interpreting the findings from the cross-site evaluation (HHS, 2023).

Characteristics of enrolled families (RPG5 and RPG6)

RPG5 and RPG6 projects, as a condition of the grant funding, were required to: (1) define the characteristics of families they intended to serve; (2) identify and work with referral sources to recruit families; and (3) enroll families in services.[3]

Focal populations

Although all RPG projects are charged with serving families that are at risk of or involved with child welfare because of a caregiver's substance use, each project defined the segment of that focal population that it intended to serve. The projects based these definitions on the needs of their communities and the people that would benefit from the planned services. Sixteen projects focused on families with an active child welfare case, and five of these projects also included families at risk of child welfare involvement. Two projects focused exclusively on families that were at risk of child welfare involvement.

Referral sources

RPG projects used several referral sources. About three-fifths of families (59 percent) were referred to the projects by partner organizations. The most common referral sources for families enrolled in RPG5 and RPG6 projects were a child welfare agency (58 percent) or a court (15 percent).

Enrollment results

The RPG5 and RPG6 projects enrolled 2,412 families (2,965 adults and 4,568 children), including 272 children in utero at the time of their mother's enrollment.[4] Eleven projects

[1] The time span covered by the data differs by cohort and data source. For RPG5, data coverage is about four years, from March 2019 through May 2023, for most data sources. For RPG6 projects, data coverage is about three and a half years, from October 2020 through March 2024, for most data sources.

[2] Some projects requested and received no-cost extensions.

[3] One RPG6 grant recipient did not contribute enrollment, service, or outcomes data to the cross-site evaluation.

[4] Per research literature in this area, children in utero are understood to be subject to the services received by the adult, particularly medications for opioid use disorder (MOUD), which is a common treatment for pregnant women in RPG projects (Kraft 2018).

reached less than 80 percent of their enrollment goal[5]; 4 projects enrolled enough families to meet at least 80 percent of their enrollment goal; and 2 projects exceeded their goal.

Key characteristics of adult participants enrolled in RPG5 and RPG6 projects include:

- Across RPG projects, most adult participants were: women (78 percent); between the ages of 25 and 34 (50 percent); and were never married at the time of enrollment (60 percent). Nearly two-thirds of the adult participants (63 percent) identified as White and non-Hispanic.
- About two-fifths of the adults (44 percent) were employed either full or part time or were self-employed. About one-third of the adults (32 percent) were unemployed but looking for work.
- More than one-quarter of enrolled adults (28 percent) had drug or alcohol screening scores that suggested high severity of use. Fewer than one-quarter of adults (22 percent) had been in publicly funded substance use treatment in the year before they enrolled in RPG.
- About 20 percent of adults had severe depressive symptoms as measured by the Center for Epidemiologic Studies Depression Scale.
- When asked to rate their attitudes about parenting and child-rearing, adults enrolled in RPG scored above the national mean in all five constructs reflecting more negative attitudes (such as inappropriate expectations and lack of empathy for their child).

Key characteristics of children at enrollment in RPG5 and RPG6 projects include:

- Almost half of the children (49 percent) were age 4 or younger. The average age was almost 6 years old. About half of the children (51 percent) were White and non-Hispanic; 18 percent were Black and non-Hispanic; 16 percent were Hispanic or Latino; and 9 percent were multiracial and non-Hispanic.
- More than four-fifths of children (87 percent) were receiving assistance from Medicaid, the nation's public health insurance program for people with low incomes.
- More than three-quarters of the children (70 percent) were living with at least one biological parent, which meant they lived with a biological mother only, a biological father only, both biological parents, or a biological parent and another relative or adult. About 12 percent of the children lived with a relative other than a biological parent, and 17 percent lived with a nonrelative foster parent.
- Nearly half of children (48 percent) enrolled in RPG were involved with the child welfare system in the year before they entered RPG. This includes the 22 percent of children who had been removed from their homes. Almost two-thirds of children (62 percent) had been involved in the child welfare system during their lifetime.

[5] Many RPG5 projects began enrollment before the start of the cross-site evaluation and continued beyond the end of cross-site data collection. Additionally, many RPG5 and RPG6 projects served families that did not consent to participation in evaluation activities. As a result, projects reported higher enrollment numbers than the number of families with cross-site data.

- Compared with a national sample of children, focal children[6] in RPG demonstrated more emotional and behavioral problems and a higher total amount of problem behaviors. (Total problems are a combination of emotional, behavioral, and other problems).[7]
- However, at enrollment in RPG, focal children were similar on sensory processing (being over- or under-responsive to stimuli) to a national sample of children.

Services received by families (RPG5 and RPG6)

Because each project designed its own set of services, families that enrolled in RPG5 and RPG6 projects participated in different types and amounts of services.[8]

- Of the 2,410 families enrolled in RPG5 and RPG6 projects, 92 percent attended at least 1 service encounter, and 89 percent attended more than 1 service encounter.
- Most services delivered to RPG families (90 percent) were primary services, which delivered the main content of each project. Most service encounters were either: (1) case management or service coordination; or (2) therapy or counseling.
- Most projects (15) provided services that offered additional support to families, such as transportation, medical services, or screening or assessments (typically to develop a service plan for the family). Across all RPG5 and RPG6 projects, nearly three-quarters of families (71 percent) received a supportive service.
- Sixteen projects operated programs that delivered services in an outpatient or as-needed manner, while one operated a residential treatment program. In the projects delivering services as needed, the average intensity of services was about 44 service encounters per family. In the residential treatment program, offering multiple services on a daily basis, the average family received about 199 service encounters while enrolled.
- Services were overwhelmingly provided to adults without children in attendance (90 percent of service encounters). Children mostly attended parenting training or home visiting services as well as supportive services. On average, children attended just about 10 percent of service encounters.
- Most projects (11) used staff from the grant recipient organization alone to provide services, rather than engage with partners for service provision. Five projects used staff from partner organizations to provide all services. One project used both grant recipient and partner organization staff to provide services.

[6] To limit the burden associated with data collection, the project teams collected data for the child well-being measures on a single child in each family, who is referred to as the focal child. Each project determines its own rules for selecting a focal child.

[7] The terms “emotional problems” and “behavioral problems” are taken directly from the names of the scales in the standardized instrument used to measure child outcomes (Achenbach & Rescorla, 2000, 2001).

[8] One of the 18 RPG5 and RPG6 projects did not submit usable service data to the cross-site evaluation for any of their families, and one project did not report on all of its core and funded services. Therefore, these analyses do not fully represent the experiences of the families enrolled in those projects.

- Nine of the 10 projects that planned to use peer recovery mentors ultimately used them to provide some services. Among the nine projects, peer mentors provided a third of all service encounters. For five of these projects, peers were the only service providers.

Collaboration between child welfare agencies and substance use treatment providers (RPG6)

Given the importance of collaboration between child welfare agencies and substance use treatment providers to RPG projects, the cross-site evaluation conducted site visits to examine how these organizations worked together to achieve the goals of RPG. In 2023, the cross-site evaluation team conducted telephone interviews with RPG6 projects.

In most RPG6 projects, child welfare agencies and substance use treatment providers actively partnered to support families, as the RPG program intended. Five of the project teams intentionally collaborated with child welfare for referrals to RPG and to support enrolled families as a collaborative team. They created protocols for referring families to RPG treatment services and routinely shared information to support participants' recovery goals and progress in their child welfare cases. Three project teams either did not collaborate or only minimally collaborated on referrals and interagency case consultation; however, one did so intentionally to protect families' confidentiality, even as the partners jointly oversaw project plans.

Past collaborative endeavors were key to the progress made during the grant period. Previous collaborations gave most projects a head start during the planning year either because buy-in and trust had been established or they were continuing past work. This was especially helpful when the COVID-19 pandemic interrupted their planning periods. The pandemic also exacerbated challenges with staff turnover and hiring difficulties. Turnover among child welfare staff in particular was cited as contributing to fewer opportunities to meet and lower-than-expected referral rates—raising the need for ongoing cross-system training and identifying varied referral sources. Ultimately, all projects succeeded in using the RPG opportunity to expand access to substance use treatment services. Most did so by strengthening the pathway for families involved in child welfare to enroll in treatment services or by offering new (such as peer support) or more intensive and individualized treatment than usual.

Experiences of parents in RPG (RPG6)

Including the experiences of participants enrolled in RPG services in the RPG cross-site evaluation offers a firsthand look at their multifaceted lives and how services can support the well-being, permanency, and safety of children. In 2023, the cross-site evaluation team conducted an exploratory study to learn more about the parents enrolled in RPG6 services.

The information reported by the parents provided insight into the intergenerational nature of chronic adversity and how it contributes to ongoing challenges for families enrolled in RPG programs. Parents especially experienced challenges with housing, relationships with family and peers, and substance use. These challenges often overlapped and repeated throughout childhood and adulthood. These experiences factored into their beliefs, from an early age then into

adulthood, that they were alone, abandoned, and had to appear strong even when they were struggling. As a result, parents' early exposure and dabbling with substances turned into increased use over time as they tried to manage overwhelming circumstances and emotions. They understood that their substance use issue was a factor in their child welfare involvement. But many parents reported that the separation from their children often worsened these issues, which prolonged their child welfare involvement. Parents reported being caught in a vicious cycle that was nearly impossible to stop.

In contrast, parents displayed strength, hope, and resilience when they had strong supports and relationships with others. Parents reported being proud when they took control of their own circumstances, overcame obstacles, and were able to protect and care for others, including their children. Parents' previous attempts to stop using substances taught them that their own motivation is the biggest factor in getting sober and staying in recovery. Although parents reported needing the internal strength and confidence to persevere through life's challenges, they knew they could not do it alone and that help from others, including child welfare staff, was needed for long-term success.

How did families change over time? (RPG5 and RPG6)

RPG's purpose is to improve the well-being, permanency, and safety of children who are in or at risk of out-of-home placements because of their parents' or caregivers' substance use issues. The cross-site evaluation team examined whether participants' outcomes improved after enrolling in RPG5 and RPG6 projects. (Box ES.1 lists key limitations of the analysis.) The outcomes analysis examined the following five domains of interest to Congress and the Children's Bureau: (1) adult recovery; (2) family functioning; (3) child safety; (4) permanency; and (5) child well-being.

Adult recovery

- Adults reported decreased use of both drugs and alcohol from project entry to project exit. However, this finding is based on a response rate of about 49 percent.

Box ES.1. Limitations of analysis of change over time

A substantial proportion of the eligible sample did not have both baseline and follow-up data on child well-being, adult substance use, and family functioning outcomes (obtained from standardized instruments). The subset of individuals who had both baseline and follow-up data differed on some demographic characteristics and baseline outcomes, compared to those who did not have the data at both time points. Because of the differences, the families in the analysis cannot provide information that is representative of the full population of families served by RPG. To address this concern, the cross-site evaluation team created and used nonresponse weights to improve the representativeness of the data.

A more general limitation of an analysis of change over time is that it cannot reveal whether the services themselves caused the observed changes. Other factors might have led to the changes. For example, people who entered RPG might have done so because they were ready to take action to improve their situations, and they might have improved even if they hadn't enrolled in RPG.◢

- The percentage of adults in publicly funded substance use treatment programs increased in the year after they enrolled in RPG5 and RPG6 compared with the year before they enrolled. Additionally, the percentage of adults who completed treatment increased in the year after they enrolled in RPG5 and RPG6 compared to the year before. These results are based on eight projects that submitted treatment episode administrative data.
- Adults reported fewer symptoms of trauma at project exit than at project entry. The result is based on a 51 percent response rate.

Family functioning

- Adults reported fewer symptoms of depression at project exit than at project entry (50 percent response rate). The average score on the depressive symptoms instrument decreased from 7.8 to 6.0 (both scores in the range of mildly depressed), a statistically significant decrease.
- There were statistically significant improvements in two of the five parenting attitude scales (inappropriate expectations for child and values corporal punishment), indicating a reduced risk for maltreatment of their children following participation in RPG. These results are based on a 47 percent response rate.

Child safety

- Maltreatment rates (based on both substantiated and unsubstantiated reports) for children enrolled in the RPG5 and RPG6 projects decreased by a statistically significant amount from the year before enrollment to the year following RPG entry. In a sample of 1,490 focal children from the 15 projects that submitted data, the incidence of reported maltreatment was 49 percent in the year before RPG enrollment and 16 percent in the 1-year period following RPG enrollment. However, this may be partly because of drops in the rates of child maltreatment reports and substantiations following the COVID-19 pandemic, when children were no longer in school in person (Children's Bureau, 2022; Children's Bureau, 2023).

Permanency

- There were statistically significant reductions in removals from the home from the year before RPG enrollment and the following year. A total of 360 eligible focal children, or 24 percent, were removed from their home in the year before RPG enrollment. This number decreased to 105 children, or 7 percent, in the following year—a statistically significant decrease of 17 percentage points.

Child well-being

- The emotional and behavioral problems of focal children in RPG5 and RPG6 improved significantly from project entry to exit. These results were based on a 28 percent response rate.
- There were no significant changes in the percentage of children with an atypical sensory processing assessment from RPG project entry to project exit. These results are based on a 32 percent response rate from 14 projects.

Project sustainability planning (RPG6)

A major aim of RPG, as outlined in the RPG6 Notice of Funding Opportunity, is for grant recipients to develop a sustainability plan to continue offering services and interventions implemented during the grant period. To examine sustainability plans and activities and understand the data used to monitor and improve services, the cross-site evaluation team surveyed all eight RPG6 grant recipients and their partners in 2023.

All eight RPG6 projects planned to sustain their services, and seven of them accomplished at least a moderate amount of sustainability planning at the time of the survey. Most projects had identified an organization to lead the partnership after RPG6 funding ended and had made substantial progress in determining which services to continue and data to collect about those services.

RPG6 projects had strong implementation supports and data collection infrastructure in place, suggesting the capacity to continue services after RPG6 funding ended. Most projects had a team in place to manage those services, a process to resolve barriers to implementing services, and a process to assess service quality. Additionally, most projects reported that they analyzed data to inform program improvement and shared data with staff, partners, and the community.

Although only one project had a funding source in place, seven projects planned to use state funding sources (versus federal, local, or other sources) to pay staff and sustain services. For half of the RPG6 projects, respondents reported that their organizations planned to contribute financial and in-kind resources beyond the RPG6 funding period.

Introduction to projects funded in 2022 (RPG7)

When analysis for this report was in progress, RPG7 projects had completed a required planning period ranging in length of 5 to 12 months. During this period, grant recipients engaged in TA and internal planning activities to refine their focal population, services, and evaluation designs; develop partnerships and data collection protocols; hire staff; and secure IRB approvals and data sharing agreements.

RPG projects work with families in which adults have a suspected or diagnosed SUD, and children have experienced or are at risk of maltreatment. Projects typically choose to focus on families with one or more levels of engagement with the child welfare system. All but three RPG7 projects planned to focus on families with an active child welfare case, along with either families at risk of child welfare involvement and those in which a child was removed from the home, or both. Two of the remaining three focused only on families at risk for child welfare involvement, and the final project focused only on families in which a child has already been removed from the home.

All 18 RPG7 projects planned to provide case management or service coordination. Fifteen planned to offer screening or assessment, whereas 13 planned to provide parenting or family strengthening supports. Thirteen planned to provide trauma or mental health treatment. Twelve

planned to provide SUD treatment. Most grant recipients planned on serving the adult or the family unit.

All RPG7 partnerships included the state or local child welfare agency (as a partner to the grant recipient in all but one project), and all but one partnership included the state or local substance use or mental health system agency (as a partner agency in 15 projects). Court or judicial systems involved in child welfare dependency cases were involved as partners on 14 projects.

HHS requires projects to conduct local evaluations to learn more about the implementation and outcomes of their unique set of services. As of November 2023, 15 of the 18 projects had proposed impact evaluations, using either a quasi-experimental design (10 projects) or randomized controlled trial (5 projects). The remaining three projects proposed outcome evaluations, which descriptively examine the change in outcomes for the treatment group over time.

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I. INTRODUCTION

One of the most common risk factors for experiencing maltreatment in childhood—either neglect or abuse—is a caregiver's substance use (Box I.1). In 2022, about 24 percent of children who experienced maltreatment[9] (that is, nearly 96,000 children) had a caregiver who misused drugs (Children's Bureau [CB], 2024).[10] That same year, about 15 percent of victims (more than 46,000 children) had a caregiver who misused alcohol (CB, 2024).[11] Among these children, more than 36,000 infants were referred to child protective services (CPS) for prenatal substance exposure and were screened in for investigation (CB, 2024).

Box I.1. Terminology in this report

This report uses non-stigmatizing language, such as substance use disorder and substance use, as set forth in the U.S. Surgeon General's report (HHS, 2016) and recommended by the Office of National Drug Control Policy (Botticelli, 2017), except when older terminology appears in proper names.◢

Parental substance use can influence child well-being. Children exposed prenatally to alcohol and other drugs are at higher risk for both short-term effects, such as slower fetal growth and neonatal withdrawal, and long-term negative effects on their growth, cognition, and behavior (Behnke & Smith, 2013). Children who are removed from their home and whose parents use substances tend to be in foster care longer than other children (Mowbray et al., 2017). In addition, children who experience maltreatment are themselves at greater risk of eventually using substances and perpetuating a generational cycle of substance misuse and potential child maltreatment (Cicchetti & Handley, 2019).

However, families involved with CPS often have strengths and motivation to change. A group of 10 clinicians who served parents involved with CPS described the parents' commitment to their child, desire to care for them, and interest in improving their parenting skills (Yoo et al., 2022). The clinicians also noted that in addition to substance use issues, the parents often struggled with limited knowledge about parenting and had few resources or support for either issue (Yoo et al., 2022)—areas that might be amenable to intervention. A small study of parents who were at risk of having their children placed in foster care found that many of them wanted help with their parenting practices (Bolen et al., 2008).

Improving outcomes for children affected by their parent or caregiver's substance use was one of the goals when Congress passed the Child and Family Services Improvement Act of 2006 (Pub. L. 109-288). The legislation amended Section 437 of the Social Security Act (42 U.S.C. 629g[f]) to authorize the Children's Bureau in the Administration on Children, Youth, and

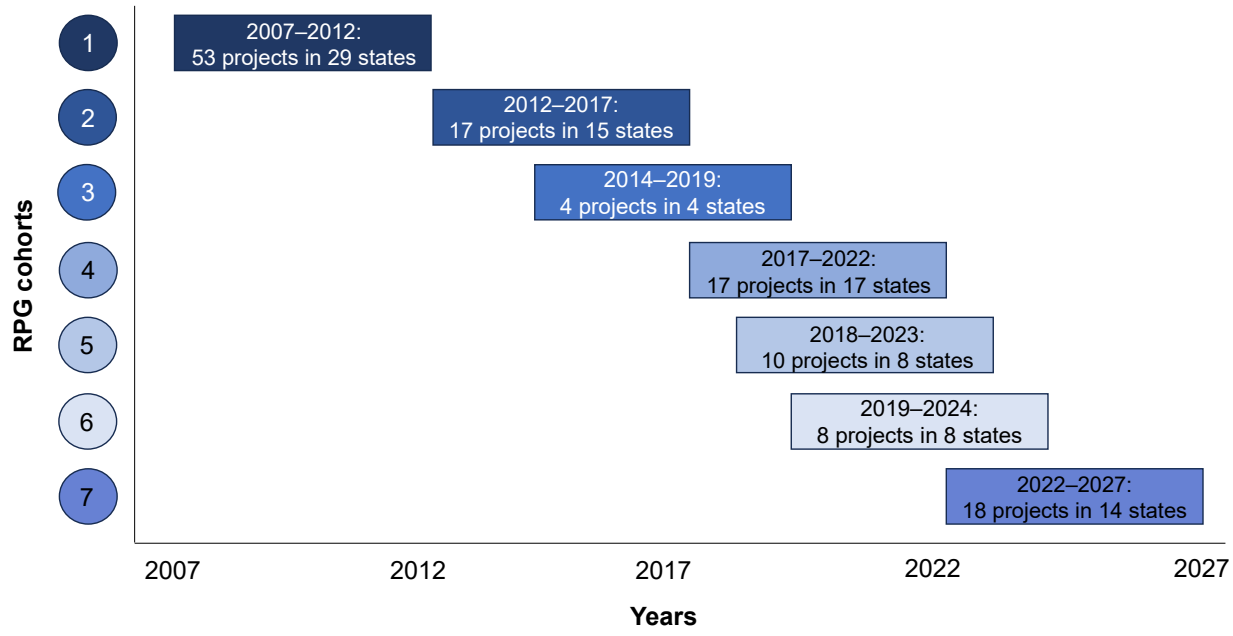
[9] States determine whether maltreatment is substantiated or indicated—that is, maltreatment may not have been substantiated under state law or policy, but there was reason to suspect that at least one child may have been maltreated or was at risk of maltreatment (CB, 2024).
[10] The risk factor was categorized as "drug abuse," which was defined as "the compulsive use of drugs that is not of a temporary nature" (CB, 2024). These results were limited to 39 states that reported data on "drug abuse" as a possible risk factor.
[11] The "alcohol abuse" risk factor, which was defined as "the compulsive use of alcohol that is not of a temporary nature," was reported by 33 states (CB, 2024).

Families (ACYF) within the Administration for Children and Families (ACF) at the U.S. Department of Health and Human Services (HHS) to fund discretionary grants to improve safety, well-being, and permanency outcomes for children at risk of or in out-of-home placement because of their caregiver's substance use.

In response, in 2007, HHS launched a competitive grants program, the Targeted Grants to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Methamphetamine and Other Substance Abuse,[12] also known as the Regional Partnership Grants (RPG) program. Reauthorized in 2011, again by the Bipartisan Budget Act of 2018 (Pub. L. 115-123), and most recently in 2025 (Public Law 118-258), these grants are designed to support partnerships among child welfare agencies, substance use treatment organizations, and other social services systems and thereby improve the well-being, permanency, and safety of children and families. Eligible applicants include entities that are "related to the provision of child and family services" and can include child welfare agencies, substance use treatment providers, tribal organizations, and community behavioral health providers, among others (ACF, 2019).

Since 2007, HHS has awarded grants to seven cohorts of grant recipients (referred to in this report as RPG1–RPG7). As Figure I.1 shows, the cohorts have included 127 RPG projects. RPG5, RPG6, and RPG7, which are the subjects of this report, included 36 grant recipients that were active in 2023 or 2024.

Figure I.1. Timing and number of RPGs awarded, 2007–2024



[12] This report only uses the term "substance abuse," which has a high association with negative judgments and punishment (National Institute on Drug Abuse, 2021), when it is the actual term used in legislation, report and document titles, or organization or program names.

To help assess whether the RPG program operates as intended and meets its desired goals, Congress requires HHS to define and collect performance measures data from the grant recipient for each grant. The authorizing legislation requires HHS to evaluate the services and activities that are provided with RPG funds. To evaluate the overall program and to satisfy the legislative mandates, HHS contracted with Mathematica and its partner, WRMA Inc., to conduct a national RPG cross-site evaluation. As part of the evaluation, HHS has submitted eight reports to Congress that were prepared by the contractor (Appendix A).[13]

This chapter introduces the Ninth Report to Congress. Section A describes the 36 RPG projects in the 3 cohorts (RPG5, RPG6, and RPG7) included in the report. Section B is an overview of the technical assistance (TA) that grant recipients received. Section C is an overview of the content and organization of the remainder of the report.

A. Current grant recipients

The three cohorts are in different stages of their grants. The RPG5 cohort completed its grants in September 2023. In September 2024, the RPG6 cohort period of performance ended[14] and the RPG7 cohort had finished the second year of its grants.

1. RPG5 cohort

HHS funded 10 RPG projects in 2018, as shown in Table I.1. The grants were disbursed to and administered by lead entities, also known as grant recipients. A variety of organizations received a 2018 grant, with behavioral health services providers being the most common type. Applicants could apply for up to $1.9 million for a single 3-year project and budget period, with the required percentage of matching funds from grant recipients increasing over time (ACF, 2018). In total, HHS awarded $15,517,100 in amounts ranging from $745,143 to $1,900,000. Midway through the initial grant period, HHS offered two-year extensions with additional funds to align the project and budget periods with all other cohorts of RPG grants. Nine of the 10 grant recipients applied for and received the extension. Half of the 2018 projects were led by a previous RPG grant recipient. The projects were spread across the East Coast and the Midwest, in both urban and rural areas.

Table I.1. Grant recipients funded in 2018 (RPG5)

State where located and grant recipient name	Area served[a]	Congressional district	Organization type[b]	Previous RPG	Total program funding[c]
Florida: Citrus Health Network dba Citrus Family Care Network	Miami-Dade County	FL-24	Entity contracted to oversee child welfare service providers	RPG3	$3,169,624

[13] A separate contractor prepared the Reports to Congress for RPG1, which concluded before the cross-site evaluation began with RPG2.
[14] Twelve grant recipients requested and received no-cost extensions (seven RPG5 and five RPG6 grant recipients).

State where located and grant recipient name	Area served[a]	Congressional district	Organization type[b]	Previous RPG	Total program funding[c]
Florida: Family Support Services of North Florida	Duval County	FL-4	Entity contracted to oversee child welfare service providers	No	$2,952,624
Illinois: Centerstone of Illinois, Inc.	Franklin, Jackson, Madison, Perry, Randolph, St. Clair, Washington, and Williamson counties	IL-12	Behavioral health service provider	No	$745,173
Iowa: Judiciary Courts for the State	Eastern region of Iowa	IA-02	Court or judicial agency	No	$3,069,624
Iowa: Northwest Iowa Mental Health Seasons Center	Buena Vista, Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Sioux, and Woodbury counties	IA-004	Behavioral health service provider	RPG4	$3,069,624
Massachusetts: Institute for Health and Recovery, Inc.	Worcester County	MA-002	Behavioral health service provider	No	$2,943,997
Missouri: Preferred Family Healthcare, Inc.	Boone, Callaway, and Cole counties	MO-003	Behavioral health service provider	RPG4	$3,159,390
New York: Montefiore Medical Center	Bronx County	NY-015	University hospital or clinic	RPG3	$3,169,623
Pennsylvania: Health Federation of Philadelphia	Bucks and Philadelphia counties	PA-001	Family support service provider	RPG2	$3,169,623
South Dakota: Volunteers of America, Dakotas	Sioux Falls	SD-South Dakota at Large	Substance use treatment provider	No	$2,918,656

[a] Areas are cities unless otherwise indicated.

[b] For this table, substance use treatment providers are entities that offer only addiction recovery services. Behavioral health service providers offer an array of behavioral health services, including substance use treatment and mental health care. Family support service providers primarily offer social services rather than behavioral health care.

[c] The amounts in the table include the original three-year award plus the two-year extension award, except for Illinois, which did not apply for the extension.

Note: dba = doing business as; RPG = Regional Partnership Grants; TA = technical assistance.

Source: Grant recipients' RPG applications; calls between Mathematica and grant recipients, local evaluators, federal project officers, and programmatic TA providers; and summaries of projects provided by the National Center on Substance Abuse and Child Welfare.

2. RPG6 cohort

HHS funded eight RPG6 projects in 2019, as shown in Table I.2. Applicants could request up to $2,650,000 for a single 5-year project and budget period (ACF, 2019). Five of the eight RPG6 awardees had received a grant before, including one that received an award in 2018.

The projects were concentrated in the Midwest and along the East Coast, in both urban and rural areas. As with the RPG5 cohort, behavioral health service providers were the single most common type of grant recipient.

Table I.2. Grant recipients funded in 2019 (RPG6)

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

[a] Areas are cities unless otherwise indicated.

[b] These categorizations describe the grant recipient as a whole and differ somewhat from how grant recipients are classified in Chapter IV, which focuses on the collaboration between child welfare and substance use treatment providers within each RPG6 project. For example, in this table, substance use treatment providers are entities that offer only addiction recovery services. In contrast, in Chapter IV, an organization is categorized as a substance use treatment provider if it offers those services and/or mental or behavioral health treatment or supports to adults, children, or the family unit affected by substance use.

Note: dba = doing business as; RPG = Regional Partnership Grants; TA = technical assistance.

Source: Grant recipients' RPG applications; calls between Mathematica and grant recipients, local evaluators, federal project officers, and programmatic TA providers; and summaries of projects provided by the National Center on Substance Abuse and Child Welfare.

3. RPG7 cohort

In 2022, HHS funded 18 RPG projects, which are shown in Table I.3. Thirteen of the 18 grant recipients had participated in earlier RPG rounds. The annual grant award could range from $250,000 to $600,000 per year, or up to $3 million in total for 5 years (ACF, 2022). Seven grant recipients received the maximum award amount. Most grants were awarded to behavioral health service providers or family support providers. The projects were primarily concentrated in the Midwest and along the East Coast, but also included Alaska. They operate in both urban and rural areas.

Table I.3. Grant recipients funded in 2022 (RPG7)

State, lead entity name, and city where located	Area served[a]	Congressional district(s)	Organization type[b]	Previous RPG	Total program funding
Alaska: Cook Inlet Tribal Council, Inc. Anchorage	Anchorage	AK-1	Family support service provider (tribal organization)	RPG1, RPG4	$2,650,000
Connecticut: State of Connecticut, Department of Children and Families Hartford	New London County	CT-2	State child welfare agency	No	$2,976,491
Florida: Broward Behavioral Health Coalition, Inc. Ft. Lauderdale	Broward County	FL-23	Contracted entity to oversee the network of behavioral health service providers	RPG4	$2,650,000
Illinois: Centerstone of Illinois, Inc. West Frankfort	Franklin, Jackson, Johnson, Madison, Perry, Randolph, St. Clair, Union, Washington, and Williamson counties	IL-12, IL-13, IL-15	Behavioral health service provider	RPG5	$3,000,000
Illinois: Youth Network Council dba Illinois Collaboration on Youth Chicago	Madison and St. Clair counties	IL-12	Youth advocacy organization	RPG4, RPG6	$2,650,000

State, lead entity name, and city where located	Area served[a]	Congressional district(s)	Organization type[b]	Previous RPG	Total program funding
Iowa: Judiciary Courts for the State Des Moines	Appanoose, Davis, Des Moines, Henry, Jefferson, Keokuk, Lee, Louisa, Mahaska, Monroe, Poweshiek, Van Buren, Wapello, and Washington counties	IA-1, IA-2	Court or judicial agency	RPG5	$2,650,000
Iowa: Florence Crittenton Home of Sioux City Sioux City	Residents of any of Iowa's 99 counties; children from 30 counties located in the Department of Health and Human Services–Western Service Area (Region 1); and the 16 counties served by the Third Judicial District–Juvenile Court Services	IA-1, IA-2, IA-3, IA-4	Family support service provider	No	$3,000,000
Kentucky: Mountain Comprehensive Care Prestonburg	Floyd, Johnson, Magoffin, Martin, and Pike counties	KY-5	Behavioral health service provider	RPG4	$3,000,000
Louisiana: Volunteers of America Southeast Louisiana, Inc. New Orleans	Jefferson, Livingston, Orleans, Plaquemines, St. Bernard, St. Helena, St. Tammany, Tangipahoa, and Washington parishes	LA-1, LA-2, LA-5, LA-6	Substance use treatment provider	No	$3,000,000
Missouri: CPR of the Ozarks Springfield	Dallas, Polk, Webster, and Taney counties	MO-4, MO-7	Family support service provider	No	$2,997,864
Missouri: Preferred Family Healthcare, Inc. Springfield	Barry, Christian, Greene, Lawrence, Stone, and Taney counties	MO-7	Behavioral health service provider	RPG2, RPG4, RPG5, RPG6	$2,721,291
New York: Montefiore Medical Center Bronx	Bronx	NY-15	University hospital or clinic	RPG3, RPG5	$3,000,000
Oklahoma: Oklahoma Department of Mental Health and Substance Abuse Services Oklahoma City	Comanche, Kay, and Muskogee counties and tribal nations within or overlapping these counties	OK-5	State mental health and substance abuse services agency	RPG1, RPG2, RPG4, RPG6	$2,650,000

State, lead entity name, and city where located	Area served[a]	Congressional district(s)	Organization type[b]	Previous RPG	Total program funding
Pennsylvania: Health Federation of Philadelphia Philadelphia	Bucks and Philadelphia counties	PA-2	Family support service provider	RPG2, RPG5	$2,650,000
Tennessee: Helen Ross McNabb Center Knoxville	Knox County and Eastern Tennessee	TN-2	Behavioral health service provider	RPG1, RPG2, RPG4	$3,000,000
Tennessee: Tennessee Department of Mental Health and Substance Abuse Services Nashville	Bedford, Coffee, Franklin, Giles, Hickman, Lawrence, Lincoln, Marshall, and Maury counties	TN-4	State mental health and substance use services agency	No	$2,996,975
West Virginia: Prestera Center for Mental Health Huntington	Mason, McDowell, Mercer, and Putnam counties	WV-3	Behavioral health service provider	RPG4, RPG6	$2,650,000
Wisconsin: Meta House, Inc. Milwaukee	Milwaukee County	WI-4	Substance use treatment provider	RPG4	$3,000,000

[a] Areas are cities unless otherwise indicated.

[b] For this table, substance use treatment providers are entities that offer only addiction recovery services. Behavioral health service providers offer an array of behavioral health services, including substance use treatment and mental health care. Family support service providers primarily offer social services rather than behavioral health care.

Note: dba = doing business as; RPG = Regional Partnership Grants; TA = technical assistance.

Source: Grant recipients' RPG applications; calls between Mathematica and grant recipients, local evaluators, federal project officers, and programmatic TA providers; and summaries of projects provided by the National Center on Substance Abuse and Child Welfare.

B. Technical assistance

To support grant recipients in the implementation and evaluation of their projects, HHS provided technical assistance (TA) through two federal contractors. ACYF and the Substance Abuse and Mental Health Services Administration (SAMHSA) contracted with Children and Family Futures to manage the National Center for Substance Abuse and Child Welfare (NCSACW). Since 2007, NCSACW has provided programmatic TA to RPG projects, which can include support for collaborative practice and policy, program sustainability, and trauma-informed services.[15] Starting in 2012, as part of its contract to design and conduct the RPG cross-site evaluation, Mathematica provided TA to support each cohort's project-specific evaluations—referred to in this report as local evaluations—and grant recipients' participation in the cross-site evaluation.

[15] NCSACW also provided TA to the RPG1 cohort on collecting and submitting performance measures and conducting project-specific evaluations. For more information on NCSACW's TA to RPG cohorts, see https://ncsacw.acf.gov/technical/rpg/.

Evaluation TA evolves as the grant recipients and their partners progress through their evaluation, from designing and planning through implementation, data collection, and analysis.[16]

C. Content and organization of this report

This report summarizes findings to date from the cross-site evaluation for RPG5, RPG6, and RPG7. Through the cross-site evaluation of all RPG projects, HHS seeks to better understand (1) who enrolled in the RPG projects; (2) the services they received; (3) the partnerships that formed the basis of each project; (4) participants' outcomes; and (5) the projects' impacts[17] (D'Angelo et al., 2019). Although an impact study was planned for both the RPG5 and RPG6 cohorts, some grant recipients were unable to carry out their planned designs—for example, they could not identify a comparison group similar to the families in RPG but that did not receive services. Most grant recipients did not enroll as many families as they had planned or did not collect data from most of the families they enrolled. Thus, the cross-site evaluation team could not conduct an impact analysis across both cohorts. However, some RPG5 projects successfully conducted local evaluations with sufficient samples to allow for a cross-site impact analysis. The findings from this analysis will be released in a separate report. Additionally, some RPG5 and RPG6 project teams planned to use the data they collected to analyze the impacts of their program separately, known as a local impact evaluation.

Because the cohorts were in different stages of their grants, there are different types and levels of information about each cohort in this report. Most of the report focuses on RPG5 and RPG6, which ended in September 2023 and September 2024, respectively.[18] The time span covered by the data differs by cohort and data source. For RPG5 projects, the data cover about four years, from March 2019 through May 2023, for most data sources. For RPG6 projects, the data cover about three and a half years, from October 2020 through March 2024, for most data sources. The report also provides introductory information for RPG7. Appendix B provides more information on data sources used in the report.

Beginning in 2020 and for most of their periods of performance, RPG5 and RPG6 projects have operated during the COVID-19 pandemic, which required them to adapt in many ways. For example, some projects switched to virtual service delivery, and many tried to meet the increased needs of their participants (HHS, 2023). Some or all staff worked remotely, and staff turnover increased for some projects. This context is useful to consider when interpreting the findings from the cross-site evaluation (HHS, 2023).

[16] For more information, see https://rpg-cse.acf.hhs.gov/ and https://www.mathematica.org/projects/regional-partnership-grants-national-cross-site-evaluation.

[17] An impact study determines whether an intervention caused a change in participant outcomes. An impact study requires a group of people who did not participate in the program and who are otherwise similar to program participants on at least observable characteristics.

[18] Some grant recipients requested and received no-cost extensions.

The remainder of this report is organized as follows:

- Chapter II describes the characteristics of families and individuals enrolled in RPG5 or RPG6 projects and how they were referred to the projects.
- Chapter III describes the services that families enrolled in RPG5 and RPG6 projects received and discusses the following four broad patterns of services that characterize the grant recipients in these cohorts: (1) case management services, (2) medical care and parenting services, (3) parenting and therapy services, and (4) therapy services.
- Chapter IV examines the key partnerships for the RPG6 projects—that is, the connection between child welfare and substance use treatment systems.[19]
- Chapter V provides details of the experiences of a small sample of families enrolled in RPG6 projects, including experiences leading to their substance use and child welfare involvement and their experiences with RPG services.[20]
- Chapter VI focuses on whether and how participants' outcomes changed after receiving RPG services. The analysis examines change over time in the following five domains of interest to Congress and CB: (1) adult recovery, (2) family functioning, (3) child safety, (4) permanency, and (5) child well-being.
- Chapter VII describes RPG6 projects' efforts to sustain their services and partnerships beyond the end of grant funding.
- Chapter VIII introduces the RPG7 cohort, including information on the planned focal populations, services, and local evaluations as well as information on partnerships and planning year activities.

Terms used throughout the report are defined in Box I.2.

Box I.2. Terms and definitions in this report

Administrative data. Records that governments or other organizations collect as part of their operations. Although they can be used for research, administrative data are not collected for that purpose but to support and document the administration of programs.

Cases. The family, household, or group of individuals who enroll into an RPG project to receive services together.

Child well-being reporter. The focal child's current primary caregiver, who has cared for the child for the past 30 days or longer.

Evidence-based practices. Practices that integrate the best available research and practice expertise in a given field to support implementation.

[19] Data on RPG5 cohort partnerships were reported in the Eighth Report to Congress.
[20] The findings reported in Chapter V are from a pilot study conducted with four RPG6 projects to collect participant experience data. The data collection methods used in this study will be expanded in the RPG7 cohort to include all projects.

Family functioning adult. The focal child's biological or adoptive parent. If a biological or adoptive parent was not part of the case enrolled in RPG, the reporter was the adult with the goal of reunification with the focal child.

Focal child. A single child in each family whom the project teams collected data on for the child well-being measures, to limit the burden associated with data collection. Each project team defined criteria for the focal child (such as the youngest child in a family, if there were multiple children) and used them to select the focal child within each enrolled family.

Impact evaluation. A study that determines whether an intervention caused a change in participant outcomes. An impact study requires a group of people who did not participate in the program and who are otherwise similar to program participants on at least observable characteristics. This comparison group represents what would have happened to participants if they had not received the intervention.

Lead entity. The organization that was awarded the RPG grant.

MOUD. Medications for opioid use disorder.

Outcome evaluation. A study that measures whether participant outcomes change from the beginning of an intervention to after the intervention.

Partners. The organizations that work with a lead entity to serve families as part of the RPG project.

Partnership. The relationships between organizations involved in an RPG project.

Process evaluation. A study that examines measures related to program implementation, processes, and procedures, such as the quality of services provided or the number of referrals received from each partner.

Recovery domain adult. The adult who is at risk of developing a substance use issue, has an active substance use issue, or is in recovery from a substance use issue. If no such adult is part of the case, the family functioning adult will also be the recovery domain adult.

RPG program. The grant program that funds RPG projects.

RPG project. The lead entity along with its partner organizations and/or the services they provide through RPG.

Service encounter. An interaction between a service provider and the family receiving the RPG service, such as a meeting with a case manager or therapist, a support group, a mentoring session, or a parenting training program. Projects report details about the interaction that include the location, duration, attendance, and topics covered.

Service type. There are two service types: (1) primary services and (2) supportive services. *Primary services* deliver the main content of the RPG project to families and include case management or service coordination, mentoring, parenting training or home visiting programs, support groups or workshops, and therapy or counseling. *Supportive services* are ancillary services that may complement the primary services, such as child care, financial or material support, housing, screening or assessment, and transportation.

Standardized instrument. A set of questions and response options that are given to eligible respondents, usually with instructions on how to answer or interpret the questions. The instrument is scored in a standard or consistent manner, which makes it possible to compare the relative performance of individuals or groups.

Substance. A psychoactive compound with the potential to cause health and social problems, including substance use issues (HHS, 2016).

Substance misuse. The "use of any substance in a manner, situation, amount or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute … misuse (e.g., underage drinking, injection drug use)" (HHS, 2016).

Substance use disorder (SUD). A medical illness caused by repeated misuse of a substance or substances (HHS, 2016).

Substance use issues. The term used in this report to encompass substance use, substance misuse, and substance use disorder.

Substance use treatment. A service or set of services that can include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate use of alcohol and/or other drugs, address associated physical or mental health problems, and restore the patient to maximum functional ability (HHS, 2016).

II. CHARACTERISTICS OF FAMILIES ENROLLED IN RPG5 AND RPG6 PROJECTS

Although all RPG projects are charged with serving families at risk of being involved or already involved with the child welfare system because of a caregiver's substance use, each project defined the segment of that focal population that it intended to serve. Each project based its definition on the needs of the communities and of the people expected to benefit from the planned services. For example, some projects enroll families based on the age of their children or whether they have an open child welfare case. The characteristics of participants enrolled in RPG will reflect projects' successes in enrolling those they strive to serve.

This chapter discusses the families and individuals who enrolled in RPG5 projects from March 1, 2019, through May 19, 2023, and in RPG6 projects from October 1, 2019, through March 15, 2024.[21] Section A describes the focal populations for each RPG5 and RPG6 project. Section B focuses on the referral pathways for RPG5 and RPG6 projects. Section C provides a broad overview of the characteristics of the families enrolled in RPG5 and RPG6 projects. Section D describes the sociodemographic characteristics of the adults and children who enrolled in RPG5 and RPG6. Lastly, Section E describes the substance use, family functioning, and well-being characteristics of adults and children who enrolled in RPG5 and RPG6 projects.

A. Focal populations served by RPG5 and RPG6 projects

RPG5 and RPG6 projects defined their focal populations using some combination of the following three factors: (1) family demographics, (2) child welfare involvement, and (3) substance use issues. Table II.1 provides a summary of the focal populations for the 10 RPG5 and 8 RPG6 projects. Four projects narrowed their focal population based on adult or child characteristics—for example, by focusing on enrolling pregnant women or parents of children who were five years old or younger.[22] Almost all of the projects (16) focused on families with an active child welfare case, 5 projects also included families at risk of child welfare involvement. Only two projects focused exclusively on families who were at risk of child welfare involvement.

[21] RPG5 projects completed training for data collection on enrollment, services, and outcomes for the cross-site evaluation on March 1, 2019. May 19, 2023, was the last date that RPG5 projects could upload outcomes data before their grants ended. RPG6 projects completed training for data collection on enrollment, services, and outcomes for the cross-site evaluation by October 1, 2019. March 15, 2024, was the last date that RPG6 projects could upload outcomes data before data analysis for this report began. One RPG6 grant recipient did not contribute enrollment, service, or outcomes data to the cross-site evaluation. However, this grant recipient contributed data to other parts of the cross-site evaluation.

[22] All RPG grants are awarded based on criteria in the legislation and the strength of the application in responding to the program requirements. The three projects focusing on pregnant women and parent of young children are experts in serving those populations.

Table II.1. Focal populations served by the RPG5 and RPG6 projects

State	Grant recipient	Eligibility characteristics		
		Pregnant women and/or parents of young children[a]	Families with an active child welfare case	Families at risk of child welfare involvement
RPG5 projects				
Florida	Citrus Health Network dba Citrus Family Care Network		✓	
Florida	Family Support Services of North Florida	✓	✓	
Illinois	Centerstone of Illinois, Inc.		✓	
Iowa	Judiciary Courts for the State		✓	
Iowa	Northwest Iowa Mental Health Seasons Center		✓	✓
Massachusetts	Institute for Health and Recovery, Inc.		✓	
Missouri	Preferred Family Healthcare, Inc.		✓	
New York	Montefiore Medical Center	✓		✓
Pennsylvania	Health Federation of Philadelphia	✓	✓	✓
South Dakota	Volunteers of America, Dakotas		✓	✓
RPG6 projects				
Colorado	Colorado Judicial Department		✓	
Georgia	Georgia State University		✓	
Illinois	Youth Network Council		✓	
Missouri	Preferred Family Healthcare, Inc.		✓	
New Hampshire	Mary Hitchcock Memorial Hospital/Dartmouth-Hitchcock Medical Center		✓	✓
New Jersey	Acenda, Inc.		✓	✓
Oklahoma	Oklahoma Department of Mental Health and Substance Abuse Services	✓		✓

State	Grant recipient	Eligibility characteristics		
		Pregnant women and/or parents of young children[a]	Families with an active child welfare case	Families at risk of child welfare involvement
West Virginia	Prestera Center for Mental Health		✓	

[a] Young children were defined as children who were five years old or younger.

Note: dba = doing business as; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: RPG grant applications, Semi-Annual Progress Reports.

B. RPG5 and RPG6 projects' referral sources

To enroll families in services, RPG5 and RPG6 projects used multiple referral sources. As shown in Table II.2, more than half of the families received referrals to the projects from partner organizations (59 percent) rather than from the grant recipient—which reflects a goal of the RPG program to develop partnerships to serve families. Over half of the families enrolled in RPG5 and RPG6 projects were referred from partner child welfare agencies (59 percent). Partners such as courts (15 percent), substance use treatment providers (8 percent), and hospitals or clinics (4 percent) also referred families who enrolled in RPG projects. Nine percent of families enrolled in RPG5 and RPG6 projects were self-referred.

Table II.2. Referral sources for families enrolled in RPG5 and RPG6 projects

Referral source	Overall percentage (sample size)
Referring organization	
Grant recipient	40.8 (984)
Partner organization	59.2 (1,428)
Child welfare agency (public or private)	57.6 (822)
Substance use treatment provider	8.3 (119)
Mental or behavioral health provider	1.1 (16)
Hospital or clinic	3.6 (51)
Family support service agency	2.2 (31)
American Indian or Native American tribally designated organization	1.2 (17)
Self-referral or walk-in	9.4 (134)
Court	15.0 (214)
Other	1.5 (22)
Unknown	0.1 (2)

Note: RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

C. Number of families enrolled in RPG5 and RPG6 projects

Enrollment was an ongoing process for projects to fill their caseloads and meet enrollment targets. The cross-site evaluation focused on enrolling families (regardless of which members

received services), with a family defined as the group of people who enrolled together in RPG services. At a minimum, each family enrolled in RPG had to include one adult and one child (which could include a child in utero if the adult was pregnant at the time of enrollment).

During the 4 years of cross-site enrollment, the RPG5 and RPG6 projects enrolled 2,412 families, which comprised 2,965 adults and 4,568 children, including 272 children in utero at the time of enrollment, as shown in Table II.3.[23] The average size of a family was about three people, with one adult and two children.

Table II.3. Summary of families enrolled in RPG5 and RPG6 projects

Characteristics of enrollees	Results
Number of families	2,412
Number of individuals	7,533
Number of adults	2,965
Number of children	4,568
Children in utero at enrollment	272
Average number of people in a family	3.1
Range in family size	2–10

Note: RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

Few of the RPG5 and RPG6 projects fully met their enrollment goals.[24] Table II.4 shows each project's target enrollment; its actual program enrollment (through March 31, 2023, for RPG5 projects or through March 31, 2024, for RPG6 projects); and its enrollment in the cross-site evaluation (as of May 19, 2023, for RPG5 or as of March 15, 2024, for RPG6). Families could receive services even if they did not consent to be in the evaluation. Two of the 10 RPG5 projects exceeded their target case enrollment, and 3 projects met at least 80 percent of their program enrollment target. None of the RPG6 projects met or exceeded their target case enrollment, and only 1 project met at least 80 percent of its enrollment target.

Table II.4. Target and actual enrollment of families in RPG5 and RPG6, by project

State of project	Target enrollment	RPG program enrollment[a]	Cross-site evaluation enrollment[b]
RPG5 projects			
Florida (Citrus)	122	91	167
Florida (North FL)	225	172	158
Illinois	104	243	164
Iowa (Judiciary)	125	73	62

[23] Per research literature in this area, children in utero are understood to be subject to the services received by the adult, particularly medications for opioid use disorder (MOUD), which is a common treatment for pregnant women in RPG projects (Kraft 2018).

[24] Many RPG5 and RPG6 projects served families that did not consent to participation in evaluation activities. Consequently, projects reported higher enrollment than the number enrolled in the cross-site evaluation through the Regional Partnership Grant-Evaluation Data System.

State of project	Target enrollment	RPG program enrollment[a]	Cross-site evaluation enrollment[b]
Iowa (Seasons)	250	223	205
Massachusetts	180	143	113
Missouri	324	308	298
New York	210	205	205
Pennsylvania	283	65	61
South Dakota	310	324	327
RPG6 projects			
Colorado	170	85	0
Georgia	120	87	86
Illinois	480	256	82
Missouri	215	145	141
New Hampshire	70	56	73
New Jersey	533	95	144
Oklahoma	480	375	43
West Virginia	260	117	83

[a] Enrollment for families as reported in the Semi-annual progress reports may differ from the enrollment reported in the Regional Partnership Grant-Evaluation Data System given the different time periods. In the semi-annual progress report, projects reported total enrollment from the start of the project through March 31, 2023, for RPG5 and through March 31, 2024, for RPG6. In the Regional Partnership Grant-Evaluation Data System, enrollments were reported from March 1, 2019, through May 19, 2023, for RPG5 and from October 1, 2020, through March 15, 2024, for RPG6. For seven of the projects, the cross-site evaluation analysis included members of both the local evaluation program and comparison groups, because both groups received services funded by the grants. In these projects, the cross-site evaluation enrollment often exceeded the RPG program enrollment.

[b] One RPG6 grant recipient did not contribute enrollment data to the cross-site evaluation.

Note: RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Semi-annual progress reports, April 2023 (RPG5) and April 2024 (RPG6); Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

D. Demographic and socioeconomic characteristics of adults and children enrolled in RPG5 and RPG6 projects

RPG5 and RPG6 projects, which operated in different locations and with different focal populations, served families with a range of characteristics. Across RPG5 and RPG6 projects, most adult participants were female (78 percent); half were between the ages of 25 and 34 (50 percent), and 3 in 5 were never married at the time of enrollment (60 percent), as shown in Table II.5. Most of the adults enrolled in RPG5 and RPG6 projects were biological parents to the focal child (89 percent). Other enrolled adults were biological relatives (4 percent), stepparents or partners to a parent (4 percent), adoptive or pre-adoptive parents (2 percent), and nonrelative foster parents (2 percent). Nearly two-thirds (63 percent) of the adult participants identified as White and non-Hispanic, and almost all (98 percent) spoke English as their primary language. About one-quarter of enrolled adults had some high school education (23 percent), while 38 percent had a high school diploma or GED.

Most of the adults enrolled in RPG5 and RPG6 projects faced some economic challenges, as shown in Table II.5. Only about 2 in 5 adults (44 percent) were employed, either full-time or part-time, or were self-employed. Similarly, about 39 percent reported that their largest source of income came from wages or salary. The largest income source for about one-quarter of the enrolled adults (23 percent) was public assistance, such as Temporary Assistance for Needy Families (TANF); the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); and the Supplemental Nutrition Assistance Program (SNAP).

Table II.5. Characteristics of adults enrolled in RPG5 and RPG6 projects

Characteristic	Percentage (unless otherwise noted)	n
Sex (N = 2,965)		
Male	21.7	644
Female	78.3	2,321
Adult relationship to focal child (N = 2,960)		
Biological parent	88.6	2,623
Biological relative (grandparent, sibling, aunt or uncle, cousin)	4.4	130
Stepparent by marriage or parent's partner	3.6	106
Adoptive or pre-adoptive parent	1.7	49
Nonrelative foster parent	1.6	47
Other	0.2	5
Age (N = 2,963)		
Younger than 18	0.1	4
18 to 24	12.4	368
25 to 34	49.8	1,476
35 to 44	27.7	820
45 to 54	6.6	196
55 or older	3.3	99
Mean	33.5	2,963
Race and ethnicity (N = 2,884)		
White, non-Hispanic	63.4	1,829
Black or African American, non-Hispanic	15.0	433
AIAN, non-Hispanic	7.3	211
Asian, non-Hispanic	0.3	9
Native Hawaiian or other Pacific Island American, non-Hispanic	0.0	1
More than one race, non-Hispanic	2.9	83
Hispanic or Latino (any race)	11.9	348
Primary language[a] (N =2,921)		
English only	98.3	2,870
Spanish only	1.7	49
Other	0.1	2
Highest education level (N = 2,776)		
8th grade or less	2.6	73

Characteristic	Percentage (unless otherwise noted)	n
Some high school	22.7	630
High school diploma or GED	38.3	1,062
Some vocational or technical education	3.4	94
Vocational or technical diploma	2.7	76
Some college	19.3	537
Associate's degree	4.8	134
Bachelor's degree	4.5	124
Graduate-level schooling or degree	1.7	46
Employment status (N = 2,834)		
Full-time employment	28.7	812
Part-time employment	12.4	352
Self-employed	2.8	80
Not employed but looking for work	32.1	910
Not employed and not looking for work, or unable to work	24.0	680
Largest income source (N = 2,808)		
Wages and salary	39.3	1,104
Public assistance (TANF, WIC, SNAP)	22.6	634
Retirement, pension, and spousal survivor's benefits	0.7	21
Disability and SSI	7.8	219
Unemployment benefits	2.9	81
Child support	1.1	32
Support from other individuals	1.5	41
Child's benefits (SSI, survivor's benefits)	10.4	292
Other	0.6	18
None	13.0	366
Relationship or marital status (N = 2,898)		
Never married	60.1	1,743
Married	20.7	600
Divorced, widowed, or separated	19.2	555

[a] The Regional Partnership Grant-Evaluation Data System captured one primary language from three options: (1) English only, (2) Spanish only, or (3) other. Other languages included French and American Sign Language.

Note: AIAN = American Indian or Alaska Native; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SNAP = Supplemental Nutrition Assistance Program; SSI = Supplemental Security Income; TANF = Temporary Assistance for Needy Families; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

The demographic profile of the children enrolled in RPG5 and RPG6 projects was more balanced in terms of sex and more racially mixed than the adults' demographic profile. As shown in Table II.6, there were almost equal percentages of male (52 percent) and female (48 percent) children. About half of the children were White and non-Hispanic (51 percent); 18 percent were Black or African American and non-Hispanic; 16 percent were Hispanic or Latino (any race); 9 percent

were multiracial and non-Hispanic; and 7 percent were American Indian or Alaska Native (AIAN) and non-Hispanic. About half of the children (49 percent) were age 4 or younger. Children enrolled in RPG5 and RPG6 projects were six years old, on average.

At the time of enrollment, most children (87 percent) were receiving Medicaid, which is the nation's public health insurance program for people with low incomes (Centers for Medicare & Medicaid Services, n.d.; Rudowitz et al., 2019). This finding was consistent with the economic challenges reported by adults who enrolled in RPG5 and RPG6 projects.

Across the RPG5 and RPG6 projects, most children were living in private residences (94 percent), though the primary adults who lived with the children varied. More than half of the children (56 percent) were living with at least 1 biological parent, which included living with a biological mother only, biological father only, both the biological mother and father, or any biological parent along with another relative or other adult. About 26 percent of the children lived with a relative other than a biological parent, while 17 percent lived with a nonrelative foster parent only. Most children (91 percent) had lived in the same residence (that is, the same physical location) for the past 30 days. Residential stability has been shown to be a factor in reducing child maltreatment rates and is associated with long-term positive outcomes, including reunification for families with children in foster care (Davidson et al., 2019; Dworsky, 2014).

Table II.6. Characteristics of children enrolled in RPG5 and RPG6 projects

Characteristic	Percentage (unless otherwise noted)	n
Sex (N = 4,296)		
Male	52.1	2,237
Female	47.9	2,059
Age (N = 4,284)		
Younger than 1	16.4	704
1 to 4	32.4	1,390
5 to 8	24.8	1,063
9 or older	26.3	1,127
Mean (years)	5.6	4,284
Race and ethnicity (N = 4,190)		
White, non-Hispanic	50.8	2,130
Black or African American, non-Hispanic	18.2	761
AIAN, non-Hispanic	6.6	275
Asian, non-Hispanic	0.3	12
Native Hawaiian or other Pacific Island American, non-Hispanic	0.1	3
More than one race, non-Hispanic	9.0	378
Hispanic or Latino (any race)	16.0	678
Primary language (N = 4,271)		
English only	98.5	4,209
Spanish only	1.5	62
Other	0.0	0

Characteristic	Percentage (unless otherwise noted)	n
Medicaid status (N = 4,296)		
Receiving Medicaid	86.9	3,733
Not receiving Medicaid	6.6	283
Don't know	6.5	280
Primary type of residence at enrollment (N = 4,296)		
Private residence	93.6	4,022
Treatment facility	3.5	150
Correctional facility or prison	0.1	3
Homeless or shelter	1.3	55
Group home	0.6	24
Other	0.3	13
Don't know	0.7	29
Primary adults in household at enrollment (N = 4,296)		
Biological mother only	23.0	986
Biological father only	6.0	258
Both biological mother and father	15.1	650
Any biological parent and a relative or other adult	11.8	505
Other relative[a]	25.6	1,101
Nonrelative foster parent only	17.2	741
Other[b]	0.2	10
Don't know	1.0	45
Child lived in the same residence for the past 30 days (N = 4,296)		
Yes	91.3	3,921
No	7.7	331
Don't know	1.0	44

[a] This category includes situations where children were living with foster parents who were their relatives.

[b] This category includes families whose focal child was not in utero and did not live with any relative or a nonrelative foster parent.

Note: AIAN = American Indian or Alaska Native; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

1. Characteristics of children born while their families were enrolled in RPG5 and RPG6 projects

A subset of 272 women were pregnant when they enrolled into an RPG5 or RPG6 project. When a family exited RPG, projects reported updated information on pregnancies and birth outcomes if a child had been born by that time. (Chapter III, Section D has more information on RPG case closure.) At the end of cross-site data collection, RPG5 and RPG6 projects reported updated information for 247 pregnant women, including birth outcomes for 164 children. These results are shown in Table II.7.

Most children who were born after their mothers enrolled in RPG5 or RPG6 project had normal birth weights (84 percent), but 18 percent were born prematurely (defined as before 37 weeks gestation).[25] Less than 1 percent of children were born with a very low birth weight (defined as less than 3 pounds 5 ounces), and 12 percent were born with a low birth weight (defined as 3 pounds 5 ounces to 5 pounds 7.99 ounces). Almost one-third of the children (31 percent) spent time in a neonatal intensive care unit (NICU).[26] A low birth weight can have detrimental effects on children's socioemotional and cognitive outcomes prior to school entry (Hines et al., 2020). Research also shows that children born prematurely have more neurodevelopmental issues than their peers, such as lower levels of academic achievement and executive function and more behavioral, language, sensory, and motor issues (Aylward, 2014; Chung et al., 2020).

Receiving a diagnosis of neonatal abstinence syndrome or fetal alcohol syndrome is a risk factor to children. Children who are diagnosed with neonatal abstinence syndrome are more likely than children without that diagnosis to develop problems with their vision, motor skills, behavior, and cognition; to be at risk for child abuse or neglect and sudden infant death syndrome (Maguire, 2016); and to have educational disabilities (Fill, 2018). Children who are diagnosed with fetal alcohol spectrum disorders (FASD) experience developmental issues with motor skills, attention, executive function, and academic performance (Mattson et al., 2019). Only seven percent of children born after their mothers enrolled in an RPG5 or RPG6 project were diagnosed with neonatal abstinence syndrome, while none of the children received a diagnosis of fetal alcohol syndrome. All 11 of the children diagnosed with neonatal abstinence syndrome were exposed prenatally to opioids, and all but 1 of them had mothers who received MOUD during pregnancy.

Table II.7. Characteristics of children born after their mothers enrolled in RPG5 and RPG6 projects

Characteristic	Percentage (unless otherwise noted)	n
Child was born by the time of case closure (N = 247)		
Yes	66.4	164
No	13.8	34
Unknown	19.8	49
Mean age of child at case closure (months) (N = 164)	4.8	164
Child's sex (male) (N = 164)	53.7	88
Child's birth weight (N = 164)		
Normal birth weight (5 pounds 8 ounces or more)	84.1	138
Low birth weight (3 pounds 5 ounces to 5 pounds 7.99 ounces)	12.2	20
Very low birth weight (less than 3 pounds 5 ounces)	0.6	1
Birth weight unknown	3.0	5
Child was born prematurely (less than 37 weeks gestation) (N = 164)		
Yes	17.7	29

[25] In 2022, the preterm birth rate in the United States was 10.4 percent (Centers for Disease Control and Prevention, 2024).

[26] The reasons for spending time in the NICU and the amount of time spent there may or may not be related to a substance use issue during pregnancy.

Characteristic	Percentage (unless otherwise noted)	n
No	79.3	130
Unknown	3.0	5
Child spent time in the NICU (N = 164)		
Yes	31.1	51
No	64.0	105
Unknown	4.9	8
Child given a diagnosis of a condition related to substance exposure (N = 164)		
Neonatal abstinence syndrome	6.7	11
Fetal alcohol syndrome	0.0	0
No diagnosis of substance exposure	82.9	136
Unknown	10.4	17
If child received a diagnosis of neonatal abstinence syndrome, child was exposed prenatally to opioids (N = 11)		
Yes	100.0	11
No	0.0	0
Unknown	0.0	0
If child exposed prenatally to opioids, mother received MOUD during her pregnancy (N = 11)		
Yes	90.9	10
No	9.1	1
Unknown	0.0	0

Note: MOUD = medications for opioid use disorder; NICU = neonatal intensive care unit; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

2. Characteristics of enrolled families that did and did not receive services

Not all enrolled families participated in RPG services, so the characteristics of families that did and did not participate could differ within and across projects. Of the 2,412 families enrolled in RPG5 and RPG6 projects, 2,213 (92 percent) had at least 1 service encounter. There were some statistically significant differences between adults and children in families with at least one service encounter (participating families) relative to adults and children in families that did not participate in any service (nonparticipating families).

As shown in Table II.8, adults in participating families and nonparticipating families differed on their race and ethnicity and their largest income source. Adults in participating families were less likely to be Black or African American and non-Hispanic and more likely to be AIAN and non-Hispanic or more than one race and non-Hispanic compared to adults in nonparticipating families. Adults in nonparticipating families were more likely to report public assistance as their largest income source compared to adults in participating families.

Table II.8. Characteristics of adults in RPG5 and RPG6 projects, by families' service participation

Characteristic	Participating families		Nonparticipating families		Significance (*p*-value)
	Percentage	n	Percentage	n	
Race and ethnicity					0.000***
White, non-Hispanic	63.4	1,692	64.0	137	0.850
Black or African American, non-Hispanic	14.6	390	20.1	43	0.031*
AIAN, non-Hispanic	7.9	210	0.5	1	0.000***
Asian, non-Hispanic	0.3	8	0.5	1	0.672
Native Hawaiian or other Pacific Island American, non-Hispanic	0.0	1	0.0	0	0.777
More than one race, non-Hispanic	3.1	82	0.5	1	0.028*
Hispanic or Latino (any race)	11.6	313	16.0	35	0.051
Largest income source					0.001***
Wages and salary	39.3	1,022	39.2	82	0.980
Public assistance (TANF, WIC, SNAP)	22.0	571	30.1	63	0.007**
Retirement, pension, and spousal survivor's benefits	0.8	20	0.5	1	0.639
Disability and SSI	8.2	212	3.3	7	0.013*
Unemployment benefits	2.8	73	3.8	8	0.397
Child support	1.2	31	0.5	1	0.349
Support from other individuals	1.5	38	1.4	3	0.016*
Child's benefits (SSI, survivor's benefits)	10.0	260	15.3	32	0.975
Other	0.7	18	0.0	0	0.228
None	13.6	354	5.7	12	0.001**

Note: AIAN = American Indian or Alaska Native; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SNAP = Supplemental Nutrition Assistance Program; SSI = Supplemental Security Income; TANF = Temporary Assistance for Needy Families; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

The total number of adults was 2,965. Of those, 2,742 participated in any services and 223 did not. Missing data ranged from 0 (sex variable) to 189 (education variable).

We conducted chi-squared tests for categorical variables and Welch's t-tests on means to assess differences between families that did and did not receive services. For demographic characteristics that the groups differed on statistically, we conducted post hoc t-tests on the individual categories. This table only shows the demographic characteristics that the groups differed on statistically ($p < 0.05$). There were no statistically significant differences on the other adult demographic characteristics presented in Table II.5.

* Significantly different from zero at the .05 level, two-tailed test.
** Significantly different from zero at the .01 level, two-tailed test.
*** Significantly different from zero at the .001 level, two-tailed test.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and October 1, 2020, through March 15, 2024 (RPG6).

As shown in Table II.9, children in participating families and nonparticipating families differed on their age, race and ethnicity, Medicaid status, residence type, the adults in their household,

and their residential stability. For example, children in participating families were more likely to be nine years old or older, to be White and non-Hispanic or AIAN and non-Hispanic, to receive Medicaid, to live in a private residence, and to live with another relative than children in nonparticipating families. Children in nonparticipating families were more likely to be Black or African American and non-Hispanic, to live with their biological mother, and to be homeless or live in a shelter compared to children in participating families. Projects were also less likely to have information on children in families that did not receive services—which is not surprising because projects may not have been able to collect all of the enrollment information from families that did not engage with services.

Table II.9. Characteristics of children in RPG5 and RPG6 projects, by families' service participation

Characteristic	Participating families		Nonparticipating families		Significance (*p*-value)
	Percentage	n	Percentage	n	
Age					0.022*
Younger than 1	16.6	654	14.5	50	0.311
1 to 4	32.5	1,281	31.6	109	0.724
5 to 8	25.1	987	22.0	76	0.212
9 or older	25.8	1,017	31.9	110	0.014*
Race and ethnicity					0.000***
White, non-Hispanic	51.3	1,980	45.5	150	0.042*
Black or African American, non-Hispanic	17.3	667	28.5	94	0.000***
AIAN, non-Hispanic	7.0	272	0.9	3	0.000***
Asian, non-Hispanic	0.3	11	0.3	1	0.953
Native Hawaiian or other Pacific Island American, non-Hispanic	0.1	3	0.0	0	0.613
More than one race, non-Hispanic	9.1	352	7.9	26	0.450
Hispanic or Latino (any race)	11.6	313	16.0	35	0.153
Medicaid status					0.032*
Receiving Medicaid	87.3	3,447	82.7	286	0.015*
Not receiving Medicaid	6.5	256	7.8	27	0.342
Don't know	6.3	247	9.5	33	0.018*
Primary type of residence at enrollment					0.000***
Private residence	93.9	3,710	90.2	312	0.006**
Treatment facility	3.6	143	2.0	7	0.121
Correctional facility or prison	0.1	2	0.3	1	0.108
Homeless or shelter	1.2	46	2.6	9	0.023*
Group home	0.5	20	1.2	4	0.120
Other	0.3	11	0.6	2	0.331
Don't know	0.5	18	3.2	11	0.000***
Primary adults in household at enrollment					0.001***
Biological mother only	22.3	881	30.3	105	0.001***

Characteristic	Participating families		Nonparticipating families		Significance (*p*-value)
	Percentage	n	Percentage	n	
Biological father only	6.0	237	6.1	21	0.958
Both biological mother and biological father	15.2	601	14.2	49	0.600
Any biological parent and a relative or other adult	11.7	462	12.4	43	0.685
Other relative[a]	26.1	1,030	20.5	71	0.023*
Nonrelative foster parent only	17.5	693	13.9	48	0.083
Other[b]	0.3	10	0.0	0	0.349
Don't know	0.9	36	2.6	9	0.003**
Child lived in the same residence for the past 30 days					0.036*
Yes	91.3	3,606	91.0	315	0.874
No	7.8	308	6.6	23	0.442
Don't know	0.9	36	2.3	8	0.013*

[a] This category includes situations where children were living with foster parents who were their relatives.

[b] This category includes families whose focal child was not in utero and did not live with a biological parent or foster parent.

Note: AIAN = American Indian or Alaska Native; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

The total number of children was 4,296. Of those, 3,950 participated in any services and 346 did not. Missing data ranged from 0 (sex variable) to 59 (race and ethnicity variable).

We conducted chi-squared tests for categorical variables and Welch's t-tests on means to assess differences between families that did and did not receive services. For demographic characteristics that the groups differed on statistically, we conducted post hoc t-tests on the individual categories. This table only shows the demographic characteristics that the groups differed on statistically ($p < 0.05$). There were no statistically significant differences on the other child demographic characteristics presented in Table II.6.

* Significantly different from zero at the .05 level, two-tailed test.
** Significantly different from zero at the .01 level, two-tailed test.
*** Significantly different from zero at the .001 level, two-tailed test.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and October 1, 2020, through March 15, 2024 (RPG6).

E. Recovery and family functioning characteristics of adults and safety, permanency, and well-being of children enrolled in RPG5 and RPG6 projects

Because the RPG program is focused on improving safety, permanency, and well-being outcomes for children at risk of or in out-of-home placement because of their caregiver's substance use issue, the cross-site evaluation examined the characteristics of families at project enrollment related to these outcomes.

1. Adult substance use, recovery, and trauma

Caregiver substance use is one of the most common risk factors for involvement with the child welfare system (Ghertner et al., 2018; Mowbray et al., 2017). Therefore, a major goal of most

RPG projects is to help adults with substance use issues recover. Recovery from substance use disorder (SUD) is a process that helps people improve their health and wellness and improve the quality of their life (SAMHSA, 2012). The cross-site evaluation used various assessments as well as current and past participation in SUD treatment to examine adult recovery (Box II.1).

Box II.1. Measure of outcomes in the adult recovery domain

The cross-site evaluation used the Addiction Severity Index, Self-Report Form (ASI-SR) to measure the extent and severity of substance use by adults enrolled in RPG5 or RPG6 at enrollment and exit. Along with indicating use of alcohol and other drugs, the ASI has been shown to be predictive of SUD (Rikoon et al., 2006). However, the results from the instrument itself are not sufficient to establish this diagnosis, and the cross-site evaluation did not use it for that purpose.

a. Substance use

Adults entering RPG 5 and RPG6 commonly reported drug use. As shown in Table II.10, the average drug use score on the Addiction Severity Index, Self-Report Form (ASI-SR) was 0.08 on a scale of 0 to 1, which was slightly lower than the average observed (0.10) from a nationwide sample of individuals in substance use treatment settings (McLellan et al., 2006). This national sample might be considered comparable to the focal population for the RPG program. The mean score of 0.07 for alcohol use for adults in RPG5 or RPG6 was substantively lower than the national mean of 0.22.

More than one-quarter (28 percent) of enrolled adults had scores for drug or alcohol use that suggested a high severity of use—that is, a score for drug or alcohol use that was above the average observed in McLellan et al. (2006). Only 10 percent of adults were categorized as having this level of severity for alcohol use, but 27 percent were in the high-severity category for drug use.

Table II.10. Substance use in the 30 days before enrollment in RPG5 and RPG6 projects

Baseline scale	RPG5 and RPG6 sample size	ASI-SR score		Percentage of adults in high-severity category in RPG5 and RPG6[b]
		RPG5 and RPG6 sample mean score (SD)	National sample mean score (SD)[a]	
Drug use	2,058	0.08 (0.12)	0.10 (0.13)	22
Alcohol use	2,106	0.07 (0.14)	0.22 (0.25)	10
Any drug or alcohol use	2,041	n.a.	n.a.	28

[a] As reported in McLellan et al. (2006), which focused on a nationwide sample of individuals in treatment settings for SUD. Higher scores on the ASI-SR scales represent higher severity ratings.

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

Note: ASI-SR = Addiction Severity Index, Self-Report Form; n.a. = not applicable; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SD = standard deviation; SUD = substance use disorder.

Across 17 RPG5 and RPG6 projects that submitted the ASI-SR data, 89 percent of the families had an adult complete the ASI-SR (n = 2,158). The sample sizes ranged from 2,058 to 2,106 because of item nonresponse.

Source: Administration of the ASI-SR at RPG5 and RPG6 enrollment, including data submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

Among the drugs that adults reported using in the month before enrolling in RPG5 or RPG6, cannabis was the most-used drug. Amphetamines were the next most commonly used drug, followed by opioids—including, heroin, methadone, and prescription opioids. As shown in Table II.11, about 25 percent of adults reported using cannabis in the 30 days before entry. About 12 percent of adults used amphetamines and 7 percent used opioids in the 30 days before program entry. Adults described using cocaine and sedatives (3 percent each) as well as hallucinogens and barbiturates (1 percent each) infrequently compared to other drugs.

The same 3 drugs were the most commonly used in the past 30 days among the subset of adults in RPG5 and RPG6 who were classified as having high-severity use, but at much higher rates. These included cannabis (61 percent), amphetamines (46 percent), and opioids (24 percent). Those with high-severity use profiles also described using other drugs at higher rates compared to the overall group of adults enrolled in RPG5 and RPG6.

Table II.11. Drugs adults used in the 30 days before enrollment in RPG5 and RPG6, among those who completed the ASI-SR

Type of drug	Percentage of all adults reporting drug use within the past 30 days	Percentage of adults in high-severity category reporting drug use within the past 30 days
Cannabis[a]	25	61
Amphetamines[b]	12	46
Opioids	7	24
Cocaine[c]	3	12
Sedatives, hypnotics, and tranquilizers[d]	3	10
Hallucinogens[e]	1	4
Barbiturates[f]	1	2
Sample size	**2,096–2,122[g]**	**458**

[a] The ASI-SR defines cannabis as including marijuana, hashish, and pot.

[b] The ASI-SR defines amphetamines as including monster, crank, Benzedrine, Dexedrine, Ritalin, Preludin, methamphetamine, speed, ice, and crystal.

[c] The ASI-SR defines cocaine as including cocaine crystal, free-base cocaine, and crack or rock.

[d] The ASI-SR defines sedatives, hypnotics, and tranquilizers as including Valium, Xanax, Librium, Ativan, Serax, quaaludes, Tranxene, Dalmane, Halcion, and Miltown.

[e] The ASI-SR defines hallucinogens as including LSD (acid), mescaline, mushrooms (psilocybin), peyote, green, PCP (phencyclidine), angel dust, and ecstasy.

[f] The ASI-SR defines barbiturates as including Nembutal, Seconal, Tuinal, Amytal, pentobarbital, secobarbital, phenobarbital, and Fiorinal.

[g] Sample sizes range from 2,096 to 2,122 because of item nonresponse.

Note: ASI-SR = Addiction Severity Index, Self-Report Form; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Administration of the ASI-SR at RPG5 and RPG6 enrollment, including data submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

b. Recovery

Participation in substance use treatment is one indicator for SUD. Fewer than one-quarter (22 percent) of adults in RPG5 and RPG6 had been in publicly funded substance use treatment in the year before RPG entry. Of the 257 adults who participated in treatment, 26 percent had completed at least 1 treatment program. These adults participated in about two treatment programs, on average.

Looking at lifetime data, 44 percent of adults had been in at least 1 treatment program between the age of 18 to their enrollment in RPG. Of the adults who participated in treatment, 47 percent had completed at least 1 treatment program by the time of enrollment. On average, these adults participated in three treatment programs. However, only 8 project teams (of 18) collected the administrative data from their state or local substance use treatment agencies and 7 of them provided lifetime data, so these data do not represent the entire population of adults from all projects. In addition, the administrative data only included participation in publicly funded substance use treatment, not enrollment in private-pay settings, so the data might underestimate the number of adults who participated in treatment before RPG entry.

Results from the 2022 National Survey on Drug Use and Health showed that 7.3 million of the 48.7 million people ages 12 or older who had an SUD in the past year (14.9 percent) received substance use treatment in the past year (SAMHSA, 2023). However, the settings of substance use treatment in the national data were broader than publicly funded treatment and included treatment in an inpatient location; in an outpatient location; via telehealth; or in a prison, jail, or juvenile detention center. Thus, as a whole, adults in RPG5 and RPG6 participated in substance use treatment at higher rates than the average population with SUD, before enrolling in RPG. This is likely because the focal population for RPG is families at risk of being involved, or already involved, with the child welfare system because of a caregiver's substance use.

Box II.2. Lifetime data

RPG project teams submitted lifetime administrative data for all people in a family—that is, data for children (from birth through the end of the grant) from their state child welfare agencies and data for adults (from age 18 through the end of the grant) from their state or local substance use treatment agencies. The administrative data measured adult participation in substance use treatment and child safety and permanency.

However, only a subset of project teams submitted these lifetime data. Of the 10 RPG5 projects and 8 RPG6 projects, 5 RPG5 projects and 2 RPG6 projects submitted lifetime data on adult substance use treatment; 8 RPG5 projects and 5 RPG6 projects submitted lifetime data on child safety and permanency.

The analyses in this chapter include the focal children and the recovery domain adults (defined in Box I.2). Appendix C includes findings from the sensitivity analyses that included all children and all adults.

c. Trauma

Experiences of trauma —defined as events that are perceived as physically or emotionally harmful and have lasting effects on an individual's well-being—are strongly predictive of later substance use (Degenhardt et al., 2022). A recent analysis of 2019-2020 Behavioral Risk Factor Surveillance System (BRFSS) data found that up to 54 percent of heavy drinking and 53 percent of illicit drug use in adulthood is attributable to adverse childhood experiences (Peterson et al., 2023; SAMHSA, 2014). Adults in RPG5 and RPG6 reported that they experienced some post-traumatic symptoms in the last two months. On average, adults reported a score of 28 on a scale of 0 to 120 on the Trauma Symptoms Checklist-40 (TSC-40), an optional measure for RPG5 and a required measure for RPG6. However, they reported fewer symptoms than adults in an earlier study of 240 women enrolled in substance use treatment (Tracy et al., 2012), which observed an average score of 43.2 on the TSC-40.

2. Family functioning at enrollment

Caregivers' depressive symptoms and attitudes about parenting can affect family functioning. Box II.3 describes measures that the cross-site evaluation used to assess these factors.

a. Caregiver's depressive symptoms

At RPG5 and RPG6 entry, caregivers reported a mean score of 7.6 for depressive symptoms, which was higher than the mean score of 5.6 in a representative sample of parents of children in Head Start in the 2021 cohort of the Family and Child Experiences Survey (FACES) (Doran et al., 2024).[27] Families in Head Start represent a reasonable comparison for families in RPG, as both programs serve families with low incomes that have young children; however, families in Head Start do not necessarily have the same risk factors for child welfare involvement.[28] Although RPG does not specifically focus on serving families with low incomes, a large proportion of families that enroll in RPG face economic challenges. The percentage of adults in RPG5 and RPG6 who reported severe depressive symptoms, as measured by the Center for Epidemiologic Studies Depression Scale (CES-D), was also higher than the percentage for caregivers in FACES (20 percent versus 8 percent).

Box II.3. Measures of family functioning

The cross-site evaluation used the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977) to measure adult depressive symptoms and the Adult Adolescent Parenting Inventory (AAPI-2) (Bavolek & Keene, 1999) to measure attitudes about parenting and child-rearing at RPG enrollment and exit. Appendix C includes detailed descriptions of the CES-D and AAPI-2.

[27] Head Start is a program run by the Administration for Children and Families that provides early childhood education to eligible families with children ages 3 to 5.
[28] Both studies used the short form of the Center for Epidemiologic Studies Depression Scale (Ross et al., 1983).

b. Parenting attitudes

When asked about parenting and child-rearing on the Adult Adolescent Parenting Inventory (AAPI-2), caregivers in RPG5 or RPG6 reported scores above the national mean in all five constructs, including inappropriate expectation for child; lack of empathy for the child and oppresses child's independence; treats child like an adult peer, not a child; oppresses child's independence; and values corporal punishment, as shown in Table II.12. A higher score indicates that parents expressed more unfavorable parenting attitudes.

Adults were placed in the high-risk category for a construct if they reported attitudes suggesting they were at risk of perpetrating maltreatment on their children. Twelve percent to 33 percent of adults enrolled in RPG5 or RPG6 were in a high-risk category, depending upon the parenting attitude construct that was being measured. The constructs with the highest proportions of adults at risk of perpetrating maltreatment were lack of empathy for the child and oppressing the child's independence. The percentage of adults in the high-risk category was much higher in these two areas in the RPG sample compared to that in the national sample.

Table II.12. Caregivers' parenting attitudes at enrollment in RPG5 and RPG6 projects

Parenting attitudes	RPG 5 and RPG6 sample size	AAPI score		Percentage of adults in high-risk category in RPG5 and RPG6	Percentage of adults in high-risk category in the national sample
		RPG5 and RPG6 sample mean score (SD)	National mean score (SD)[a]		
Inappropriate expectations for child	2,113	5.9 (1.6)	5.5 (2.0)	12	16
Lack of empathy for child	2,113	6.5 (2.1)	5.5 (2.0)	33	16
Treats child like an adult peer, not a child	2,113	5.7 (2.0)	5.5 (2.0)	19	16
Oppresses child's independence	2,113	6.2 (2.4)	5.5 (2.0)	33	16
Values corporal punishment	2,113	5.7 (1.9)	5.5 (2.0)	16	16

[a] National means and SDs for the AAPI-2 are presented in the scoring manual for the instrument (Bavolek & Keene, 1999). The scales were transformed so that higher scores always indicate negative parenting attitude.

Note: AAPI-2 = Adult Adolescent Parenting Inventory; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SD = standard deviation.

The cross-site evaluation assessed parenting attitudes using the AAPI-2.

Source: Administration of the AAPI-2 at RPG5 and RPG6 enrollment, including data submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

3. Child safety and permanency before enrollment

The RPG program aims to serve families with children who are in or at risk of out-of-home placements. To examine this risk at RPG entry, the cross-site evaluation used administrative data on child safety and permanency that project teams obtained from their state child welfare

agencies. Box II.4 describes the measures of child safety and permanency. All 10 RPG5 projects and 5 of 8 RPG6 projects submitted safety and permanency data for at least one child in each family.

Box II.4. Measures of child safety and permanency

Administrative data provide two types of information that measure child safety (maltreatment) and permanency (removals and reunifications, adoptions, or guardianship).

The cross-site evaluation described two categories of reported maltreatment:

1. **Substantiated.** Included investigations that CPS classified as substantiated (the report was supported or founded as defined by state law or policy [HHS, 2020a]) or indicated (could not be substantiated, but there was reason to suspect that the child was maltreated or at risk of being maltreated)
2. **Not substantiated.** Included (1) unsubstantiated, (2) other (such as closed with no finding), or (3) alternative response (some states use this designation for a report that was not investigated but was assigned to an alternative track for CPS)

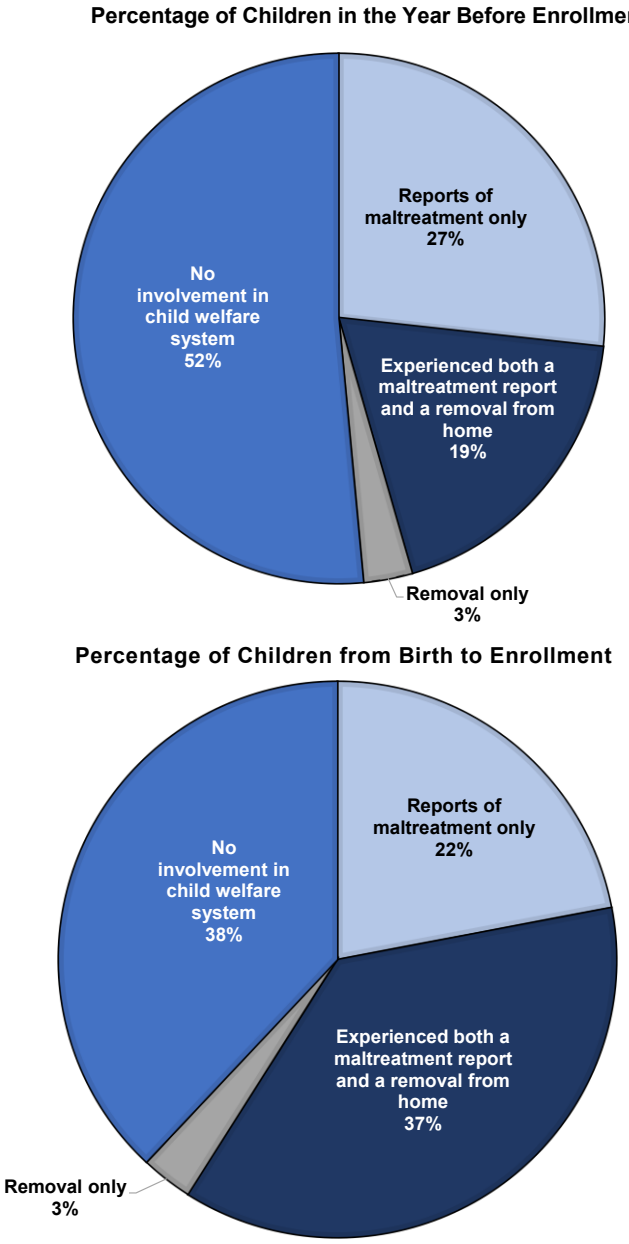
The data on permanency indicated whether children were removed from their homes within a given length of time (for example, in the year before RPG5 or RPG6 enrollment or ever from birth to enrollment) and subsequently placed within the foster care system. For children who exited the foster care system during these periods, the data showed whether they were reunified with their parents or were in another permanent living situation, such as with an adoptive family.

a. Child welfare involvement

Nearly half of children enrolled in RPG5 and RPG6 were involved with the child welfare system in the year before RPG entry. As shown in Figure II.1, 52 percent of the children who were enrolled in RPG5 and RPG6 had not been involved in the child welfare system in the year before RPG enrollment. About one-quarter (27 percent) of children had a report of child maltreatment but were not removed from their home. One-fifth of children (19 percent) experienced both a maltreatment report and a removal from the home.

Thirty-eight percent of children had not been involved in the child welfare system from birth to enrollment. Twenty-two percent of children had a report of child maltreatment but were not removed from their home, from birth to enrollment. More than one-third (37 percent) of children experienced both a maltreatment report and a removal from the home.

Figure II.1. Children with reports of child maltreatment and/or removals from home in the year before enrollment in RPG5 and RPG6 or from birth to enrollment



Note: RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Statistics are based on 2,009 focal children in 15 projects that submitted both safety and permanency data for the year before enrollment and 1,668 focal children in 13 projects for lifetime data as of enrollment. Percentages might not sum to 100 due to rounding. The cross-site evaluation defines involvement in the child welfare system with language from the Child Welfare Information Gateway (2013), which describes a report of suspected child abuse or neglect as the way most families become involved in the local child welfare system.

Source: Administrative records from state or county child welfare agencies that the projects obtained and submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

b. Safety

Before enrollment into RPG5 and RPG6, less than one-half (46 percent) of the children had been the subject of at least 1 report of maltreatment in the previous year, as shown in Table II.13. Thirty-three percent of children were the subject of substantiated reports, and 13 percent were the subject of reports that were not substantiated. The rate of maltreatment in the year before enrollment for children in RPG5 and RPG6 was substantially higher than the maltreatment rate of 4.8 percent in the national population of children in 2022 (CB, 2024).

Table II.13. Reports of maltreatment for children in RPG5 and RPG6 projects in the year before enrollment and from birth to enrollment

Type of maltreatment	In the year before enrollment		From birth to enrollment	
	Percentage of children with reports[a]	Number of children with reports	Percentage of children with reports[a]	Number of children with reports
Reports of any maltreatment (abuse, neglect, or other)	46	921	60	1,006
Reports of maltreatment that were substantiated	33	665	41	688
Reports of maltreatment that were not substantiated	13	265	22	368
Other[b]	5	99	10	168
Reports of abuse[c]	12	248	21	362
Reports of neglect[d]	31	621	41	697
Reports of other maltreatment	21	428	28	477

[a] Children may have been the subject of more than one report of maltreatment; therefore, the same child could be included in more than one major row in this table.

[b] This category includes reports that received alternative responses to investigation or where reasons were unknown and reports for children who were not the subject of an allegation but who lived in a household that received a CPS response for another child or other children in the household.

[c] This category includes physical, sexual, psychological, and emotional abuse.

[d] This category includes failure to provide needed, age-appropriate care, including medical neglect.

Note: CPS = child protective services; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Safety data include focal children in each case. Sample sizes are based on the subset of 15 projects that submitted the data for the year before enrollment and the13 projects that submitted lifetime data as of enrollment. The percentages are based on 2,009 children in the 15 projects for the year before enrollment and 1,688 children in 13 projects for lifetime data. Reports that were not substantiated included those that were unsubstantiated or had other or alternative responses; Box II.4 has definitions. Children can have reports in multiple categories, so percentages will not add to 100.

Source: Administrative records from state or county child welfare agencies that the projects obtained and submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

Child maltreatment can take the form of abuse and neglect or other experiences that are not as easy to categorize. Box II.5 defines the categories of maltreatment.

Box II.5. Categories of child maltreatment

The definition of child maltreatment varies by state (see the State Child Abuse & Neglect Policy Database).

- **Abuse** is defined as any recent act that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or an act that presents an imminent risk of serious harm to the child.
- **Neglect** is defined as any recent failure to act on the part of a parent or caregiver that may result in any of the same types of harm or that presents an imminent risk of serious harm to the child.
- **Other maltreatment** is defined as an instance of maltreatment that is not easily categorized as abuse or neglect. Examples vary by state but include threats of abuse or neglect (rather than actual abuse or neglect), abandonment, or the presence of illegal drugs in a child's body (CB, 2024).

Table II.13 shows that for the children enrolled in RPG5 or RPG6, neglect was the most reported category, both in the year before RPG enrollment (31 percent) and from birth to RPG entry (41 percent). The category for other maltreatment was the second most commonly reported type of maltreatment (21 percent in the year before and 28 percent from birth to enrollment). Abuse was least prevalent (12 percent in the year before enrollment and 21 percent from birth to RPG entry).

c. Permanency

A relatively smaller proportion of children had been removed from their homes before RPG5 and RPG6 enrollment but still at rates substantively higher than the national data. As shown in Table II.14, 22 percent of children were the subject of a report and were removed from their home in the year before entry into RPG5 and RPG6, while 40 percent were removed from their home from birth to RPG entry. In comparison, less than 1 percent of children in the United States entered foster care in 2022 (CB, 2024).[29]

On average, children had 2.3 out-of-home placements (for example, foster homes, group homes, or relative care) in the year before RPG5 and RPG6 enrollment and 2.8 placements from birth to RPG entry. Twenty-eight percent of children had 3 or more placements in the year before RPG5 and RPG6 enrollment, while 33 percent had 3 or more placements from birth to RPG entry. Of the children placed in foster care in the United States in 2021, the percentage of children with 3 or more placements ranged from 7.9 percent to 31.8 percent across states (HHS, 2022).

Foster care is intended to be a temporary solution for a child. The goal is to find a permanent, stable, and safe home. A permanency outcome is defined as family reunification, adoption, or guardianship. Table II.14 shows that 51 percent of children who had been removed from their home in the year before they enrolled in RPG had achieved permanency during the same period. Thirty-nine percent of children who had been removed did so through reunification with their families. Fifty-eight percent of children enrolled in RPG who had been removed from their

[29] Estimate calculated from the number of children entering foster care in 2022 (206,812) and the total estimated number of children in the United States in 2022 (74,112,223).

home had achieved permanency from birth to RPG entry. Forty-three percent of children did so through reunification with their families.

Table II.14. Out-of-home placements for children in the year before enrollment in RPG5 and RPG6 projects and from birth to enrollment

Out-of-home placement and permanency	In the year before enrollment			From birth to enrollment		
	Sample size	Mean (SD)	Percentage of children	Sample size	Mean (SD)	Percentage of children
Removed from home	2,009	n.a.	22	1,688	n.a.	40
Number of placements[a]	441	2.3 (3.0)	n.a.	681	2.8 (3.5)	n.a.
One placement	441	--	53	681	--	48
Two placements	441	--	19	681	--	20
Three or more placements	441	--	28	681	--	33
Achieved permanency	441	n.a.	51[b]	681	n.a.	58[c]
Reunified with family	441	n.a.	39[b]	681	n.a.	43[c]
Adoption	441	n.a.	7[b]	681	n.a.	11[c]
Guardianship	441	n.a.	6[b]	681	n.a.	8[c]

[a] Based on (1) 441 children who were removed from the home and placed at least once during the year before they enrolled in RPG5 or RPG6 or (2) 681 children who were removed from the home and placed at least once during their lifetime as of enrollment.

[b] Percentage of children who were removed from the home and achieved permanency in the year before they enrolled in RPG5 or RPG6.

[c] Percentage of children who were removed from the home and achieved permanency during their lifetime up to enrollment in RPG5 or RPG6.

Note: n.a. = not applicable; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SD = standard deviation.

Permanency data include all children in each case. Sample sizes are based on the 15 projects that submitted data for the year before enrollment and 13 projects for the lifetime data as of enrollment.

Source: Administrative records from state or county child welfare agencies that the projects obtained and submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

4. Child well-being at enrollment

Maltreatment can have lasting implications for children (Institute of Medicine & National Research Council, 2013; Lippard et al., 2020; Mahta et al., 2023). Children's emotional and behavioral problems might be associated with their caregiver's substance use (Behnke & Smith, 2013) or the caregiver's well-being and parenting skills (Neece et al., 2012). The RPG program not only strives to maintain or increase children's safety and permanency, but also to improve their well-being. Therefore, RPG5 and RPG6 projects collected data on children's emotional and behavior problems and sensory processing. Box II.6 describes how projects assessed well-being.[30]

[30] The terms "emotional problems" and "behavioral problems" are taken directly from the names of the scales in the standardized instrument used to measure child outcomes (Achenbach & Rescorla, 2000, 2001).

Box II.6. Measures of children's well-being

To measure children's well-being, the cross-site evaluation relied on reports from the caregiver most familiar with the child. Projects administered the Child Behavior Checklist and the Infant/Toddler Sensory Profile to the adult who was the primary caregiver of the focal child at RPG enrollment and exit. Appendix C defines and describes those instruments in detail.

Compared with a national sample, children in RPG5 and RPG6 demonstrated more emotional and behavioral problems and a higher total amount of problem behaviors.[31] Table II.15 shows that the mean scores of emotional, behavioral, and total problems were 53.4, 54.5, and 54.6, respectively for children at RPG5 and RPG6 enrollment. These means were slightly higher than the mean of 50 in the national sample. The percentages of children in RPG5 and RPG6 who were categorized as being at high risk were 28 percent for emotional problems, 28 percent for behavioral problems, and 31 percent for total problems. These percentages were also higher than the 10 percent reported in the national sample (Achenbach & Rescorla, 2000, 2001).

Prenatal substance exposure can affect a child's sensory processing (Chasnoff et al., 2010). However, Table II.15 shows that children enrolled in RPG5 and RPG6 were similar on sensory processing (being over- or under-responsive to stimuli) to a national sample. The percentage of focal children in RPG5 and RPG6 who were in the high-risk category for sensory processing at project entry was 30 percent, compared to 32 percent in the high-risk category in the national sample.

Table II.15. Child well-being at enrollment in RPG5 and RPG6 projects

Measure of child well-being	RPG5 and RPG6 sample size[a]	Child well-being score		Percentage of children in high-risk category in RPG5 and RPG6	Percentage of children in high-risk category in the national sample
		RPG5 and RPG6 sample mean score (SD)	National sample mean score (SD)		
Emotional, behavioral, and other problems					
Emotional problems	1,031	53.4 (13.7)	50 (10)	28	10
Behavioral problems	1,030	54.5 (14.0)	50 (10)	28	10
Total problems	1,029	54.6 (14.6)	50 (10)	31	10
Sensory processing[b]	510	n.a.	n.a.	30	32

[a] The sample sizes vary by measure because caregivers reported on different subsets of children depending upon the child's age. For example, the Infant/Toddler Sensory Profile (ITSP) has a narrow age range (birth to 36 months), so there is a small subset of children with data for that measure. The sample sizes for the Child Behavior Checklist (CBCL) vary because of item-level missing data.

[b] The RPG sample and national sample mean and SD for sensory processing were not reported in the table because they were not easily interpreted. Scores with either low or high values indicate under-sensitivity or oversensitivity, both of which indicate high risk.

Note: n.a. = not applicable; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SD = standard deviation.

[31] Total problems are a combination of emotional, behavioral, and other problems.

The cross-site evaluation collected data from one focal child in each case. Sensory processing was assessed using the ITSP; emotional and behavioral problems were assessed using the CBCL. Higher scores on the CBCL represent more problems. Fifteen projects submitted the ITSP and CBCL data.

Source: Administration of standardized instruments at RPG5 and RPG6 enrollment, including data submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

III. SERVICES RECEIVED BY FAMILIES ENROLLED IN RPG5 AND RPG6 PROJECTS

RPG5 and RPG6 projects select services to best serve the needs of their intended focal population. Some projects offer a wide variety of services, while others focus their services on a few key areas. In addition, some projects use program models, while others use less structured approaches. Although each project is individually designed, they provide common services to meet the needs of participating families and there may be similar groups of projects based on the patterns in service provision.

The RPG cross-site evaluation collected data to understand services received by enrolled families. RPG5 projects reported data from June 2019 to May 2023, and RPG6 projects reported data from October 2020 to February 2024. All 10 RPG5 projects and 7 of 8 RPG6 projects contributed data. These data included nearly 84,000 services encounters with more than 2,200 families. Projects reported data on primary and supportive services funded by the grant as well as services considered fundamental to their project but not funded by RPG. For each service encounter, projects reported the type of service, program model used, topics covered, family members attending, location and length of the encounter, level of engagement by participants, and individuals providing the service.

The findings have two key limitations. First, families enrolled in RPG projects likely received some services that the cross-site evaluation did not track. Projects often referred families to services beyond those reported to the cross-site evaluation. For example, they might refer families to programs or agencies outside the RPG5 or RPG6 project and partnership for employment assistance, health care, or housing. Thus, this report does not describe every service received by families enrolled in RPG that might support adult or child outcomes. In addition, one project did not submit service data and another project could only report on a subset of its core and funded services. Therefore, these analyses do not fully represent the experiences of all the families enrolled in those projects. Despite these limitations, the information in this chapter largely reflects services that families participated in while enrolled in an RPG5 or RPG6 project. Although there may be instances of incomplete or missing data, the cross-site evaluation team has no evidence to suggest there were systematic data quality issues that would alter the conclusions presented here.

This chapter explores the most common services received by families, highlights key therapy or counseling services, and discusses patterns in service provision. Section A describes the characteristics of services received by families enrolled in RPG5 and RPG6 projects. Section B discusses the therapy services they received, which was the most common type of service. Section C examines who provided services to families. Section D explores patterns in service delivery. Section E describes the characteristics of families that completed RPG services.

A. Overview of services

Families enrolled in the RPG5 and RPG6 projects were highly likely to participate in services. Of the 2,410 families enrolled, 92 percent attended at least 1 service encounter and 89 percent attended more than 1 service encounter. Of the families that received services, 97 percent received more than 1 service encounter.

Services were classified as either primary or supportive. Primary services are central to the goals of the RPG program. They deliver the main content of each project and fall into one of five service types: (1) case management, (2) therapy or counseling, (3) parenting training and home visiting, (4) mentoring, and (5) support group or workshop. As shown in Table III.1, nearly 90 percent of the service encounters were primary services and 97 percent of families received at least one primary service.

Most services provided by RPG5 and RPG6 projects were either case management and therapy or counseling services. All but a single project offered case management services to their families. Seven in 10 families received case management services, while two-thirds received therapy or counseling. Additionally, therapy or counseling services represented nearly half of all service encounters, even though they were provided by only 11 of the 17 RPG5 and RPG6 projects, which indicates that therapy or counseling services represented the focus of the projects that offered them. Among projects providing therapy or counseling services, most delivered these services to at least 90 percent of their enrolled families.

Parenting training and home visiting programs were offered by a similar number of projects (10 of 17) but were delivered to 40 percent of all families and represented only 7 percent of all service encounters. Four of the projects, however, provided these services to nearly all of their enrolled families (80 percent or more), which reflected the importance of parenting-related services to the RPG's goals.

Most projects (15) provided services that offered additional support to families, such as transportation, medical services, or screening or assessments (typically to develop a service plan for the family). Across all RPG5 and RPG6 projects, nearly three-quarters (71 percent) of families received a supportive service. Nearly one-third of families received a screening or assessment, making it the most common supportive service. Other notable supportive services included transportation, medical care, and financial or material supports. For some projects, supportive services were an important element of their service offerings and part of the service experience of most families. Two projects provided medical care to most of their enrolled families, making it a key element of their service provision. Three projects also provided housing in residential substance use treatment or supportive housing facilities to families enrolled in RPG5 or RPG6.

Table III.1. Number and percentage of service encounters and percentage of families receiving services, by service type

Service type	Number of projects that reported service	Number of service encounters	Percentage of service encounters	Percentage of families with at least one member who received service type
Primary services	17	73,371	87	97
Case management or service coordination	16	20,230	24	71
Therapy or counseling	11	39,993	48	66
Parenting training and home visiting program	10	6,018	7	40
Mentoring	8	3,868	5	23
Support group or workshop	3	656	1	10
Supportive services	15	12,279	16	72
Screening or assessment[a]	13	1,403	2	31
Financial or material supports	7	1,478	2	20
Transportation	6	3,402	4	17
Employment training	3	21	< 1	1
Medical care or appointment	3	1,880	2	17
Medications for opioid use disorder	3	142	3	< 1
Court or legal	3	1,182	1	6
Housing[b]	3	n.a.	n.a.	19
Child care	1	165	2	<1
Other services[c]	1	2,606	3	15

[a] Each RPG project offering screening or assessment services identified the specific tools that best served their needs, which included drug or alcohol screenings, needs assessments, and developmental screenings.

[b] Housing includes providing a residence to families, including residential treatment facilities and supportive housing. These services were typically provided for the duration of a family's enrollment in RPG services. Because families were in housing every day during that time period, projects only reported a service encounter for each family's first and last day in housing.

[c] Other services included one grant recipient's "goals group," a daily life skills development activity that teaches participants to focus on their goals as a means of impulse control.

Note: n.a. = Not applicable.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023, (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

Families received varying amounts of services. Sixteen projects operated programs that delivered services in an outpatient or as-needed manner, while one operated a residential treatment program. The average intensity of service provision in the 16 projects was about 44 service encounters per family, while families in the residential treatment program, which offered multiple services on a daily basis, received about 199 service encounters while enrolled. As in previous RPG cohorts, services were overwhelmingly provided to adults without children in attendance (90 percent of service encounters). Children mostly attended parenting training or

home visiting services as well as supportive services. On average, they attended just about 10 percent of service encounters.

B. Service area highlight: Therapy or counseling

Therapy or counseling was offered by 11 projects and had the greatest number of encounters of the services offered by RPG projects. However, therapy and counseling encapsulate a broad set of services that can meet a variety of needs for adults and children enrolled in RPG. Therapy or counseling can encompass substance use treatment; parent-child dyadic therapy; individual, couples, or family counseling; and trauma processing. Given this breadth of services, this section provides more detail about the encounters in this service type to better understand the nature of therapeutic services provided to families enrolled in RPG.[32]

The 11 projects provided therapy or counseling services to 1,469 families, or 87 percent of families enrolled in those projects, and accounted for the majority (54 percent) of their service encounters. Nearly all (99.5 percent) of those encounters focused on topics in the broad categories of adult substance use, life skills development, mental health treatment, and parenting. However, the prevalence of these topics varied by project.

Notably, 3 of the 11 projects accounted for two-thirds of all therapy or counseling service encounters. For each of these projects, these services represented more than half of all their service encounters. The therapy or counseling services for these three projects focused heavily on substance use issues and life skills training (89 percent of service encounters). Service encounters that didn't focus on those topics (10 percent) focused on mental health treatment. Parenting-related topics were discussed in 1 percent of encounters in these three projects.

The other seven projects that offered therapy or counseling services and recorded the service topic tended to focus on mental health treatment and parenting, while also including substance use treatment and life skills content. Nineteen percent of service encounters among these projects focused on all four topics. The remaining therapy or counseling service encounters were spread evenly among mental health treatment, life skills, and substance use treatment. Parenting was rarely the sole focus in service encounters (8 percent) among these projects. Typically, parenting topics were discussed in conjunction with life skills and substance use topics (32 percent). One project, however, did concentrate on parenting in therapy or counseling services, with more than 60 percent of these service encounters focused on that topic.

Projects typically employed a program model to guide therapy or counseling services. Almost all (95 percent) therapy or counseling service encounters used a program model, although each project generally used a different one. Eight different models were used by at least two of the projects. As shown in Table III.2, those models were used in about 40 percent of all therapy or counseling service encounters, which underscores the large variety of other models used by single projects.

[32] One project providing therapy or counseling services did not reliably report on the focus of services, so it was excluded from this analysis.

Table III.2. Common program models used in therapy or counseling services

Program model	Number of projects implementing	Percentage of therapy or counseling service encounters
Motivational Interviewing	7	12
Nurturing Parenting Program	6	6
Seeking Safety	4	8
Dialectical Behavior Therapy	3	9
Child-Parent Psychotherapy	2	2
Mothering from the Inside Out	2	1
Motivational Enhancement Therapy	2	1
Trauma-Focused Cognitive Behavioral Therapy	2	< 1

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023, (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

Box III.1. Program models

Program models are the curricula and strategies that RPG projects use to guide or structure their services. Some models have specific guidelines for administration, such as weekly 1-hour sessions with prescribed content for 12 weeks. Examples are curricula such as the Strengthening Families Program and Nurturing Parenting Programs. Program models can also be strategies or approaches that projects integrate into their services, such as Motivational Interviewing and Cognitive Behavioral Therapy.

C. Service providers

The staff who provide RPG services represent another important component to each project. When developing their services, projects identified which organizations would provide services and what type of staff would be involved. The plan for services included decisions on whether to engage grant recipient staff or partner organization staff or both and whether to incorporate those with child welfare or substance use experience into their service delivery.

Most of the partnerships in the RPG5 and RPG6 cohorts (11 of 17) used staff from the grant recipient organization alone to provide services, rather than engage with partners for service provision. This aligned with each project's plans for service delivery—that is, those that intended to engage partner organizations to provide services actually did so in practice. Five projects used staff from partner organizations to provide all services. In these projects, the grant recipient contracted with external organizations specifically to provide the services. One project used both grant recipient and partner organization staff to provide services. In this project, grant recipient and partner staff each provided about half of the mentoring services, while grant recipient staff provided the other services.

Similarly, 9 of the 10 projects that planned to use peer recovery mentors ultimately used them to provide some services. Peer recovery mentors have experiences similar to those of the families

in RPG, such as substance use issues or involvement in the child welfare system. Peer recovery mentors can support families' engagement in services, build trust with families, and reduce the stigma attached to parents with substance use issues (National Center on Substance Abuse and Child Welfare, 2018). Some evidence suggests that integrating peer recovery mentors into services for families with substance use issues and child welfare involvement may improve child welfare outcomes, such as out-of-home placements and reunification (Hall et al., 2021; Huebner et al., 2021).

Projects that used peer mentors to provide services did so frequently. Among the nine projects, peer mentors provided a third of all service encounters. Eight of the projects used peers to provide mentoring services. For five of these projects, peers were the only service providers. One project used peers to provide nearly all of its parenting training or home visiting service encounters. Two projects used peers to provide all of their support group or workshop services. Seven of the nine projects also used peers to provide some supportive services.

D. Patterns in service use by projects providing similar services

RPG projects provide different combinations of services to best meet the needs of their focal populations. The cross-site evaluation team used latent class analysis (LCA), a technique to create similar groups, to identify patterns of services that families received. The LCA used services actually provided to families, not planned services, to describe the experiences of families enrolled in RPG5 and RPG6 projects. The LCA grouped projects together if they were serving families that received similar types of services.

1. Description of latent class analysis

The LCA model used data on service receipt at the family level to determine the most commonly provided services and identify groups of projects that were most similar in their service provision. A number of models were explored. Appendix D details the process of determining the final LCA model. The final model included the five primary service types as well as one supportive service (medical care or appointment) that was the focus of two projects' services.

This process led to a specified number of groups (latent classes) at the family level. The model predicted which class each family was most likely to be in, based on services the family received. Each project then was assigned to the class that most of its enrolled families belonged to.[33] Four latent classes emerged from this analysis:

- **Class 1.** Seven projects that focused on case management services
- **Class 2.** Two projects that provided both medical care and parenting services
- **Class 3.** Four projects that provided both parenting and therapy services
- **Class 4.** Four projects that focused on therapy services

[33] One project did not have a full majority of families in a single class but was assigned to the class where the plurality of families belonged.

2. Profiles of services provided to families

Grouping projects provides some structure to understanding service provision, but not all families within the same class or project received the exact same types or number of services. The following profiles describe the typical service experience of families within each class.

a. Class 1 profile: Seven projects that focused on case management services

Case management services were the key element of service provision that tied Class 1 projects together. More than four-fifths (83 percent) of families in this class received case management services, across 33 percent of service encounters. Families received therapy or counseling services more frequently, representing half of all service encounters delivered, but they were delivered to less than half (44 percent) of all families. Therapy or counseling services were delivered by only three of the seven projects in this class. Six of the seven projects offered mentoring services, which were provided to half of all families but represented only 10 percent of service encounters. Supportive services, including screenings and assessments, transportation, and financial and material supports, were provided to half of all families. Most projects provided supportive services to most of their families, though one project didn't provide any supportive services.

Program models were used in less than half (45 percent) of all service encounters. About one-quarter of families received services without a formal program model. Two projects did not use any program models for any services. The most common models used among the projects in Class 1 were case management models and Motivational Interviewing (MI), an adaptable practice that can be used in many different types of services. About one-quarter of families (23 percent) received MI as part of their services, including nearly all of the families in one project. Two projects used the Wraparound Model—a team-based coordination of services where providers, family members, and other members of the family's social network collaborate to build a plan for the child and family (Donnelly et al., 2024)—with all of their families. Two other projects employed the Parent-Child Assistance Program case management model with nearly all of their families.

Six of the seven projects in Class 1 used peers to deliver services. Though peers were a common element of these projects, they provided services in 17 percent of service encounters. Peers most often provided mentoring services. They accounted for 84 percent of the mentoring services provided by Class 1 projects. Four projects used peers exclusively for mentoring services, and one of those projects used peers to provide all of its services (including case management, mentoring, support groups, and supportive services).

Many of the characteristics in this class varied widely across the seven projects. For example, although nearly half of enrolled families in this class completed RPG services, the individual completion rates across projects ranged from 18 percent to 78 percent. Dosage measures also varied widely. On average, families received 45 service encounters over 43 hours. However, this ranged from 4 encounters in 4 hours in one project to 86 encounters in 91 hours in another project.

Box III.2. Common Class 1 service characteristics: Case management services (seven projects)

Services

- **Most common services.**[a] Eighty-three percent of families received case management, 50 percent received mentoring, and 44 percent received therapy or counseling.
- **Used a program model.** Forty-five percent of service encounters used a program model.
- **Program models.** Parent-Child Assistance Program was used in 26 percent of service encounters, Wraparound was used in 9 percent of service encounters, and Motivational Interviewing was used in 6 percent of service encounters.
- **Topics.** Life skills (66 percent of service encounters) and substance use (62 percent) were the focus of service encounters.
- **Types of referrals to other services.**[a] Twenty-eight percent of families received referrals, including to SUD treatment (19 percent of referrals), therapy or counseling (15 percent), and medical or health care (13 percent).
- **Format.** Sixty-eight percent of service encounters were attended by individual families.
- **Housing.** Two projects provided housing.
- **Providers.**[b] Grant recipients provided 92 percent of service encounters, and partners provided 8 percent.
- **Peers.** Six projects used peers to provide services (17 percent of service encounters).

Dosage[c]

- **Average length of enrollment in services.** Six months
- **Average dosage of services.** Forty-five encounters over 43 hours
- **Average length of service encounter.** Fifty-seven minutes
- **Average time between enrolling in RPG program and beginning service.** Eleven days

People served

- **Received services.** Eighty-eight percent of enrolled families received services.
- **Attendees.** Ninety-six percent of service encounters were attended by adults without children present.
- **Service status.** Forty-four percent completed services, 12 percent were still receiving services, and 44 percent did not complete services.

[a] Of the families in this class that participated in services.

[b] More than one person could provide a service encounter. Therefore, the percentages may sum to more than 100 percent.

[c] Of the families in this class that participated in but were no longer receiving services at the end of data collection.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023, (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

b. Class 2 profile: Two projects that provide medical care and parenting services

Two projects focused on providing a combination of medical care and parenting-focused services. One project operated a prenatal clinic and provided home visiting services, while the other offered health care coordination and parent education services. Nearly all families (97 percent) in these projects received medical care, and nearly three-quarters of families (73 percent) received parenting training or home visiting services. Seventy-one percent of families in this class received both services.

Medical care represented a majority of services for both projects, but parenting was a stronger focus for one project than the other. Medical care comprised 55 percent of all service encounters. The projects delivered parenting training and home visiting services in 30 percent of service encounters. One project delivered parenting training and home visiting services to 85 percent of its families in one-third of its service encounters, while the other project provided these services to about one-third of its families in 17 percent of its service encounters.

Each project employed one primary program model to deliver its parenting training and home visiting. One project used the Nurturing Parenting Program, which was featured in 82 percent of its parenting training and home visiting service encounters, while the other used Attachment and Biobehavioral Catch-up in all of its service encounters of this type. Parenting training and home visiting services in this class focused on topics related to both parenting skills and life skills more broadly.

Overall, services in Class 2 were less intense than in other classes when looking at key measures of dosage. Families in Class 2 projects received an average of 17 service encounters over 11 hours. The average service encounter lasted about 39 minutes. However, families in this class were enrolled in RPG for a period of five months, which was similar to other classes.

Class 2 projects were also unique in who participated in their service encounters. Children were frequently present at service encounters in Class 2, attending 33 percent of all service encounters (either with an adult or alone). In particular, children attended nearly two-fifths (39 percent) of the parenting training and home visiting service encounters. Again, this varied across the two projects. In one project, adults and children attended 90 percent of service encounters of this type together. In the other project, that number was 39 percent.

Box III.3. Common Class 2 service characteristics: Medical care and parenting services (two projects)

Services

- **Most common services.**[a] Ninety-seven percent of families received medical care; 73 percent received parenting training or home visiting; and 42 percent received mentoring.
- **Used a program model.** Twenty-seven percent of service encounters used a program model.
- **Program models.** Nurturing Parenting Program was used in 23 percent of service encounters and Motivational Interviewing was used in 2 percent of service encounters.
- **Topics.** Life skills (58 percent of service encounters), health (57 percent), parenting (55 percent), and substance use (45 percent) were the focus of service encounters.
- **Types of referrals to other services.**[a] Thirty-two percent of families received referrals, including to medical services (40 percent of referrals) and therapy or counseling (22 percent).
- **Format.** All service encounters were attended by individual families.
- **Housing.** Neither project provided housing.
- **Providers.**[b] Grant recipients provided 80 percent of service encounters, while partners provided 20 percent.
- **Peers.** One project used peers to provide services (39 percent of service encounters).

Dosage[c]

- **Average length of enrollment in services.** Five months
- **Average dosage of services.** Seventeen encounters over 11 hours
- **Average length of service encounter.** Thirty-nine minutes
- **Average time between enrolling in RPG program and beginning service.** Eleven days

People served

- **Received services.** Ninety-one percent of enrolled families received services.
- **Attendees.** Sixty-seven percent of service encounters were attended by adults without children; 29 percent of service encounters were attended by adults and children together.
- **Service status.** Fifty percent of families completed services, 5 percent were still receiving services, and 45 percent of families did not complete services.

[a] Of the families in this class that participated in services.

[b] More than one person could provide a service encounter. Therefore, the percentages may sum to more than 100 percent.

[c] Of the families in this class that participated in but were no longer receiving services at the end of data collection.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023, (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

c. Class 3 profile: Four projects that provide parenting and therapy services

Most families in Class 3 projects received therapy or counseling and parenting services. Each service type was provided to more than four-fifths of families (90 percent and 83 percent,

respectively). Three-quarters of families received both services, indicating that these projects pursued a dual focus on these service types. Most families (77 percent) also received case management services, though this type represented only 14 percent of service encounters.

In addition to therapy or counseling and parenting services, almost all families (95 percent) received supportive services—most often transportation (30 percent of families). All four projects provided a supportive service to more than 85 percent of their families. Supportive services for one project accounted for nearly half (45 percent) of its service encounters, because it provided a substantial amount of financial and material supports to families.

Therapy or counseling services in Class 3 focused on mental health.[34] Mental health topics were discussed in nearly three-quarters of service encounters (74 percent). Topics related to life skills and SUDs were discussed in nearly half of all therapy or counseling service encounters (46 percent and 49 percent, respectively). Overall, life skills (36 percent), mental health (35 percent), and substance use (32 percent) all were topics in about a third of all service encounters in this class. Parenting training and home visiting services in Class 3 more singularly focused on parenting-related topics than those in Class 2. More than four-fifths of all parenting training or home visiting service encounters covered topics related to parenting skills.

The service dosage varied within this class because one project provided residential treatment with daily intensive services.[35] Families enrolled in this project received an average of almost 200 service encounters and 194 hours of services in 4 months. The other two projects with dosage information provided between 10 and 20 service encounters on average and 14 to 23 hours of services in 3 to 6 months.

Box III.4. Common Class 3 service characteristics: Parenting and therapy services (four projects)

Services

- **Most common services.**[a] Ninety percent of families received therapy or counseling, 83 percent received parenting training or home visits, and 77 percent received case management.
- **Used a program model.** Fifty-six percent of service encounters used a program model.
- **Program models.** Motivational Interviewing was used in 7 percent of service encounters, and the Nurturing Parenting Program was used in 6 percent of service encounters.
- **Topics.**[b] Life skills (36 percent of service encounters), mental health (35 percent), substance use (32 percent), and parenting (16 percent) were the focus of service encounters.
- **Types of referrals to other services.**[a] Forty-one percent of families received referrals, including to therapy or counseling (15 percent of referrals) and housing (14 percent).
- **Format.** Sixty-five percent of service encounters were attended by individual families.

[34] One project did not reliably report on the topics covered in service encounters, so that project was excluded from this analysis.
[35] One project did not reliably report on the number of service encounters and the length of each service encounter, so that project was excluded from the dosage analysis.

- **Housing.** One project provided housing.
- **Providers.**[c] Grant recipients provided 85 percent of service encounters, while partners provided 15 percent.
- **Peers.** None of the projects used peers to provide services.

Dosage[d, e]

- **Average length of enrollment in services.** Four months
- **Average dosage of services.** Ninety-nine encounters and 99 hours
- **Average length of service encounter.** Sixty minutes
- **Average time between enrolling in RPG program and beginning service.** Eight days

People served

- **Received services.** Ninety-seven percent of enrolled families received services.
- **Attendees.** Eighty-seven percent of service encounters were attended by adults without children present.
- **Service status.** Forty-four percent of families completed services, 9 percent were still receiving services, and 46 percent of families did not complete services.

[a] Of the families in this class that participated in services.

[b] One project did not reliably report on the topics covered in service encounters, so that project was excluded from this analysis.

[c] More than one person could provide a service encounter. Therefore, the percentages may sum to more than 100 percent.

[d] Of the families in this class that participated in but were no longer receiving services at the end of data collection.

[e] One project did not reliably report on the number of service encounters and the length of each service encounter, so that project was excluded from the dosage analysis.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023, (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

d. Class 4 profile: Four projects that provide therapy services

The four projects in Class 4 emphasized therapy or counseling services: 97 percent of families that received a service had a therapy or counseling service encounter. Case management services were also prominent for projects in this class, with 61 percent of families receiving this service. Sixty percent of families received both case management and therapy or counseling services, indicating that nearly every family that received case management services also received therapy or counseling services. Overall, therapy or counseling services represented 63 percent of service encounters among families in Class 4 and accounted for more than half of service encounters in all four projects.

Therapy or counseling services in this class focused primarily on topics related to adult SUD. SUD topics were the focus of 67 percent of all therapy or counseling service encounters. In three of the four projects, SUD topics were the most prominent topic. The remaining project's therapy or counseling services focused on mental health topics (discussed in 90 percent of that project's therapy or counseling service encounters).

Just under one-third of service encounters (30 percent) included the use of a program model. Most families (52 percent) received two or more models as part of their RPG services. Many different models were used across the projects in this class, but several models were common across more than one project, including Child-Parent Psychotherapy, Mothering from the Inside Out, Nurturing Parenting Program, Seeking Safety, and Strengthening Families Program. Most models were used in a relatively small number of service encounters, but Nurturing Parenting Program, Seeking Safety, and Strengthening Families Program were each used in between five and seven percent of service encounters.

As in Class 3, key measures of dosage varied across the projects in Class 4. One project delivered considerably more service encounters—an average of 343 service encounters for an average of 152 hours. The other projects delivered between 13 and 27 service encounters on average in an average of 11 to 22 hours.

Class 4 is the only class that, on average, used partner organization staff to provide most service encounters (77 percent). However, this is influenced by the fact that the one project using partner staff to provide services provided most of the service encounters (78 percent) in this class. The other three projects used grant recipient staff to provide all of their services.

Three projects in Class 4 used peer mentors to provide services. Peers provided 20 percent of service encounters, including half of all case management services. Although peers did not frequently provide therapy or counseling services, one project did have them provide 19 percent of therapy or counseling service encounters. Another project used peers as providers in all of its support groups and more than 90 percent of its case management services. This project's case management services generally focused on topics related to SUDs, which aligns with a peer mentor's role.

Box III.5. Common Class 4 service characteristics: Therapy services (four projects)

Services

- **Most common services[a]** Ninety-seven percent of families received therapy or counseling services; 61 percent of families received case management services.
- **Used a program model.** Thirty percent of service encounters used a program model.
- **Program models.** Motivational Interviewing was used in 8 percent of service encounters, the Nurturing Parenting Program was used in 7 percent of service encounters, Strengthening Families Program was used in 5 percent of service encounters, and Seeking Safety was used in 5 percent of service encounters.
- **Topics.** Substance use (88 percent of service encounters), life skills (22 percent), and mental health (19 percent) were the focus of service encounters.
- **Types of referrals to other services.[a]** Sixteen percent of families received referrals, including to substance use disorder treatment (44 percent of referrals) and therapy or counseling (22 percent).

- **Format.** Seventy-seven percent of service encounters were attended by individual families.
- **Housing.** None of the projects offered housing services.
- **Providers**[b] Partners provided 77 percent of services encounters, while grant recipient provided 23 percent.
- **Peers.** Three projects used peers to provide services (20 percent of service encounters).

Dosage[c]

- **Average length of enrollment in services.** Five months
- **Average dosage of services.** Eighty-one encounters and 44 hours
- **Average length of service encounter.** Sixty-six minutes
- **Average time between enrolling in RPG program and beginning service.** Eight days

People served

- **Received services.** Ninety-two percent of enrolled families received services.
- **Attendees.** Ninety-eight percent of service encounters were attended by adults without children.
- **Service status.** Fifty-nine percent of families completed services, 10 percent were still receiving services, and 31 percent of families did not complete services.

[a] Of the families in this class that participated in services.

[b] More than one person could provide a service encounter. Therefore, the percentages may sum to more than 100 percent.

[c] Of the families in this class that participated in but were no longer receiving services at the end of data collection.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

e. Summary of services across classes

Based on projects' use of the five primary service types and medical services, the LCA grouped RPG5 and RPG6 projects that provided similar services to families. Although most families in RPG5 and RPG6 projects received a case management service, Class 1 families mainly received case management services, alongside a variety of other services. Class 2 projects provided medical care as the key service. These projects also provided parenting training and home visiting services, but their emphasis providing on a supportive service was unique. Projects in both Class 3 and Class 4 provided therapy to most of their families, but the focus of their services was different. Class 3 projects provided parenting training or home visiting along with therapy or counseling services, which focused more on mental health topics. Seventy-five percent of families in Class 3 received both types of services. Therapy or counseling services in Class 4 projects focused more on SUDs. Additionally, most services in this class were provided by partner staff rather than grant recipient staff, which was more typical in RPG5 and RPG6 projects.

Table III.2. Key service characteristics, by class

	Class 1	Class 2	Class 3	Class 4
Number of RPG5 and RPG6 projects	7	2	4	4
Most common services[a]	Case management	Medical care, parenting training and home visiting	Therapy or counseling, parenting training and home visiting, case management	Therapy or counseling
Typical attendees	Adults only	Adults only; adults and children together	Adults only	Adults only
Typical format	Individual and multiple families	Individual families only	Individual and multiple families	Individual and multiple families
Provided housing	2 projects	None	1 project	None
Average length of enrollment in services	6 months	5 months	4 months	5 months
Average service dosage	43 hours, 45 encounters	11 hours, 17 encounters	99 hours, 99 encounters	44 hours, 81 encounters
Typical providers	Grant recipients, peers	Grant recipients, peers	Grant recipients	Partners, peers
Percentage of families that completed services	44	50	44	59

[a] The most common services includes all types that have more than 75 percent of families receiving those services in the class.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

E. Families exiting RPG5 and RPG6 projects and completing services

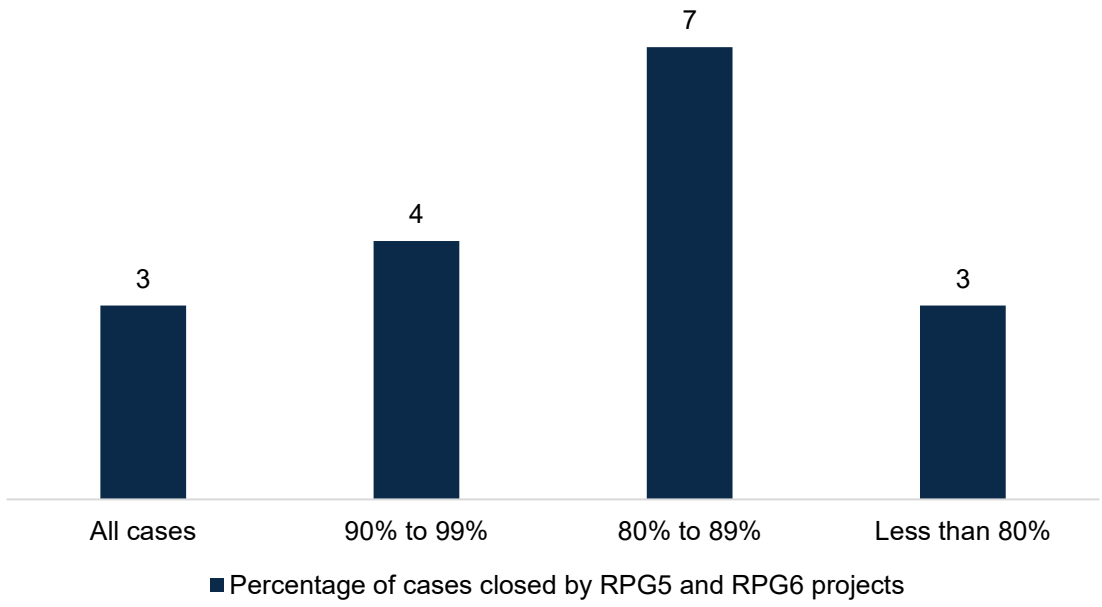
Families may exit a project because they have finished RPG services (RPG program completion) or they may drop out or be discharged before completing services. Box III.6 provides details on the information collected by projects upon a family's exit.

Box III.6. RPG case closure

Projects enroll families in RPG services as a unit, which is referred to as a case. They close cases when families complete their services, drop out, or are otherwise discharged from a project. Projects then record (1) the date the case was closed (not necessarily the date of the last RPG service), (2) the primary reason the case was closed, (3) the updated residence for children in the case, and (4) the birth outcomes for any children born since enrollment. Projects were encouraged to adopt a grace period (for example, 30 or 60 days) so that families with lapsed service participation could re-engage before their case was closed. The length of RPG enrollment was defined as the time between enrollment and case closure—which is distinct from the length of service enrollment, or the time between the first and last service encounter.

Many RPG5 and RP6 projects provided services to families after cross-site data collection ended. Therefore, not all cases were closed at the end of data collection. Ten percent of the 2,412 cases remained open, though this varied by project. As shown in Figure III.1, most projects (11) closed between 80 percent and 99 percent of their cases, while 3 projects closed all of their enrolled cases.

Figure III.1. Number of RPG5 and RPG6 projects by percentage of cases closed



Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

Some families were still actively receiving services from projects at the end of data collection. Of the 249 cases that remained open at the end of data collection, 7 percent had received a service in the last 30 days, 8 percent in the last 60 days, and 46 percent in the last 90 days. The remaining 39 percent had no service encounters in at least 90 days, suggesting they were no longer actively engaged in RPG services.

1. Completing RPG5 and RPG6 services

More than half (52 percent) of the closed cases had completed their services (Table III.4). Each project defined program completion for the cross-site evaluation based on its requirements for enrolled families—for example, whether a family participated in all services that were outlined in its treatment plan. Some projects had more families complete services than others. The rate of completion at the project level ranged from 19 percent to 91 percent. In 8 of 17 projects, more than half of the families successfully completed their program.

The most common reason that families did not complete services was because they withdrew, either formally or informally, as shown in Table III.4. Fifteen percent of families were discharged from their project because they missed an excessive number of appointments or became unresponsive. Twelve percent of families decided to stop participating in RPG services.

Table III.3. Reasons for project exit

Reasons for case closure	Percentage of closed cases	Average number of months enrolled in project
Completed RPG	52	8
Excessive missed appointments or unresponsive	15	6
Family declined further participation	12	4
Unable to locate	5	7
Other	3	4
Incarceration	3	6
Family moved out of the area	2	5
Transferred to another service provider	2	5
Drug use (ongoing or relapse)	2	5
Other program noncompliance	1	6
Child entered out-of-home placement	< 1	6

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

On average, families that achieved successful completion of their RPG program were enrolled in RPG for slightly more than seven months. Families that became unresponsive were enrolled in RPG5 or RPG6 projects for an average of six months, while families that declined further participation were enrolled for four months on average.

2. Family characteristics at case closure

Most children lived in a stable residence at the time the family left RPG services (Table III.5). More than 8 in 10 children (85 percent) lived in the same residence for the 30 days before case closure. Most children (79 percent) who lived in a stable residence at case closure also had lived in one at enrollment. Only 5 percent of children lived in a different type of residence at both time points. However, the cross-site evaluation does not have data on whether children lived in the same residence at enrollment and case closure. A few children had a stable residence at enrollment but not at case closure (3 percent) or a stable residence at case closure but not at enrollment (6 percent). Overall, most children lived in a private residence at case closure (88 percent), which was similar to what was reported at enrollment for these children (94 percent).

Table III.4. Children's residence type and stability at case closure

Child's residency type and stability at case closure	Percentage
Child's primary type of residence at case closure[a]	
Private residence	88
Homeless or shelter	< 1
Treatment facility	< 1
Group home	< 1
Correctional facility or prison	0
Other	< 1
Unknown	10
Child changed residence type between enrollment and case closure[b]	5
Child lived in the same residence for the past 30 days at case closure[a]	
Yes	85
No	4
Unknown	11
Residential stability between enrollment and case closure[b, c]	
Child had stable residence for the past 30 days at enrollment and case closure	79
Child had stable residence for past 30 days at enrollment but not case closure	3
Child had stable residence for the past 30 days at case closure but not enrollment	6
Child did not have a stable residence for the past 30 days at enrollment or case closure	< 1

[a] n = 4,056 children; includes all children with case closure data, including children who were born after the family enrolled in an RPG project.

[b] n = 3,891 children; includes children with both enrollment and case closure data.

[c] Percentages do not add up to 100 percent because children's residential stability status could have been reported as "unknown" at enrollment or case closure.

Note: Children whose cases were still open were excluded from these calculations.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

Most children (80 percent) either lived with one or both biological parents at enrollment and exit or lived with neither biological parent at those time points (Table III.6). Forty-five percent of children lived with a biological parent at enrollment and exit. Twenty percent lived with a biological parent at one time point but not the other. Only one percent of children experienced both a change in residence type and the adults in their household.

Overall at case closure, most children (56 percent) lived with at least one biological parent, typically the mother. Fifteen percent of children lived with both biological parents. Children who did not live with a biological parent either lived with other relatives (21 percent) or nonrelative foster parents (13 percent).

Table III.5. Primary adults residing with children at case closure

Primary adults residing with children at case closure	Percentage
Change in adults present at case closure compared to enrollment[a]	
Child lived with a biological parent at enrollment and closure[b]	45
Child did not live with a biological parent at enrollment or closure	35
Child lived with a biological parent at enrollment only	10
Child lived with a biological parent at closure only	10
Adults in household with child at case closure[c]	
Biological mother only	27
Biological father only	6
Both biological mother and father	15
Other relative[d]	21
Any biological parent and a relative or other adult	8
Nonrelative foster parent only	13
Other[e]	< 1
Unknown	10

[a] n = 4,056 children; includes children with both enrollment and case closure data.

[b] This category includes 317 children who lived with one or both biological parents at both enrollment and closure but experienced a change in the exact composition across time periods. Specifically, 37 children lived with their biological mother at enrollment and father at closure, 48 children lived with their father at enrollment and mother at closure, 99 children lived with both parents at enrollment and only the mother at closure, 19 children lived with both parents at enrollment and only the father at closure, 96 children lived with the mother at enrollment and both parents at closure, and 18 children lived with the father at enrollment and both parents at closure.

[c] n = 3,892 children; includes all children with case closure data, including children who were born after the family enrolled in an RPG project.

[d] This category includes situations where children were living with foster parents who were their relatives.

[e] This category includes families whose focal child was not in utero and did not live with a biological or foster parent.

Note: Children enrolled in open cases were excluded from these calculations.

Source: Regional Partnership Grant-Evaluation Data System data, from March 1, 2019, through May 19, 2023 (RPG5) and from October 1, 2020, through March 15, 2024 (RPG6).

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IV. COLLABORATION BETWEEN CHILD WELFARE AGENCIES AND SUBSTANCE USE TREATMENT PROVIDERS

Collaboration is the foundation of RPG projects, and collaboration between child welfare agencies and substance use treatment providers is particularly important. The RPG notice of funding opportunity asked RPG6 applicants to demonstrate an existing collaborative infrastructure between child welfare agencies and substance use treatment providers that could support their proposed activities and help them serve their intended focal populations (ACF, 2019). Partnerships between child welfare agencies, substance use treatment providers, and courts can support the implementation of best practices (Ogbannaya & Kenney, 2018; Palinkas et al., 2014), improve access to care (Bai et al., 2009; Chuang & Lucio, 2011; Seekamp et al., 2022), and promote positive outcomes for children and families (Bai et al., 2009; He, 2017; He & Phillips, 2017; Ogbannaya & Kenney, 2018; Phillips, 2023). Yet, child welfare agencies and substance use treatment providers often face challenges in working together—such as conflicting priorities, goals, or service timelines; dedicated staff time and stability; and restrictions on information sharing (Colvin et al., 2021; Green et al., 2008; Herbert et al., 2021)—that can hinder collaboration if they are not addressed.

Given how important it is for child welfare agencies and substance use treatment providers in RPG projects to collaborate, the cross-site evaluation conducted virtual site visits with all RPG6 projects to examine how they worked together to achieve the RPG's goals. After describing the site visit sample, this chapter discusses how child welfare agencies and substance use treatment providers worked together to plan and implement projects, how much they collaborated when referring and serving families, the facilitators of and barriers to collaboration, and their successes and opportunities for improvement.

A. Sample overview

1. Site visit timing and respondents

The cross-site evaluation team conducted telephone interviews with RPG6 projects in winter 2023, when the RPG6 cohort was midway through its fourth grant year. The COVID-19 pandemic, which affected most places by March 2020, had disrupted the cohort's planning and early implementation activities but no longer presented day-to-day implementation challenges. In all, the cross-site evaluation team conducted 41 interviews with 57 RPG staff or partner respondents from the 8 RPG6 projects. About half of these interview respondents were directors, managers, or administrators with child welfare agencies, substance use treatment providers, or another entity. About 30 percent were frontline staff. The rest were supervisors. Fewer than half (44 percent) of the respondents represented a lead entity, while the others represented a partner entity. Appendix E provides more information about the respondents.

2. Types of entities included in the site visit analysis

Because of the variety of treatment services available through RPG, a substance use treatment provider is defined broadly in this chapter as any implementing agency that offers recovery services (such as MOUD or residential treatment) to adults with substance use issues and/or that offers mental or behavioral health treatment or supports (such as intensive case management, assessments, wraparound care, peer mentorship, counseling, or therapy) to adults, children, or the family unit affected by substance use. The provider might also offer family strengthening or parenting supports or other services connected to its mission (such as medical services).[36] By this definition, four lead entities provided substance use treatment, while the other lead entities (two state agencies, one university research center, and one family advocacy organization) partnered with a substance use treatment provider.[37]

RPG6 projects were led by a substance use treatment provider or another type of entity, and they each intended to partner with a child welfare agency. This arrangement could influence how they worked together. For instance, a lead entity that is a substance use treatment provider might work directly with a child welfare agency to implement services, while another type of lead entity might broker a partnership between substance use treatment providers and child welfare agencies. Most child welfare agency partners were a state or local public agency; one was a contracted (private) provider of intact family preservation services.

B. Progress toward collaboration

Even when there is a directive to work together, interagency collaboration is most likely to happen if it is workable for the partners, reflects each partner's core business and policies, and inspires buy-in based on jointly held values (Horwath & Morrison, 2011). To better understand how substance use treatment providers and child welfare agencies worked together to achieve RPG's goals, this section documents their joint endeavors for planning and implementing projects. In six of the RPG6 project teams, substance use treatment providers and child welfare agencies worked together at least minimally. Primarily, their collaboration facilitated referrals to RPG and ongoing, coordinated support for enrolled families.

1. Collaborative planning activities

HHS required RPG6 projects to complete a one-year planning period before serving families. During this period, RPG6 teams finalized their service and evaluation designs, clarified roles and responsibilities, established recruitment and enrollment procedures with referral partners, and established governance structures, among other tasks (HHS, 2023). The following analysis

[36] This definition is based on the U.S. surgeon general's definition of SUD treatment as "a service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability" (HHS, 2016).

[37] For this analysis, entities offering any RPG substance use treatment, even if they mainly offer other services like medical care or court services, are considered substance use treatment providers. As a result, one lead entity classified as a substance use treatment provider in this chapter is classified differently in Chapter I, which considers their main service function.

focuses on substance use treatment and child welfare agencies' roles in planning and creating shared goals and formalized procedures, which are foundational to interagency partnerships (Colvin et al., 2021; Herbert et al. 2021).

Participation in planning discussions and creating shared goals. Both substance use treatment and child welfare partners in six of the eight RPG6 projects were involved, at least minimally, in planning their projects. For example, four lead entities convened their partners during the planning period to educate them about the project and begin to foster a relationship. Some state-level child welfare partners shared information with the project team about other state initiatives, such as the state's prevention services plans, or they helped connect the project team to wider initiatives, such as available trainings. Three of the six projects had also worked together on the grant application.

Two project teams did not include a child welfare partner in either their planning activities or project implementation because they felt that their RPG6 project goals did not align with the goals or requirements of their state child welfare agencies. One of them had envisioned that the state child welfare agency would be its main referral source when it applied for funding. Though the lead entity tried to align the project with child welfare requirements, the misalignment persisted and contributed to this project's difficulty in reaching families involved with child welfare and in meeting its enrollment targets. In contrast, the six substance use treatment providers and child welfare agencies that had at least minimal involvement in planning did have shared goals for their projects, and those goals aligned with their agency priorities. For example, a child welfare respondent noted that the RPG project goals aligned with the agency's efforts to implement the Family First Prevention Services Act.

RPG6 project goals. Regardless of whether partners held shared goals, all eight project teams had a goal to improve adult, child, and/or parent well-being. Some also described their goal as adding certain services, such as peer support, or expanding services for rural communities (Table IV.1). Half of the project teams also mentioned a collaborative goal. Lead entities wanted to strengthen referrals with child welfare agencies to reach their focal populations.

> ***"We want to create safe environments for children and have parents be successful…. It's preventing child abuse and neglect from happening because we're addressing the concerns and giving them [the] support they need to be successful."***
>
> ***—Child welfare partner***

Table IV.1. Staff and partners' RPG project goals

RPG project goal	Number of RPG6 projects
Improve well-being for adults, children, and/or families	8
Expand services (certain services or services to certain communities)	5
Strengthen partnerships to support referrals	4

Source: Site visit interviews with RPG6 project staff, partners, and parents.

Use of formal agreements. Seven of the RPG6 project teams established a formal agreement to support partners' contributions. Three of them executed a memorandum of understanding (MOU) and others had a data sharing agreement and/or a contract. One of them obtained a data sharing agreement with their state child welfare agency to support the evaluation but did not otherwise partner as part of the project planning or implementation activities. The MOUs varied in specificity, with a few left intentionally flexible enough to allow for processes or responsibilities to unfold as the work progressed.

Planning period challenges and successes. The COVID-19 pandemic was by far the greatest obstacle projects faced during the planning period. As one project director put it, they "couldn't have designed a worse time to implement a grant." Five projects reported that the pandemic slowed their team's planning progress. Three of them modified their referral or service delivery approaches for virtual rather than in-person delivery. Although it was a major disruption for a period, respondents from two project teams described lasting, direct consequences to their RPG6 projects. Before the pandemic began, one team was concerned for the staff's workload and had difficulty coming to a consensus with child welfare and court partners about who would be responsible for the referral and consent process. The pandemic heightened their concerns over staff burden and made a consensus more difficult. This contributed to setbacks in enrolling families that lasted throughout the project period. On the other project team, the project director felt that the child welfare partner had pulled back early in the pandemic as the child welfare agency's staff turnover worsened and its priorities shifted. The child welfare agency never fully returned to a key project aim (implementing a new systemwide screening tool), although the agency moved forward with providing direct services anyway.

> ***"Everyone was learning about how to live virtually and how to have meetings virtually and how to meet patients virtually. A lot of our partners, like a lot of us, for the first few months [of the pandemic] were just trying to figure it out."***
>
> ***—Project coordinator***

In addition, from the outset, two teams had difficulty staffing their projects—a challenge exacerbated by the pandemic. One team had trouble filling multiple positions, including the project director's role. Another team's project director and child welfare liaison left during the planning period, requiring the new leads to restart efforts to build a relationship. (See Section IV.C. for further discussion of staffing challenges.)

However, most project teams (five out of eight) also recalled planning period strengths. For three teams, establishing commitment, trust, and communication among partners were key successes. Other facilitators, such as a having a road map from past projects to follow, are discussed in Section IV.C.

2. Joint activities for serving participants

Interagency collaboration can be understood as the joint activities that partners undertake when working together (Bardach, 1998, 2001; Colvin et al., 2021; He, 2015). The RPG6 teams worked with their partners on five common activities (Table IV.2).

Table IV.2. Types of collaboration activities

Type of collaborative activity	Number of RPG6 projects
Project guidance	7
Referrals	6
Interagency collaborative case management or consultation	6
Court hearings or decisions	5
Cross-system improvements	3

Source: Site visit interviews.

Project guidance. Nearly all projects reported that both substance treatment and child welfare partners were involved in project governance or management to some degree. Four teams described holding regular meetings, at least quarterly, to discuss project progress. They tended to hold quarterly steering committee meetings to discuss project implementation, policies, and procedures as well as engage in problem-solving and brainstorming about challenges. Even with standing appointments, however, turnover among the child welfare liaisons could result in a partner's hit-or-miss attendance or inattentive participation. This was especially true when the state child welfare agency was not otherwise an active partner.

Referrals. Six RPG6 project teams partnered with child welfare agencies for referrals to meet their project enrollment targets. For four teams, the child welfare partner was the most common referral source, responsible for half or more of all referrals. (See Section IV.B.3 for more information about referrals.)

Interagency collaborative case management or consultation.[38] Most substance use treatment and child welfare partners worked together to some degree to support joint cases. Staff and partner respondents shared that exchanging information with another entity required participant consent, trust, and reciprocity, while slow responses or lack of two-way communication could make service provision more difficult and delay outreach to families. (See Section IV.B.3 for more information about interagency case consultation.)

Court hearings or decisions. Five of the projects that received referrals from child welfare agencies also had at least some interactions with the courts. Respondents from two project teams regularly attended meetings and hearings. On another project team, federal treatment courts operated (via a contractor) the RPG-funded substance use treatment services. Respondents from two teams described efforts to strengthen the court's support for RPG. The project directors, for

[38] This chapter defines interagency case consultation as the range of interactions between entities about a single case, from staff at different entities simply communicating about families to more formalized and structured interactions (such as through joint case management or use of co-located or integrated staffing teams).

instance, met with judges to raise the credibility of their RPG services, which they felt helped the courts embrace the services as important for child welfare cases.

Cross-system improvements. A few projects actively supported or advanced cross-system initiatives at the state or local level. One team regularly participated in meetings with the state's Perinatal Quality Improvement Collaborative, for instance. Staff from another project joined community events and initiatives to help bolster available resources in their rural community (such as by responding to overdose emergencies).

3. Degree of collaboration on referrals and interagency case consultation

Most substance use treatment providers and child welfare agencies worked together to help families access RPG and give them ongoing support. Collaboration varied from ad hoc to structured protocols that supported frequent and routine information sharing. This variation is consistent with literature characterizing interagency collaboration as operating along a continuum from a low to high degree of collaboration (Grace et al., 2012; Horwath & Morrison, 2007; Ogbonnaya & Kenney, 2018; Palinkas et al., 2014). Understanding the entities' interactions within this continuum is important for documenting what their collaborations entailed and whether they achieved the collaborative goals of the RPG6 funding opportunity.

To deepen understanding of the progress that substance use treatment providers and child welfare agencies made in working together, the cross-site evaluation team examined the variation in their two central collaborative activities: (1) referrals and (2) interagency case consultation. To do this, the team developed a collaboration framework, shown in Figure IV.1 (HHS, 2025), which assesses how formalized and systematic a collaboration was in its day-to-day work. The framework was based on the first three levels in Horwath and Morrison's (2007) framework for interagency collaboration:

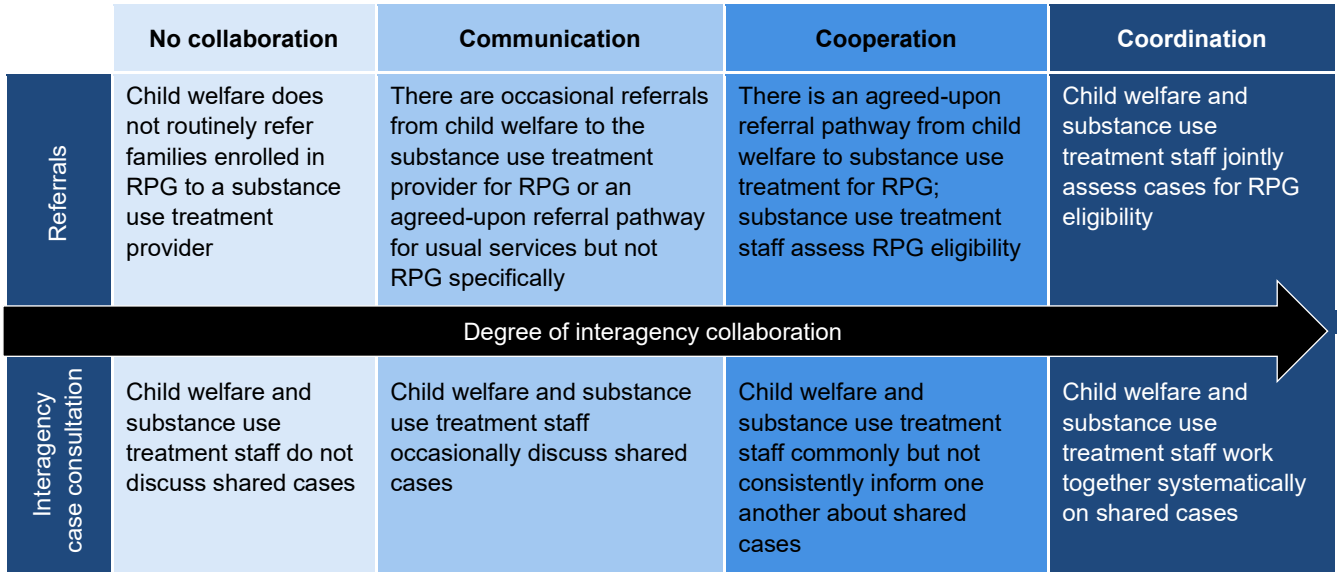
1. **Communication.** Individuals from different disciplines talking together
2. **Cooperation.** Joint work on a case-by-case basis
3. **Coordination.** More formalized joint work, but no sanctions for noncompliance[39]

The evaluation team then classified the degree of collaboration between substance use treatment providers and child welfare agencies on referrals and interagency case consultation. Results are shown in Table IV.3.[40]

[39] The other two levels in Horwath and Morrison's (2007) interagency collaboration framework are coalition (joint structures sacrificing some autonomy) and integration (organizations merging to create a new joint identity). The RPG encourages lead entities to build partnerships to support families involved in multiple systems but does not expect them to sacrifice autonomy or merge. Thus, this chapter draws only on the first three levels of this framework.

[40] Where the lead entity was not a substance use treatment provider, this analysis focused on the degree of collaboration between the substance use treatment providers and child welfare agencies they partnered with, irrespective of the lead entity's role.

Figure IV.1. Classifying the collaboration on referrals and interagency case consultation



Note: This graphic shows the criteria that the cross-site team used to classify the degree of collaboration that took place between child welfare agencies and substance use treatment providers when referring families to RPG and working together with shared cases.

Source: Levels of collaboration are based on Horwath and Morrison's (2007) interagency collaboration framework and updated from the Eighth Report to Congress (HHS, 2025.). Information about the partnership between the child welfare agency and substance use treatment provider came from site visit interviews.

Table IV.3. Level of interagency collaboration on referrals and interagency case consultation

Level of interagency collaboration	Number of RPG6 projects	
	Referrals	Interagency case consultation
No collaboration	2	2
Communication	1	1
Cooperation	4	1
Coordination	1	4

Source: Site visit interviews.

Degree of collaboration on referrals and interagency case consultation. Overall, most substance use treatment providers and child welfare partners achieved a relatively high level of collaboration. On five of the projects, they cooperated or coordinated to support referrals from child welfare to RPG services and enrolled families' ongoing needs. In contrast, three projects had either no communication or only occasional communication with child welfare agencies—sometimes intentionally, as described next.

No collaboration

- **Referrals.** Two projects reported that they did not receive RPG referrals from child welfare agencies. This was by design for one project that enrolled families with high-risk pregnancies. The other project was unable to establish a referral pathway with the child

welfare agency, despite the lead entity's best intentions and efforts. (Similarly, child welfare agencies were not involved in these project teams' planning efforts.)

- **Interagency case consultation.** Substance use treatment and child welfare partners from two project teams, including the one focused on high-risk pregnancies, did not communicate with one another about ongoing cases. They both felt it was important that participation remain anonymous and confidential to maintain the services as a safe and open space for families seeking support. At most, direct services staff could communicate with child welfare staff at a parent's request, such as by sending a letter to a caseworker or attorney on the parent's behalf.

Communication

- **Referrals.** By design, one project received only ad hoc referrals from child welfare to RPG treatment services. The lead entity and child welfare partner from this project did not want to add screening and consent responsibilities to child welfare staff's workload nor undermine the message to families that services were voluntary and anonymous, which they believed conflicted with a referral from child welfare (or the courts). Halfway through the funding period, this team permitted child welfare staff to refer families—but only informally, not as a case plan goal.
- **Interagency case consultation.** One substance use treatment lead entity occasionally discussed families' ongoing cases with child welfare staff. Although the lead entity was unable to establish a partnership with child welfare at the agency level, caseworkers and direct services staff could exchange information (such as on service needs) if the participant signed a release of information.

Cooperation

- **Referrals.** Half of the project teams established an agreed-upon referral pathway from child welfare to substance use treatment providers for RPG. The structured referral pathways enabled child welfare agencies to routinely refer families to RPG services. Typically, the lead entity was the substance use treatment provider. The provider usually determined RPG eligibility and communicated frequently with child welfare staff, either to gather more information to determine the family's eligibility or to notify child welfare about the enrollment decision and sometimes to ask for help contacting families.
- **Interagency case consultation.** Communication between child welfare and substance use treatment staff occurred inconsistently in one project. The extent of communication was usually short and varied across caseworkers, who could be responsive or silent.

Coordination

- **Referrals.** Child welfare and substance use treatment partners on one project team jointly determined if a family was a good fit for RPG. Referrals were initiated from the child welfare agency and were approved by both substance use treatment and child welfare supervisors. Direct services staff from both entities participated in initial meetings with families to introduce the RPG services and conduct eligibility assessments.

- **Interagency case consultation.** On four project teams, child welfare and substance use treatment staff systematically communicated with each other to support families and their child welfare cases. Their communication could be frequent—as often as multiple times per week when the situation called for it. Three of the projects also held joint supervision meetings, when supervisors and direct services staff (or other types of staff) from both entities met to discuss cases.[41] Staff shared information about case plans and treatment goals, progress, concerns, and day-to-day matters such as parental visitations. Across the four projects, staff maintained distinct but complementary responsibilities that enabled them to focus on their specialties while supporting families as a coordinated team. As one caseworker explained, having a partner with specialized knowledge of substance use issues alleviated the pressure on them and allowed them to devote more time to other concerns, such as housing assistance. To further collaboration, one project team allocated space for the substance use treatment staff to co-locate in the child welfare offices. However, in practice, neither staff spent much time in the office. This team also coordinated on joint enrollment decisions.

> ***"It's like having an extra set of eyes and hands on the family. When caseloads are high, things get missed and services are delayed, so having someone with a SUD specialty helps keeps families intact and breaks down barriers to accessing services like transportation, day care, and drug screens."***
>
> ***—Child welfare caseworker***

C. Facilitators of and barriers to collaboration

All projects faced internal and external factors that helped or hindered their collaborative efforts, regardless of how much collaboration there was within the teams. Interviews covered nine structural or contextual factors thought to affect the success of interagency collaboration, shown in Table IV.4 (Bronstein, 2003; Colvin et al., 2021; Drabble et al., 2011; Green et al., 2008; He, 2017; Herbert et al., 2023; Mattesich et al., 2001). Across the projects, two facilitators and three barriers were typically present. Three other facilitators were present but with limitations. One factor, local policy context (not shown in Table IV.4), did not seem to influence the partnerships on its own. All projects dealt with circumstances in their local communities and legal or policy environments, but most (seven) thought they did not substantially support or hinder their RPG6 efforts.

[41] In one project, the family treatment court coordinator communicated with child welfare staff, rather than the contracted direct services staff for RPG treatment services. This differed from the other project teams, where direct services staff from the two entities were in direct contact with one another. However, the project was included in the Coordination level because respondents described the interagency communications as systematic, frequent, through formalized processes, and about similar topics as the other projects in this category.

Table IV.4. Facilitators of and barriers to interagency collaboration

Factor	Overall influence on partnerships	Number of RPG6 projects
Funding	Facilitator	8
History of working together	Facilitator	6
Staff time and turnover	Barrier	7
Competing priorities and timelines	Barrier	7
Ability of child welfare and substance use treatment staff to meet (in person or virtually)	Barrier	3
Capacity to serve participants	Facilitator with limitations	7
Leadership support	Facilitator with limitations	4
Staff training	Facilitator with limitations	3

Note: If a factor is called a facilitator, projects most often described it as a strength or facilitator to collaboration. If a factor is called a barrier, projects most often described it as a challenge or barrier to collaboration. Facilitator with limitations indicates that projects most often identified it as a facilitator, but several also described limitations that may have meant they did not benefit from the factor as much as they could have in the absence of those limitations. See Appendix E for details.

Source: Site visit interviews.

1. Common facilitators of interagency collaboration

RPG funding and a history of working together strengthened all or most collaborations.

Funding. Sufficient funding and resources are necessary for interagency staff to work together (Colvin et al., 2021; Drabble, 2011; He, 2017; Wei et al., 2022).[42] RPG funding was a critical asset. It enabled providers to serve families, which brought the partners together, and it paid for project directors or coordinators within the lead entities who could spearhead collaborative efforts. All projects thought the RPG6 funding was sufficient for achieving their service and collaboration goals (which centered on referrals), although respondents from at least three projects suggested they might have served more people with even more funding. Some respondents also appreciated the funding's flexibility, which enabled them to engage in state or local initiatives that aligned with their project goals, such as outreach activities and relationship building with other community partners. Project leaders' main funding concern was sustaining services when the project period ends, as would be expected for any funded cross-agency initiative (Iachini et al., 2014).

History of working together. Previous collaboration provides a foundation upon which agencies and individuals can build (Bronstein, 2003; Drabble, 2011; Kothari et al., 2021). Seven teams had a history of working together, either with all or some of the substance use treatment providers and child welfare agencies involved in the project. Six of them cited their shared histories as a strength. Drawing on past collaborations gave these RPG6 teams a jumping off point. Five teams, for example, indicated that they had pursued an RPG6 award to continue or replicate work they had already begun under another RPG award or otherwise. Building from

[42] Funding and resources—particularly staff time and energy—are often inseparable concepts (Colvin et al., 2022). Because the RPG makes funding available for services, this analysis separates funding from staffing resources.

their previous efforts was a major asset because it gave them a template to inform their RPG6 planning and implementation. Even when beginning on a new effort together, as the other project team did, starting with some staff who were familiar with one another also helped establish buy-in and trust across staff levels (including among new staff or partners) and made difficult conversations easier. One collaboration did not go as hoped, however. Despite other ongoing joint endeavors, the RPG service approach that the substance use treatment provider had selected did not align with child welfare requirements (as discussed in Section IV.B).

2. Common barriers to interagency collaboration

Staff time and turnover as well as competing priorities and timelines were barriers to collaboration between child welfare agencies and substance use treatment providers in most projects. The inability of child welfare and substance use treatment staff to find time to meet was a challenge in three projects.

Staff time and turnover. High staff turnover in the child welfare and substance use treatment fields is pervasive (Eby et al., 2010; Kim & Kao, 2014), often due to organizational factors such as burnout, stress, high workloads, low pay, and a lack of support from leadership (Casey Family Programs, 2023; Child Welfare Information Gateway, 2016; He et al., 2018; Katz et al., 2022; Leake et al., 2017). Unfortunately, the COVID-19 pandemic exacerbated these longstanding issues (Kothari et al., 2021; NRI, 2020; Paul et al., 2022).[43] High turnover among child welfare staff in particular presented lasting challenges, according to respondents from six RPG6 projects. One child welfare respondent reported that their agency's usual turnover rate increased from 35 percent to 55 percent. A project director observed 80 percent turnover in the prior year: "I have never seen the kind of staff turnover that there is now." Some respondents reported that child welfare offices used financial incentives to help tackle the problem. One added productivity incentives and retention bonuses; another raised salaries by $5,000. The latter also held staff recognition celebrations and reviewed staff feedback during exit interviews to identify patterns that the child welfare agency could address to increase retention.

However, the problem was not easily resolved. New child welfare hires were unfamiliar with the projects, which lessened their referrals to RPG. Turnover among court staff had similar consequences for at least one project. As one respondent noted, one of their counties "needs [RPG services] the most but doesn't refer the most" due to staffing challenges. The cycle of knowledge loss required frequent reminders to child welfare staff about RPG projects. Turnover among child welfare leaders or their appointed liaisons also strained partnership-building efforts in at least three projects. These challenges may also reflect the difficulty that nonfunded partners—such as child welfare agencies—generally face in making time for collaboration (Kothari et al., 2021).

[43] According to an NRI (2020) report on the impact of COVID-19 on state mental health services, nearly three-quarters of state mental health agencies experienced workforce shortages and had to reduce services in response to the pandemic. National data on the extent of child welfare turnover during the pandemic are not available. However, anecdotal reports suggest that turnover and recruitment challenges escalated (Paul et al., 2022).

> ***"RPG is one of the services that helps us survive, because it's so intensive…. They help us know that families are getting the services they need and safety is being maintained at the same time."***
>
> ***—Child welfare supervisor***

Overstretched and new child welfare staff also had less time to support RPG families. Treatment staff did not always know which caseworker to contact to help a family, and responses from child welfare caseworkers could be uneven. Substance use treatment staff from one team helped fill the gaps when caseworkers turned over, by answering parents' questions and helping them contact their new caseworker. They even got approval to supervise parent visits with their children, which they saw as an important motivation for parents in treatment. As respondents from two project teams noted, the intensity of their RPG services had the benefit of encouraging buy-in and referrals from busy child welfare staff.

Substance use treatment staffing for RPG6 projects appeared to be relatively more stable than staffing for the child welfare partners. Only three of the RPG6 projects reported hiring and turnover difficulties in substance use treatment providers, particularly early on during the severity of the pandemic. They ascribed the difficulty to finding staff who were willing to travel or meet families in their homes, which was unfamiliar to and worrisome for job candidates, especially at the height of the pandemic. Driving long distances to reach families also lacked appeal. Finding solutions could be difficult, particularly for projects in rural areas that intended for home-based services to help overcome families' obstacles with transportation. Two projects reported that raising salaries, offering retention or productivity bonuses, and increasing the milage reimbursement rate helped improve retention. One of the projects also changed its position criteria from requiring a master's degree to a bachelor's degree with strong experience.

Competing priorities and timelines. Philosophical differences between child welfare and substance use treatment systems are well documented (Colvin et al., 2021; Drabble, 2007; Iachini et al., 2014; Wei et al., 2022), including differing views on who their client is and how to respond to a parent's relapse (Drabble & Pool, 2011; Green et al., 2008; Iachini et al., 2014). These types of differences were discussed in seven of the projects. As one respondent explained, although all partners are concerned with the family's safety and well-being, substance use treatment is "for the parents," child welfare is focused on the child, and the court "looks at everything from a legal standpoint." Clearly delineated roles can be helpful when the systems are working in concert, as another respondent noted, "Everyone needs their role in place for safe families and kids." But setbacks can arise if agencies or individuals do not see eye to eye on addiction or the value of RPG treatment services. Four projects experienced this when they encountered some reluctance from child welfare or court staff to refer families. As one respondent shared, some child welfare supervisors were open to using new avenues to get parents into treatment, while others held negative perceptions of parents struggling with drug addiction.

Competing priorities could also be seen in differing requirements or preferences for sharing client information, particularly due to legal protections for health data (Drabble, 2011; Gopalan et al., 2021). Respondents from three project teams expressed concerns about whether substance

use treatment providers should or can share information about families with child welfare cases. For example, one substance use treatment provider feared that partnering with local child welfare offices would dissuade families from seeking medical care. Another respondent reported that family treatment courts declined to refer families to RPG because they would not make families sign a release of information. To help reconcile reporting requirements with providing a safe space for parents to discuss their recovery, another project team opted not to make RPG services a child welfare case plan goal.

Fixed child welfare timelines for working with families also complicated cross-system collaboration in half the projects. The timeline in which child welfare must file for a termination of parental rights if reunification has not occurred was shorter than the time frame for the treatment services. The referral timing could also add to the timeline pressures. When families were referred later in their case or as a last resort before filing to terminate parental rights, as was initially occurring in at least three of the projects, the treatment providers felt it did not give parents enough time to demonstrate sufficient progress in their sobriety or on other case plan goals. To address this, three of the projects reported training child welfare workers on when to make referrals or working with the courts to try to adjust the case timeline.

Ability of child welfare and substance use treatment staff to meet. Communication and networking between members of a partnership can contribute to their satisfaction with the collaboration, their ongoing commitment to it, and a more effective implementation of shared strategies (Butterfoss, 2007). Developing shared plans, goals, and referral pathways, conducting joint case consultation, and working through hiccups often required that partners meet formally or informally. Respondents from three projects thought the partners' inability to meet was, overall, a challenge to their collaboration. Three others encountered similar challenges to meeting but did not characterize them as harming their partnership. These challenges included finding virtual meetings—a necessity early in the pandemic—less productive for building trust with partners and sites than in-person meetings were (cited by three projects). As one project director said, "Building face-to-face relationships was the hardest part of the pandemic." Respondents from three other projects could not always meet with busy child welfare staff as often as they wanted or felt that state child welfare liaisons were not engaged when meeting virtually. On the other hand, one child welfare supervisor noted that frequent team meetings could be overwhelming and even discourage more child welfare referrals, underscoring the need for balance.

Despite the challenges, most child welfare and substance use treatment partners did meet to accomplish their joint activities. They described several practices for strengthening day-to-day communication among managers or direct services staff: (1) communicate frequently (via email, text, or phone) and at standing meetings to keep each other updated on shared cases, answer questions, and troubleshoot barriers and concerns; (2) clarify expectations to help overcome initial resistance or misconceptions about RPG services; (3) build on successes and revisit shared goals if you get off track. For instance, one team appointed child welfare "champions" to share RPG success stories with their colleagues and encourage more referrals.

3. Factors that facilitated interagency collaboration in a more limited way

Three facilitators to interagency collaboration were typically present in the RPG projects, but circumstances appeared to temper their benefits: (1) the capacity to serve participants, (2) leadership support, and (3) staff training.

Capacity to serve participants. As noted, most RPG projects engaged partners to support referrals for, and thus access to, RPG services. Even though seven projects reported having enough capacity to serve referred families, half the projects noted having excess capacity due to lower-than-expected referrals—mostly due to child welfare staff turnover, low initial buy-in from some referring partners, and the pandemic. Because of the pandemic, some project teams were slow to build partnerships; then, they experienced an early drop in their recruitment pools due to school closures and declines in child welfare reports. However, RPG6 teams did not characterize substance use treatment staffing shortages as a limitation to serving more families, suggesting that several projects might have served more families if they had received more referrals.

Leadership support. Leadership is important for developing and maintaining collaborations between child welfare agencies and substance use treatment providers (Drabble, 2011). Partners from seven project teams praised the RPG project directors' leadership, and three teams described leadership support overall as a strength. However, four project teams thought the support from child welfare agency leaders was helpful but limited. For example (as noted in Section IV.B), one state child welfare agency partner could not keep its commitment to one of the project goals (implementing a new screening tool). As another project director stated, "child welfare is at the center of a lot of the RPG work," but its absence at steering committee meetings signaled a lack of support.

Notably, the three projects that perceived strong support from child welfare leaders had worked closely with child welfare offices on past RPG projects. However, these teams also actively encouraged investment from the leaders, such as by pointing to their successes with families or using their longstanding child welfare connections to establish new connections.

Staff training. Cross-system trainings are widely used collaborative strategies for advancing clinical, program, and policy issues (He, 2017; Drabble et al., 2011). Five projects described holding cross-system trainings that strengthened their cross-system efforts; three of them also described limitations to the trainings. Respondents from two teams felt like the substance use treatment staff had taken on responsibility for delivering a substantial amount of informal training to child welfare staff. These trainings occurred informally as the direct services staff coordinated with caseworkers to support families. The respondents hoped to see more formal cross-system training opportunities in the future on the nature of substance use and recovery. Formal cross-system learning opportunities were held by three

> ***"[The trainings] are a good reminder that we are all coming at it from a different lens. But, at the end of the day, we're all trying to do the same thing—strengthening families and returning kids to families if possible."***
>
> ***—Child welfare respondent***

teams, although one of them regretted holding only one of their planned trainings.

Whether formal or informal, the trainings served similar purposes: (1) to reaffirm shared goals and the benefits of RPG services and (2) to strengthen knowledge about addiction and improve perceptions of recovery and treatment models (including the RPG services). For example, one substance use treatment staff recalled countering child welfare caseworkers' negative views (such as, "once a drug addict, always a drug addict") by emphasizing that parents in recovery can be good parents who love their kids. Respondents also noted that the trainings helped child welfare staff (and where applicable, court staff) better understand the RPG project—including the eligibility requirements, referral process, and roles—and inspired more referrals.

D. Successes of RPG partnerships in supporting families

The cross-site evaluation team asked the project teams to reflect on ways the RPG-funded services or collaborations helped families and on any additional supports that families needed.

1. Ways the RPG services and collaboration helped families

Increased access to substance use treatment services. RPG funding enabled project teams to deliver new treatment services to families in or at risk of involvement in child welfare that they might not have been able to provide otherwise. Respondents from all eight projects viewed the new services as a key success of their partnership or project. Although the core services differed across projects, two service aspects emerged as important to staff and partners:

- Services were more individualized and intensive than their usual services.
- RPG services can (in some projects) outlast child welfare cases, so families can continue receiving support when other case services end. One project, for example, attempted to establish a lasting "recovery ecosystem" that families could lean on throughout their recovery.

Support for keeping families together. In keeping with RPG's goal, staff and partner respondents from half the teams highlighted times they observed their project helping to keep families together. Some staff in prevention-focused projects observed RPG services improving the chances that children stayed at home. For example, one court respondent explained that court staff were more likely to keep a family intact "knowing RPG could be involved to help the family and keep an eye on them."

Improved cross-system awareness of substance use issues and available services. Six projects felt they had improved their partners' awareness through conversations about recovery and available supports. Staff and partner respondents from two teams observed that some child welfare caseworkers started viewing parents with substance use issues as in need of support. A child welfare supervisor described it as

> ***"The drug epidemic is horrendous, and we can't continue to keep taking kids. We've got to do something. I think as [child welfare] supervisors and workers, we're just at a phase where—let's try!"***
>
> ***—Child welfare respondent***

an "aha moment" when caseworkers understood how hard it really was for people who are actively using substances to participate in programming.

Stronger referral pathways from child welfare to substance use treatment. Staff and partner respondents from four projects described improved referrals as a key aim of collaboration and as a measure of their partnership's success. Two of the projects noted that the new referral pathways, along with improved awareness of treatment services, could continue to support access to services even when the project ends.

2. What is still needed to meet families' needs

All of the project teams identified ways their collaboration or services could be further strengthened to support their goals or communities.

- **More engagement or buy-in from child welfare.** Substance use treatment providers or lead entities from five projects noted that despite their progress in working with child welfare, they would like even more engagement and communication from child welfare staff at the state or local levels
- **Opportunities to serve more families.** Respondents from three projects discussed opportunities they saw to strengthen referrals by expanding the RPG partnership beyond child welfare, such as to courts or judges, other treatment providers, hospitals, and other types of providers in the community that support the same families. Another project shared its hope of expanding to more prevention cases by encouraging the child welfare and court partners to refer families earlier in their case.

E. Summary

- All eight RPG6 project teams believed that by delivering substance use treatment services to help families stay together, they made progress toward their collaboration goal, even if they had not reached as many families or taken their partnerships as far as they had hoped. In six RPG projects, child welfare agencies and substance use treatment providers actively partnered to plan projects and oversee implementation, as the RPG notice of funding opportunity had intended. Five of the project teams also worked together on day-to-day activities. These five teams intentionally collaborated with child welfare for referrals to RPG and to support enrolled families as a collaborative team. They created protocols for referring families to RPG treatment services and routinely shared information to support participants' recovery goals and progress in their child welfare cases. Three project teams either did not collaborate or only minimally collaborated on referrals and interagency case consultation; however, one did so intentionally to protect families' confidentiality, even as the partners jointly oversaw project plans.
- Where child welfare agencies and substance use treatment providers worked together, past collaborative endeavors were key to their progress. Previous collaborations gave most projects a head start during the planning year either because buy-in and trust had been established or they were continuing past work. This was especially helpful when the

COVID-19 pandemic interrupted their planning periods. The pandemic made it harder for some teams to gain traction. Despite their shared histories, improving their collaborations was sometimes an explicit goal. More than half the projects cited partners' improved awareness of substance use issues and available treatments as a success of their partnership, though several wanted more training opportunities.

- Several projects also experienced barriers common to interagency collaboration, which potentially reduced referrals and the reach of RPG projects. Nearly all project teams faced high staff turnover or hiring difficulties, which predated and yet were exacerbated by the COVID-19 pandemic. Turnover among child welfare staff in particular was cited as contributing to fewer opportunities for partners to meet and lower-than-expected referrals—raising the need for ongoing cross-system training and identifying varied referral sources. Ongoing interactions and formal trainings helped some substance use treatment providers and child welfare partners better align their views of adults with substance use issues and the benefits of referring families to RPG, especially early in their case or as a prevention strategy. Still, many teams saw their collaboration as a work in progress.

Ultimately, all projects succeeded in using the RPG opportunity to expand access to substance use treatment services. Most did so by strengthening the pathway for families involved in child welfare to enroll in treatment services or by offering new (such as peer support) or more intensive and individualized treatment than usual. These achievements served staff and partners' top goal and greatest success: supporting parents' recovery and families' well-being.

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V. PARENT EXPERIENCES

Prioritizing the experiences of parents and youth is essential in the design and operation of child welfare programs, and this should include opportunities for them to provide feedback on program services (CB, 2019). Programs for families involved with child welfare and dealing with substance use issues can be improved by engaging with participants to gain a better understanding of their needs and motivations, which can increase their access to resources (HHS, 2022). Including participants' descriptions of the RPG services they received helps the RPG cross-site evaluation offer information on parents' lives and how services can improve the well-being, permanency, and safety of children.

In 2023, the cross-site evaluation team conducted an exploratory study to learn more about the parents enrolled in RPG services as well as to pre-test data collection tools and processes for a future large-scale study of parent experiences.[44] The study provided a preliminary understanding of what parents thought about (1) the factors that led to their substance use issues and child welfare involvement and (2) their experiences with RPG services. Box V.1 presents a brief overview of the study sample, data collection methods, and data analysis. Box V.2 describes the limitations of the exploratory study. Appendix F provides more information about the study, including a brief description of the analytic methods used to summarize the data.

Box V.1. About the study

The study used two data collection methods—in-depth interviews and focus groups—to learn more about the parents enrolled in RPG services. Two RPG6 projects helped recruit parents who were either enrolled in or had recently exited from their services for the study. The parents all had a current or previous open child welfare case and a substance use issue.

Eight parents participated in the in-depth interviews, which were designed to understand the factors over time that led to their substance use and child welfare system involvement. Eight parents participated in the focus groups, which were designed to understand their experiences in RPG services, such as their motivation for enrollment in RPG and how the services they received improved their outcomes related to recovery and child welfare involvement. The cross-site evaluation team used semi-structured interview and focus group guides during the in-person site visits. Transcripts from each type of collected data were thematically coded in NVivo, a software used for qualitative data analysis. Detailed analytic coding was then conducted in Excel, which informed the subthemes presented in this chapter.

This chapter describes the findings from the in-depth interviews and focus groups conducted with parents enrolled in services in two RPG6 projects. The chapter starts with parents' descriptions of their experiences and circumstances from childhood to adulthood and how these experiences and circumstances factored into their substance use and child welfare involvement as parents. Then, the chapter discusses parents' experiences in RPG6 services as they described them in the in-depth interviews and focus groups. The chapter concludes with key takeaways from the parents' reports of their experiences receiving RPG services.

[44] This exploratory study will be scaled up for the cross-site evaluation of RPG7 projects.

Box V.2. Study limitations

This exploratory study provides a preliminary understanding of the factors that led to parents' substance use and child welfare involvement and their experiences in RPG services. Parents recruited for the pilot study represented a small portion of the total population served by RPG6 projects and only a small number of parents served by the two participating projects. The data do not represent parents who had lower levels of engagement in services or who enrolled but never participated in services. The data do not represent parents who are at risk of child welfare involvement but never had an open case.

Additionally, findings from the pilot study are not generalizable. The study is descriptive and cannot make causal statements related to adult, family, or child outcomes in RPG. The findings are based on parents' reports and descriptions. Their accounts do not necessarily reflect the views of their children, RPG project staff, or others mentioned in parents' responses.

Finally, although the data collection protocols covered all the topics of interest, we did not ask every question of or follow up with potential probes in the case of every parent.

A. Factors that led to parents' substance use and child welfare system involvement

A person's view of their past experiences may shape their present life circumstances (Giele & Elder, 1998; Mortimer & Shanahan, 2003). The in-depth interviews identified the experiences that contributed to parents' beliefs about themselves and the world and the coping behaviors that resulted, including the use of substances. Parents described how their substance use progressed over time and how their substance use influenced and was influenced by their involvement with the child welfare system.

1. Parents' formative life experiences

The parents' formative experiences across childhood, adolescence, and adulthood affected their lives in multiple ways and contributed to challenges at each stage of life. Parents reported on how these formative experiences created the conditions for chronic adversity that contributed to and was worsened by significant turning points in their lives.

Chronic adversity.[45] Parents described adverse experiences that started in childhood and paved the way for chronic adversity into adulthood. For most of the parents, adversity began very early in life. One father summed up this common experience when describing his earliest memories of adversity: "If you want to know the real struggles, it started [when] I was three."

Parents described a pattern of multiple adverse experiences occurring at the same time, which created circumstances that were often overwhelming. Although they reported a wide range of

[45] Adverse childhood experiences (ACEs) are traumatic events—such as abuse, neglect, and family economic hardship—that occur in childhood and can have long-term negative effects on a person's health and well-being (Felitti et al., 1998) due to a "toxic stress" response (National Scientific Council on the Developing Child, 2014; Nelson et al., 2020). ACEs have been linked to an increased risk of substance use, mental health conditions, and chronic health problems, with greater risk associated with a higher number of ACEs (Centers for Disease Control and Prevention, 2024; Felitti et al., 1998).

adverse experiences throughout their lives, the most common were related to housing, relationships with family and peers, and familial substance use. For example, every parent discussed frequent moves or significant housing and custody changes during their childhood and adolescence that disrupted their well-being and early relationships with family and peers. The moves resulted from changes in who had custody of them, placement with relatives, and placement disruptions during their own child welfare involvement. As adults, every parent also experienced unexpected changes in housing. Some faced chronic housing instability, while others underwent fewer but significant housing changes. In many instances, these housing changes were related to difficulties with significant relationships, such as intimate partner violence—which was reported by over half of the parents interviewed. The death of a close family member or friend was also common and contributed to housing changes for several parents, either because the person who died had provided the housing or because grief led to behaviors that got them evicted.

Substance use often factored into negative housing and relationship experiences. Many parents described childhoods marked by the substance use of their own parents or other family members, such as siblings. Parents described how their regular exposure to others' substance use in childhood negatively affected their physical and emotional well-being, relationships with their caregivers, and a sense of healthy limits or boundaries. The negative effects continued into adulthood, when the parents' own substance use became intertwined with housing and relationship challenges. Many parents described how each of these challenges created a cycle that was difficult interrupt.

Significant turning points. The parents often identified negative turning points when asked about significant events that shaped their lives. When a significant negative event occurred for parents with existing adversities, it typically made their circumstances worse and sometimes set in motion a prolonged period of hardship. Parents described how even positive events and experiences were often overshadowed by negative ones. As a result, they described low points, high points, and turning points that were deeply intertwined. One mother described how she tried to make a positive life for herself in early adulthood by going back to school and preparing for work. However, the death of her own mother abruptly halted her progress and led to several adverse experiences that were similar to her childhood—unstable housing, disrupted family relationships, intimate partner violence, a lack of social supports, and regular exposure to substances.

Every parent described a turning point that involved loss. Sometimes parents experienced a physical loss such as the death of a family member; other times they described an emotional loss such as the absence of their own parents in childhood or being abandoned by an adult who had been supportive in the past. For all parents, loss was intertwined with a lack of supportive relationships, which meant parents felt like they had to grieve that loss alone. As one parent stated, "I lost my only person that I had." Having to grieve alone and manage difficult life circumstances at the same time left many parents feeling overwhelmed and abandoned.

2. Parents' core fundamental beliefs

Chronic adversity combined with significant turning points shaped the development of two fundamental beliefs that parents had about themselves and how the world operates: (1) feeling alone, abandoned, and unheard and (2) needing to stay strong for others. Every parent described elements of both fundamental beliefs, suggesting that each one reinforces the other. But they did not always explicitly connect the two.

Feeling alone, abandoned, and unheard. Parents described feeling alone, abandoned, and unheard as a result of physical and emotional losses throughout their lives. For most parents, this belief took root during their childhood due to physical and emotional separations from their own parents or caregivers. These separations often compelled them to search for ways to be with their family, even when their family homes and relationships were unstable. One mother described how repeated separations from her own mother and siblings resulted in an overall sense of disconnection from others: "I didn't have a whole lot…. I tried to fit in everywhere and didn't fit in anywhere…. I think for the most part I was just really lost as a kid."

Feelings of loneliness, abandonment, and being unheard carried into adulthood. For many parents, their family continued to be a primary source of rejection, stress, or conflict, rather than a system of support in times of need. Some of the parents reported being treated like an outcast by family members; others said family members stood in the way of their efforts to reunify with their children. Further, many parents said that they felt that the service systems let them down—particularly child welfare, family courts, and schools—as they navigated difficult life circumstances. Parents described instances when staff in service systems ignored their needs or did not recognize their efforts to improve their lives, which left them feeling unsupported and unable to ask for help: "I didn't have nobody to talk to…. I felt lonely. I feel lonely now. I feel lonely all the time."

Needing to stay strong for others. Parents described feeling responsible for the well-being of others even when they were dealing with the physical and emotional effects of chronic adversity. Despite the profound loneliness experienced throughout childhood and adulthood, many parents viewed themselves as strong and as a protector. They strived to protect others from hardship. Parents reported caring for siblings during childhood when their own caregiver was neglectful or intoxicated, not reporting a sexual assault to protect the feelings and safety of their family members, and relinquishing custody of their own children—permanently or temporarily—as examples of how they tried to provide a stable environment for their own children.

A few parents also described instances when they tried to stay strong to ensure their child's well-being and safety. But, despite good intentions, their actions worsened the situation and contributed to a relapse or child welfare involvement. For instance, one mother tried to protect her newborn from physical harm during a fall, but suffered a major injury that worsened her substance use because she used substances to cope with the pain. Another mother tried to stay strong while her children were in an out-of-home placement. But she described reaching a breaking point upon learning about reduced visitation with her children, even though she had completed an inpatient treatment for her substance use issues. Out of frustration, she stopped

engaging in services and experienced a relapse, which interfered with her progress in her child welfare case. Although this mother viewed handling adversity like this on her own as a sign of strength, she recognized it was causing harm: "I am a really strong person, but … I can't handle it anymore."

3. Parents' coping behaviors

Parents described negative and positive behaviors that stemmed from their fundamental beliefs, which they used to achieve a sense of stability and to cope with challenges in their lives.

Using substances. All parents reported extensive substance use throughout adulthood to deal with adverse experiences and trauma. However, most of the parents said that their first experiences with substances were because of early exposure and easy access to them, not because they wanted to be intoxicated. They said they "just wanted to see what it was" or that "it just sounded like a good idea." Many parents tried drugs or alcohol in childhood or early adolescence with family members, such as cousins and siblings, which may have normalized substance use early in their lives. Only a couple of parents were introduced to substances through peers. Parents' casual substance use continued into early adolescence and, for some, until early adulthood. However, as parents faced a life full of relentless challenges, their substance use worsened as they increasingly used drugs and alcohol to cope with overwhelming feelings of loneliness, abandonment, and needing to stay strong. For example, one mother turned to drugs during adolescence to deal with the loneliness that came after the death of her father, who was the most supportive person in her life: "To this day, I don't even know how to grieve. I don't know how to cope, because back all the way to [my teenage years] my coping skill was drugs."

For many parents, drugs or alcohol featured prominently in their relationships with peers or romantic partners in adulthood. At first, substances helped them feel connected to other people and cope with feelings of loneliness. But substances increasingly contributed to conflict in their relationships and worsened their substance use, which often led to other life challenges such as housing instability and unemployment. Parents reported that the combination of stressors often left parents feeling alone and unable to overcome difficult circumstances. One mother described how she felt "stuck … with this guy that's a drug dealer," even though she wanted to leave that relationship, engage in treatment, and begin her recovery journey. Parents described how facing challenges in the household, such as intimate partner violence and financial hardship, caused them to feel lonely, isolated, and stuck in a cycle of substance use as a coping behavior.

Bottling everything up. Parents often bottled up or internalized their emotions to cope with chronic adversity and low points in their lives. For some, bottling up everything was deeply connected to persistent feelings of loneliness and abandonment. They reported thinking they could not turn to other people for support, or they feeling rejected by other people when they tried to seek support for loss or trauma. For others, bottling up emotions was seen as a sign of strength, which some of them learned from their family: "I bottle everything up cause that's how I was raised." These parents noted the belief that internalizing their feelings demonstrated an

ability to control their situation or protect those close to them from feeling burdened by their problems. However, these initial acts of strength often worsened parents' loneliness and substance use and exacerbated their circumstances, because they did not receive the help and support they needed. One mother described how she drank alcohol to cope with her emotions, but that her drinking increased over time and contributed to her eventually using and selling methamphetamine, which was a factor in becoming involved in the child welfare system.

Taking charge and persevering. Parents also used positive coping behaviors that helped them persevere in the face of challenges and prioritize their children's well-being. Parents reported feeling proud of the times they acted positively and accomplished their goals, especially goals related to employment, education, relationships, and sobriety. A couple of parents said they navigated adversity and the goals they set for themselves by "being the best" or most-liked person in a group. This strategy helped them conquer feelings of loneliness and abandonment, but it also created considerable pressure to live up to standards that they could not always achieve. Even so, these parents were able to use this coping behavior to fuel major life changes in their sobriety and parenting.

Many parents also used their own difficult family experiences as motivation to do things differently for their children's well-being. As one father stated, "I have seen what addiction did to my family. I'm not going there." Even when parents struggled with substance use or life challenges, they tried to find ways to protect and care for their children. Although these efforts were not always enough to prevent child welfare involvement, they fostered an outlook that led to perseverance through challenges.

4. Parents' interactions with the child welfare system

Parents understood why their substance use factored into their involvement with the child welfare system, but they reported their belief that the system imposed additional hardships that made it difficult for them to maintain sobriety. They discussed their relationship with the child welfare system, especially their positive parenting practices amid substance use, the incompatibility between child welfare requirements and recovery timelines, and the importance of their own motivation in maintaining sobriety.

Perceptions of good parenting. Parents reported that the child welfare system did not do enough to recognize their willingness and capacity to be a good parent. Many parents wished the child welfare system would recognize that not all people with a substance use issue are abusive or neglectful. They often described how they prioritized their children's daily needs—such as eating, brushing their teeth, and doing homework—despite their ongoing substance use issues. One mother underscored this by saying that her "kids are before anything." Parents also noted that they wished that the child welfare system would consider the other chronic challenges in their lives and would do more to help them develop positive parenting behaviors in the face of these challenges. They said that being supported by the child welfare system in positive ways would provide motivation for their sobriety so that family separation could be prevented.

System requirements and timelines. Parents reported that the child welfare system's requirements and timelines created additional pressure that interfered with their sobriety, even when they knew that sobriety was essential to maintaining custody of or reunifying with their children. Some parents said that the initial opening of a child welfare case, regardless of whether the children were removed from the home, may worsen substance use issues. They noted that parents were more likely to bottle everything up and not reach out for help because they would worry about the consequences from the child welfare system. A few parents also described experiences where their significant efforts to meet child welfare's requirements seemed to go unnoticed. This experience was similar to times when they felt unheard and abandoned in their early lives, thus reinforcing this fundamental belief about themselves and the way the world operates.

Parents stated that the pressure of child welfare requirements and limited recognition of their efforts left them feeling caught in a vicious cycle. If they struggled to stay sober, the system separated them from their children, even as the stress of involvement with child welfare worsened their substance use issues. Similarly, the longer they were separated from their children, the more parents grew increasingly discouraged and faced a threat to their sobriety. Parents said they wanted child welfare staff to know that a relapse did not automatically mean that they did not want to get sober or be a good parent. Parents suggested that child welfare staff acknowledge and document even the small steps that parents take on the path to recovery and reunification.

Parent motivation. Parents reported their own motivation as a more significant factor in their substance use treatment and sobriety than child welfare and court requirements. They talked about earlier periods of sobriety, often before child welfare involvement, and believed that they could get sober again. Parents drew on their internal strength and confidence during difficult times and when thinking about their capacity to make positive changes. As they gained more confidence, they reported being more motivated to make other positive changes. They found jobs that were meaningful to them, they took care of their children and household chores, and they engaged more in community life. Each positive step they took increased their confidence and their willingness to reach out for support rather than struggle alone.

Although parents talked about the importance of their own motivation in staying sober, they stated that the child welfare system could do more to help them make positive life changes. They reported that acknowledging relapse as part of the recovery process was essential and that parents should be empowered, rather than afraid, to admit mistakes. In the instances that child welfare staff did support parents through an experience with relapse and other challenges, parents shared that they had increased belief in their own abilities and motivation to persevere.

B. Parents' experiences in RPG services

During the in-depth interviews and focus groups, parents responded to questions about their referrals to and enrollment in RPG services and their interactions with RPG program staff and

service partners. Parents also discussed how well RPG services aligned with their substance use recovery needs, other aspects of well-being, and child welfare case requirements.

In this exploratory study, parents reported viewing RPG services as synonymous with the RPG6 grant recipient. Parents found the RPG services offered by the substance use treatment provider were essential to their recovery journey and capacity to make positive changes.[46] Through RPG services delivered by the substance use treatment providers, parents received emotional support; tailored support to meet day-to-day needs and achieve their goals; and, in one project, assistance with their child welfare case.

Referrals and enrollment processes. Referrals to RPG services largely depended upon whether or not the parent was involved with the child welfare system at the time of the referral. More than half of the parents reported that a child welfare or related agency referred them to RPG services or encouraged their participation. Some parents stated that their child welfare caseworker's referral made enrollment in RPG services seem mandatory, despite being voluntary, though they reported staying in services because they found them beneficial. Several parents also noted that, in hindsight, they wished they had been referred to RPG services sooner because they would have benefitted earlier in their recovery path and child welfare case.

Parents reported that the process for enrolling in RPG services was mostly quick and easy. They appreciated that RPG program staff contacted them quickly upon their referral to RPG services. In one project, a few parents reported minor enrollment delays due to the eligibility requirements for the project's services. The parents in this project still had an overall positive view of enrollment, but they reported that they wanted to be enrolled sooner to start benefitting from the services. Despite the overall positive experience with enrollment, many of the parents were overwhelmed by the amount of intake paperwork and lengthy assessments. Parents found it helpful when RPG program staff tried to reduce the burden by breaking the process into manageable segments over several sessions. This tailored approach to meeting parents' needs carried through into other aspects of the program and contributed to their overall positive experience in RPG services.

Tailored support with needs and goals. Parents reported that RPG services helped them meet a range of needs to support their sobriety, improve their life circumstances, and comply with child welfare requirements. RPG services typically helped parents with multiple needs simultaneously—for instance, with logistical day-to-day needs such as access to stable housing and food for their family. RPG services also helped with different aspects of well-being, such as accessing inpatient substance use treatment and mental health services, obtaining employment for financial stability, and creating connections with supportive people.

[46] As in Chapter IV, this chapter uses the broad definition of "substance use treatment provider" for the entities collaborating with child welfare agencies and courts in RPG projects. The two RPG6 organizational entities that participated in the exploratory study are the grant recipients. They provide behavioral health services—such as case management, peer support, and relapse prevention programs—that supplement substance use treatment services delivered by separate providers not directly involved with their RPG project.

Parents emphasized that RPG services were tailored to address their individual circumstances and goals so that they could work on what they saw as important. They reported that it was helpful that service delivery was organized around their schedules, especially work and school schedules, and that services were provided in the home or other easy-to-access community locations. They also shared that they appreciated when RPG services addressed the needs of the whole family—although, some parents noted the services could have been more family-centered, such as by offering family therapy and other resources that supported the entire family. One parent stated the program had improved their life overall: "I really reflected on where I started at to where I was at that point. And I was like, you know, I'm a lot better than when I started. I know a lot more now. I feel a lot more confident. I'm doing better at work, at home."

Parents reported that RPG services showed them that they could turn to others for help and that this help could support them in achieving their goals. Through RPG services, many parents experienced small and frequent successes that built their confidence for making positive changes. Importantly, they viewed RPG staff as supportive teammates who challenged and motivated them when needed, picked them up when they fell, and believed in them when they did not always believe in themselves. Parents stated this especially helped them achieve goals that increased their chances for reunification with their children. For example, one mother said of the staff: "I don't think I'd be where I am today, as strong as I am, if it wasn't for them."

Emotional support. Parents reported that RPG program staff provided much-needed emotional support and encouragement to help them work toward their goals. For many parents, participating in RPG services was the first time they received a consistent and nonjudgmental source of support. On parent noted: " I ended up getting a support team behind me. … Getting into the RPG program, I actually felt like I had people on my side who would understand and actually be willing to truly help me." Parents said that they met regularly with staff during scheduled appointments and that staff answered their texts and phone calls even during unscheduled times. The emotional support and lack of judgement offered by the RPG program staff at the substance use treatment provider counteracted most parents' experiences with child welfare and other service systems. One parent stated: "None of my other care team or … anybody in my life, really, said, I'm proud of you. And that's what I really needed at the time. And [RPG program staff] were the ones to be like, Hey, you know what? You did a good job. You know what? You're on the right track. You're doing good. And that was—that was definitely really cool."

The emotional support provided in RPG services also counteracted parents' negative beliefs about themselves and other people. Parents said someone was actually listening to them and that they did not have to face challenges alone. They noted that this support helped them persevere in their recovery and deal with life's challenges, so they could accomplish goals related to employment, housing, and family relationships. As one parent stated: "It's always good to have somebody there to talk to when you feel like you don't have nobody." Although parents indicated that all staff within the RPG projects provided emotional support, they identified peer support as critical because it helped to have someone who could relate to their experiences and give practical tips for dealing with challenges. When parents reported that peer support was not

provided in one project, they indicated that the service was needed. One parent summed up this perceived value of peer support: "[Peer support is] not like you're just a mandated reporter and this is your job, you know. Like you're actually somebody that's been where I've been, and you care because you don't want to see me go down the same road you went down."

Coordination between the child welfare agency and the RPG substance use treatment provider. Parents emphasized the benefits of ongoing coordination between partners, in keeping with the research literature (Drabble, 2011; Green et al., 2008; Herlihy, 2016). Parents from one project where this coordination occurred praised it as a critical component of RPG because it created alignment between their recovery goals and child welfare requirements and helped move their case forward. Parents identified coordination between the two entities as most helpful when RPG program staff communicated with child welfare staff or the court about their sobriety and participation in RPG services. Parents reported appreciation for RPG program staff providing access to urine analysis tests to prove their abstinence from substances, attending court to support them, and helping with supervised visits to support family reunification.

Parents who did not experience this level of coordination in the other projects said they would have preferred more communication between the entities so that child welfare staff and the courts better understood the parents' progress. Without this coordination, some parents described worrying about whether they were taking the steps their caseworkers wanted. These parents also noted that if their cases lingered too long, it became harder to maintain sobriety because of the added frustration on top of already challenging life circumstances.

C. Key takeaways about participant experiences

Parents' experiences provided insight into the intergenerational nature of chronic adversity and how it contributes to ongoing challenges for families enrolled in RPG programs. Parents especially experienced challenges with housing, relationships with family and peers, and substance use. These challenges often overlapped and repeated throughout childhood and adulthood. Sometimes, it was difficult for parents to tease apart low points, high points, and significant turning points because they occurred simultaneously. These experiences factored into their beliefs, from an early age then into adulthood, that they were alone, abandoned, and had to appear strong even when they were struggling. As a result, parents' early exposure and dabbling with substances turned into increased use over time as they tried to manage overwhelming circumstances and emotions. They understood that their substance use issue was a factor in their child welfare involvement. But many parents reported that the separation from their children often worsened these issues, which prolonged their child welfare involvement. Parents described being caught in a vicious cycle that was nearly impossible to stop.

In contrast, parents displayed strength, hope, and resilience when they had strong supports and relationships with others. Parents said they were proud when they took control of their own circumstances, overcame obstacles, and were able to protect and care for others, including their children. Parents' previous attempts to stop using substances taught them that their own motivation is the biggest factor in getting sober and staying in recovery. Although parents

reported needing internal strength and confidence to persevere through life's challenges, they knew they could not do it alone and that help from others, including child welfare staff, was needed for long-term success.

The parents suggested several ways that RPG services could further support improvements in outcomes related to adult recovery and family functioning:

- Develop child welfare system requirements, timelines, and practices that account for relapse as part of the process.[47]
- Train child welfare staff to understand the underlying circumstances that contribute to parents' substance use, so parents feel empowered to reach out when they need support.
- Include substance use treatment services that provide emotional support, peer support, and therapeutic services for the entire family; that connect families to community resources; and that assist parents with setting goals and building their confidence to achieve their goals.
- Provide individualized coordination between the substance use treatment provider and child welfare staff on each parent's case.

[47] The Adoption and Safe Families Act (ASFA) of 1997 attempted to shorten the time children spend in foster care and promote quicker adoptions. Parents' mention of quick child welfare agency timelines compared to recovery timelines may be related to the agencies trying to adhere to ASFA timelines.

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VI. HOW DID FAMILIES IN RPG5 AND RPG6 CHANGE OVER TIME?

RPG aims to improve the well-being, permanency, and safety of children who are in or at risk of out-of-home placement due to their parents' or caregivers' substance use issues. This chapter explores whether participants' outcomes improved after they received RPG5 and RPG6 services. The analysis focuses on five domains of interest to Congress and CB: (1) adult recovery, (2) family functioning, (3) child safety, (4) permanency, and (5) child well-being:

1. **Adult recovery.** RPG services are designed for families with caregivers facing substance use issues, a prevalent risk factor for child maltreatment (CB, 2024). Only one in five parents involved with the child welfare system successfully completed substance use treatment, compared to about half of individuals in the general population seeking treatment (Brady & Ashley, 2005; Choi & Ryan, 2006).
2. **Family functioning.** Parents and other adult caregivers are essential to the development of the children in their care. They are responsible for providing the health, safety, nurturing, and guidance necessary for children to grow into well-functioning adults. The mental health of parents and the quality of their parenting are linked to the risk of child maltreatment and negative outcomes for children (Budd et al., 2006; David, 2021; Dubowitz et al., 2011; Sidebotham et al., 2001; van Santvoort et al., 2015).
3. **Child safety.** In 2022, CPS agencies received an estimated 4.28 million referrals alleging maltreatment of about 7.5 million children (CB, 2024). CPS screened in 2.2 million referrals for investigation or an alternative response to investigation and determined that about 559,000 children were victims of child abuse and neglect. Among the substantiated reports, over 74 percent involved neglect; about 17 percent involved physical abuse; 11 percent involved sexual abuse; and 6.8 percent involved psychological maltreatment.[48] The negative effects of maltreatment are well-documented (Casanueva et al., 2012).
4. **Permanency.** Children thrive on consistency, predictability, and attachment to a caring adult, which can be disrupted when they lack a permanent living situation (Casey Family Programs, 2018). Placement instability—or frequent disruptions to a child's living arrangement—can delay permanency and increase risks for children. For instance, children experiencing placement instability are significantly more likely to develop behavioral problems compared to those with stable foster care placements (Rubin et al., 2007). They are at risk for decreased academic outcomes, poor socioemotional health, and weak attachments (Arif et al., 2024; Gauthier et al., 2004). They may also struggle more with stress regulation (Dozier et al., 2002) and executive function deficits (Fisher et al., 2013) than children with consistent caregivers.
5. **Child well-being.** Children whose caregivers have substance use issues are at risk for being maltreated or involved with the child welfare system. Maltreatment can have long-term effects on children (Institute of Medicine & National Research Council, 2013; Mahta et al., 2023). For example, maltreatment has been linked to poor socioemotional and behavioral

[48] Percentages sum to greater than 100 because allegations can be substantiated for more than one type of maltreatment.

adjustment (English et al., 2005; Font & Berger, 2015) as well as lower academic and cognitive performance (Crozier & Barth, 2005; Jaffee & Maikoich-Fong, 2011; Mills et al., 2011) and increased risky behaviors and depression (Arata et al., 2005; Lippard et al., 2020), compared to children who have not experienced maltreatment.

This chapter provides an overview of the methods used for the analysis, including statistical adjustment for nonresponse (Section A), then delves into the theoretical framework supporting the analysis (Section B). After that, the chapter examines outcomes by domain: adult substance use and treatment (Section C), family functioning (Section D), safety and permanency (Section E), and child well-being (Section F).

The analysis showed that most outcomes for children and adults enrolled in RPG5 and RPG6 improved from project entry to exit. However, there are three main limitations to keep in mind when interpreting these findings. First, the analysis comparing outcomes from project entry to exit is a descriptive assessment of individual change over time. It cannot determine whether the RPG5 and RPG6 projects, collectively or individually, caused positive or negative changes. For example, people who entered RPG5 and RPG6 might have done so because they were ready to take action to improve their situations, and their improvements might have occurred without enrolling in RPG. Without an impact study that includes comparable families not enrolled in RPG, the improvements in outcomes cannot be attributed solely to the RPG5 and RPG6 projects.

Second, a significant portion of the eligible sample lacked both baseline and follow-up data from standardized instruments that measure child well-being, adult substance use issues, and family functioning outcomes. Those included in the pre-post change analysis differed in some demographic characteristics and baseline outcomes from those without follow-up data, which could have introduced bias in the estimated results. For example, adults without follow-up data were more likely to report high-severity drug use than those with follow-up data. (Appendix C includes more information about this analysis.)

The cross-site evaluation team applied nonresponse weights to the pre-post change analysis of standardized instrument data to mitigate these differences and enhance the generalizability of the results. However, weighting adjustment does not fully ensure the representativeness of the sample. There could be unmeasured factors related to nonresponse that the nonresponse weights did not account for in the analysis. Despite conducting a variety of sensitivity analyses that demonstrated consistent findings across several defensible analytic approaches (including one that ignored the nonresponse weights), alternate approaches might yield different results for this analysis and result in substantively different interpretations.

Third, some outcomes—for example, children's sensory processing—might not have been significantly impacted immediately after families completed RPG5 or RPG6 services. As illustrated in the framework, this is a longer-term outcome. That is, it is possible that more time is needed for improvements in adult recovery, family functioning, and safety and permanency to substantively affect child well-being outcomes. However, it is encouraging to observe improvements in children's emotional and behavioral problems at project exit. Assessing child

sensory processing 6 to 12 months after project exit (the current outcomes were measured 6 to 12 months after project entry) might enhance the likelihood of observing improvements.

A. Methods

To understand how individuals change, data are needed on outcomes of interest at two points in time. For the RPG cross-site evaluation, HHS expected projects to collect data on participating adults and children by using standardized instruments at project entry—referred to as baseline—and at project exit (successful completion or dropout), referred to as follow-up. Chapter II described standardized measures to assess the outcomes of adults and of the focal children in their care. Projects also collected administrative child welfare and SUD treatment data. Appendix C includes information on the data and methods used to summarize outcome data in this chapter, along with results of the sensitivity analysis.

1. Nonresponse and weighting

A substantial portion of the eligible sample did not have both baseline and follow-up data on child well-being, adult substance use issues, and family functioning outcomes, which were collected using standardized instruments. The eligible sample that contributed to this analysis ranged from 27 percent to 50 percent of eligible children or adults across the standardized instruments.

To understand who was included or excluded from the analysis, the cross-site evaluation team compared individuals with and without follow-up data. This comparison revealed that the two groups differed on some demographic characteristics and baseline outcomes. Because of these differences, the families included in the analysis did not represent the full population of families receiving RPG5 and RPG6 services. (Appendix C details the response rates and the differences between the two groups.) Thus, the cross-site evaluation team developed nonresponse weights to enhance the representativeness of the data (Little & Rubin, 2002; Rubin, 1976, 1987). The team applied weight values so that responses of underrepresented individuals weighed more, or had more importance, and overall so that the analysis results better represented the full population receiving RPG services. These weights were applied to estimate all descriptive statistics (means and standard deviations and the proportion of individuals characterized as high risk by their scores on or responses to the instrument) as well as to conduct statistical tests of the differences in the outcomes over time.

This chapter presents the results of the benchmark analysis,[49] using nonresponse weights for outcomes measured with standardized instruments and unweighted data for outcomes measured with administrative data (for all eligible RPG5 and RPG6 participants from projects that submitted these data). The cross-site evaluation team also performed various sensitivity analyses, such as analyses without weights. (Appendix C provides detailed findings from the

[49] The benchmark analysis that served as the primary answer to the research questions used all available data with weights for a given standardized outcome of interest and administrative data for the focal child or recovery domain adult.

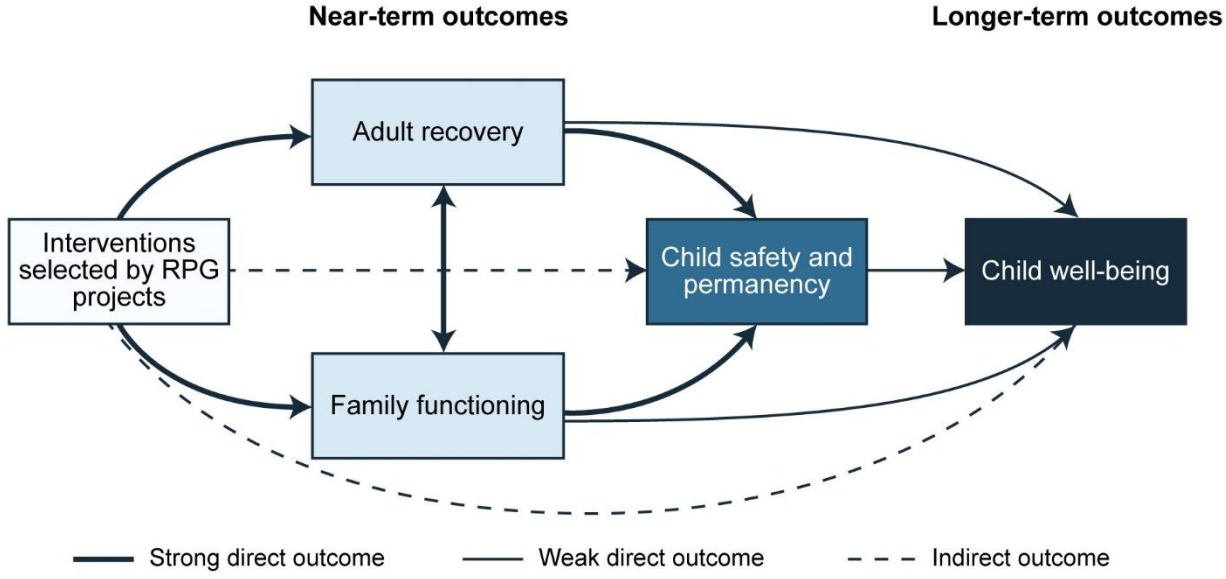
sensitivity analyses.) The sensitivity analyses indicated that the patterns of findings were similar to the benchmark estimates.

B. Framework

Figure VI.1 provides an illustrative framework for examining and understanding the changes in adult and child outcomes from RPG project entry to exit. As presented in Chapter III, most RPG5 and RPG6 services focused on substance use, mental health, or parenting through case management or therapy or counseling services. Notably, these projects primarily served adults, making adult recovery and family functioning outcomes directly influenced by the intervention (near-term outcomes in the framework) and most likely to change (World Health Organization, 2002).

In addition to being the outcome domains most likely to change due to the intervention, the adult recovery and family functioning domains also influence each other. Improvements in one domain are likely to have spillover effects on the other—that is, as recovery improves, family functioning improves (and vice versa). For example, reduced drug use could directly improve mental health, while improved mental health could lead to reduced drug use. However, analyses comparing outcomes at project entry and exit cannot conclusively demonstrate that RPG projects caused any improvements in outcomes because the analyses were not designed to answer that question.

Figure VI.1. Framework of relationships between RPG participation and the outcome domains



Although RPG5 and RPG6 services were designed primarily for adults, improvements in adult outcomes may directly influence child safety and permanency. Several studies have demonstrated that improvements in adult outcomes can affect child safety and permanency (Berger, 2004; Kepple, 2018; Shay & Knutson, 2008; Staton-Tindall et al., 2013; Testa & Smith,

2009). The literature also suggests that the near-term outcomes of adult recovery have a more direct impact on child well-being than the intervention itself (Calhoun et al., 2015; Hussong et al., 2007, 2008), as do family functioning (Masten et al., 2006, 2011; Neece et al., 2012) and improvements in child safety and permanency (Becker-Weidman, 2009; Viezel et al., 2014).

While child well-being was a goal of the grant program, Chapter III revealed that most projects' services focused on reducing adult substance use and improving parents' well-being and parenting. Few projects provided services specifically focused on child well-being. Therefore, any improvements in child well-being outcomes would probably occur indirectly through changes in adults' outcomes. Thus, child well-being might not have improved as much as other outcomes examined in the cross-site evaluation. Child well-being is presented as a longer-term outcome in the framework.

C. Adult substance use and participation in treatment

RPG5 and RPG6 projects provided services to improve parents' or caregivers' substance use and treatment outcomes because they may affect the safety, permanency, and well-being of children in their care. The cross-site evaluation examined adults' substance use and participation in treatment in the recovery domain.

1. Adult substance use

Adults reported decreased use of both drugs and alcohol between project entry and exit. This finding is based on a response rate of about 49 percent, or 1,180 adults from 17 projects. (See Appendix C for a discussion of the differences between adults who had data at both project entry and exit and those who did not.)

As shown in Table VI.1, the mean drug use severity score decreased from 0.08 to 0.04, a statistically significant improvement. The percentage of adults categorized by the cross-site evaluation as having high-severity drug use[50] decreased by 13 percentage points, from 21 percent to 8 percent, which was also statistically significant.

Table VI.1. Change in substance use by adults, from project entry to exit

Substance	Sample size	At project entry		At project exit		Change from project entry to exit	
		Mean score (SD)	Percentage in high-severity category	Mean score (SD)	Percentage in high-severity category	Mean change score	Percentage in high-severity category
Drug use	1,116	0.08 (0.11)	21	0.04 (0.07)	8	-0.04*	-14*
Alcohol use	1,157	0.07 (0.13)	9	0.05 (0.10)	4	-0.02*	-5*

[50] High-severity drug use was defined as a severity score higher than the average score of a nationally representative sample of adults enrolled in substance use treatment. The high-severity drug use threshold was 0.15 and 0.10 for females and males, respectively.

Substance	Sample size	At project entry		At project exit		Change from project entry to exit	
		Mean score (SD)	Percentage in high-severity category	Mean score (SD)	Percentage in high-severity category	Mean change score	Percentage in high-severity category
Use of drugs or alcohol or both	1,102	n.a.	27	n.a.	10	n.a.	-16*

Note: Higher scores on the ASI-SR indicated greater severity of substance use. Change scores might not exactly match the simple difference in the two time points because of rounding.

Sample sizes were based on the 17 projects in RPG5 and RPG6 that submitted the ASI-SR data. Sample sizes varied by measure because of item nonresponse.

Any improvements in outcomes over time cannot be interpreted as caused by the RPG project.

* Statistically significant difference between time points at the 0.05 level.

ASI-SR = Addiction Severity Index, Self-Report Form; n.a. = not applicable; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SD = standard deviation.

Source: Results of the ASI-SR instrument, administered at project entry and exit, including data submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6. Results in this table were adjusted using nonresponse weights.

The decrease in severity of alcohol use was also statistically significant. The alcohol use mean score decreased by a statistically significant 0.02 points, from 0.07 at project entry to 0.05 at project exit. The prevalence of adults enrolled in RPG5 and RPG6 in the high-severity category declined from 9 percent at project entry to 4 percent at project exit.[51]

The prevalence of high-severity use of either drugs or alcohol also decreased significantly over time. At project entry, 27 percent of adults were categorized as having high-severity use of either drugs or alcohol. This decreased to 10 percent at project exit.

The analysis also found statistically significant reductions in the prevalence of recent use of cannabis, opioids, amphetamines, and cocaine between project entry and exit (Table VI.2). The largest reduction was in the percentage of adults using cannabis in the past 30 days, followed by amphetamines. Cannabis was the most commonly used drug at project entry (26 percent) and had a reduction of 11 percentage points from project entry to exit—a decrease of 42 percent. At project entry, about 11 percent of adults reported using amphetamines, while only 3 percent of adults reported using these drugs at project exit—a reduction of 73 percent.

Table VI.2. Change in the percentage of adults using each type of drug from project entry to exit

Type of drug	At project entry	At project exit	Change from project entry to exit
Cannabis[a]	26	15	-11*
Amphetamines[b]	11	3	-8*
Opioids	7	3	-3*
Heroin	2	1	-2*

[51] The high-severity alcohol use threshold was 0.20 for females and 0.22 for males.

Type of drug	At project entry	At project exit	Change from project entry to exit
Methadone	2	2	-0
Other opioids and analgesics[c]	3	1	-2*
Cocaine[d]	3	1	-2*
Sedatives, hypnotics, and tranquilizers[e]	2	1	-1

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

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

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

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

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

Note: Records for 1,152 to 1,165 adults were examined to obtain these statistics. Sample sizes varied by substance because of item nonresponse. Change scores might not exactly match the simple difference in the two time points because of rounding.

Any improvements in outcomes over time cannot be interpreted as caused by the RPG project.

* Statistically significant difference between time periods at the 0.05 level.

ASI-SR = Addiction Severity Index, Self-Report Form; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Administration of ASI-SR instrument at project entry and exit, including data submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6. Results presented in this table were adjusted using nonresponse weights.

2. Participation in substance use treatment

The percentage of adults in publicly funded substance use treatment programs increased as did the percentage of program completion among adults who participated in treatment for the year after they enrolled in RPG5 and RPG6 compared to the year before. Table VI.3 shows that, in the year before enrolling in RPG5 and RPG6, 24 percent of adults had enrolled in a publicly funded treatment facility and 14 percent of them ultimately completed the program that year. In the year following RPG5 and RPG6 entry, 36 percent of adults enrolled in a program (a statistically significant increase of 12 percentage points) and 22 percent completed the program during that year (a statistically significant increase of 8 percentage points). However, these results were based on only eight projects that submitted recovery data. The other nine grant recipients were unable to obtain recovery data from the state or local substance use treatment agencies in time for this report.

Table VI.3. Change in participation in substance use treatment: Year before to year after RPG5 and RPG6 enrollment

Recovery measure	In the year before RPG5 and RPG6 enrollment		In the year after RPG5 and RPG6 enrollment		Change between years
	Sample size	Percentage	Sample size	Percentage	
Percentage of adults enrolled in at least one substance use treatment setting[a]	891	24	891	36	12*
Percentage of those enrolled in at least one instance of substance use treatment who completed the program[b]	214	14	325	22	8*

[a] Restricted to adults who had data at both time points.

[b] Restricted to adults who enrolled in substance use treatment in a given period; the same adults did not necessarily enroll in substance use treatment in the year before and after RPG5 and RPG6 enrollment.

Note: Sample sizes were based on eight projects that submitted substance use treatment data for the year before and the year after RPG enrollment.

Any improvements in outcomes over time cannot be interpreted as caused by the RPG project.

* Statistically significant difference between time periods at the 0.05 level.

RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Administrative data from state substance use services agencies on treatment participation in the year before and the year after RPG5 and RPG6 enrollment, which projects obtained and submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

3. Trauma symptoms

Adults reported fewer symptoms of trauma before project exit than at project entry. Table VI.4 shows that, among adults with data at both time points, there was a statistically significant decrease in their average trauma symptoms score—from 28.0 at project entry to 21.6 at project exit. The sample included 990 adults across the 15 projects that submitted data on trauma symptoms, representing a 51 percent response rate among those projects.

Table VI.4. Change in adult depressive symptoms and trauma symptoms from project entry to exit

Measure	Sample size	At project entry		At project exit		Change from project entry to exit	
		Mean score (SD)	Percentage in high-severity category	Mean score (SD)	Percentage in high-severity category	Mean change score	Percentage in high-severity category
Depressive symptoms	1,191	7.8 (7.9)	21	6.0 (7.4)	15	-1.9*	-6*
Adult trauma symptoms	990	28.0 (19.4)	n.a.	21.6 (19.0)	n.a.	-6.4*	n.a.

Note: Depressive symptoms were assessed using the CES-D and childhood and adult trauma symptoms (not experiences) were assessed using the TSC-40. Higher scores on these measures represented worse

mental health outcomes. Change scores might not exactly match the simple difference in the two time points because of rounding.

Sample sizes were based on 17 projects that submitted CES-D data and 15 projects that submitted TSC-40 data. The TSC-40 was an optional measure for RPG5 and a required measure for RPG6. Sample sizes also varied by measure because of item nonresponse.

Any improvements in outcomes over time cannot be interpreted as caused by the RPG project.

* Statistically significant difference between time points at the 0.05 level.

CES-D = Center for Epidemiologic Studies Depression Scale–Short Form; n.a. = not available; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SD = standard deviation; TSC-40 = Trauma Symptoms Checklist.

Source: Administration of the standardized instruments at project entry and exit, including data submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6. Results in this table were adjusted using nonresponse weights.

4. Summary of outcomes on adult substance use and participation in treatment

Adult drug and alcohol use and severity and trauma symptoms decreased significantly from project entry to exit among the group with scores at both time points. For example, the percentage of adults classified as having high-severity drug or alcohol use decreased from 27 percent at project entry to 10 percent at project exit. Compared to the year before their enrollment in RPG5 and RPG6, these adults were more likely to enroll in publicly funded substance use treatment programs and more likely to complete those programs in the year after enrolling in RPG5 and RPG6. Adults enrolled in RPG5 and RPG6 also reported fewer symptoms of trauma at project exit than at project entry.

D. Family functioning

Although adult misuse of substances is a key risk factor for child maltreatment and involvement in the child welfare system (CB, 2024), it often does not exist in isolation from other challenges. Commonly, substance use, mental health problems, and limitations in parenting skills and attitudes coexist and negatively reinforce one another (Lander et al., 2013). The cross-site evaluation examined each of these adult outcomes under the family functioning domain.

1. Depressive symptoms

Adults reported fewer symptoms of depression at project exit than at project entry. There was a statistically significant decrease in the average score on the measure of depressive symptoms, from 7.8 to 6.0 (although both scores were in the range of mild depressive symptoms), as shown in Table VI.4. This change indicates an improvement in the mental health of primary caregivers who completed the measure at both time points. In addition, fewer adults scored in the high-severity category for depressive symptoms at project exit, after a statistically significant decrease of 6 percentage points. However, this result was based on data from only 1,191 adults from 17 projects that submitted data on depressive symptoms, which was a 50 percent response rate. (See Appendix C for differences between adults who had data at two time points and those who did not.)

2. Parenting attitudes and skills

The analysis found statistically significant improvements in parenting attitudes and skills among those who provided data at both time points, as shown in Table VI.5. Primary caregivers' scores decreased from project entry to exit on two subscales: (1) inappropriate expectations for child and (2) values corporal punishment. This finding indicates a reduced risk of child maltreatment after participating in RPG5 and RPG6 projects. In addition, the analysis found a statistically significant decrease in the percentage of adults characterized as high risk for maltreatment on one other subscale (treats child like an adult peer, not a child). These results were based on data from 1,135 adults in the 16 projects that submitted them—a 47 percent response rate.

Table VI.5. Change in caregivers' parenting attitudes from project entry to exit

	At project entry		At project exit		Change from project entry to exit	
Parenting attitudes	Mean score (SD)	Percentage in high-severity category	Mean score (SD)	Percentage in high-severity category	Mean score (SD)	Percentage in high-severity category
Inappropriate expectations for child	5.9 (1.5)	11	5.6 (1.7)	11	-0.3*	0
Lack of empathy for child's needs	6.5 (2.0)	31	6.5 (2.3)	33	0.0	2
Values corporal punishment	5.7 (2.0)	17	5.2 (2.0)	14	-0.5*	-3
Treats child like an adult peer, not a child	6.3 (2.3)	19	6.4 (2.2)	13	0.1	-5*
Oppresses child's independence	5.7 (1.8)	32	5.6 (1.8)	29	-0.1	-2

Note: The AAPI-2 scales were transformed so that higher scores indicate a negative parenting attitude. Change scores might not exactly match the simple difference in the two time points because of rounding.

Sample sizes on all measures included 1,135 adults, based on the 16 projects that submitted the AAPI-2 data.

Any improvements in outcomes over time cannot be interpreted as caused by the RPG project.

* Statistically significant difference between time periods at the 0.05 level.

AAPI-2 = Adult-Adolescent Parenting Inventory-2; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SD = standard deviation.

Source: Administration of the AAPI-2 at project entry and exit, including data submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6. Results presented in this table were adjusted using nonresponse weights.

3. Summary of family functioning outcomes

Adults' mental health and their parenting attitudes and skills improved from project entry to exit. After enrolling in RPG5 and RPG6, adults reported fewer symptoms of depression and expressed fewer parenting attitudes that placed their children at risk of maltreatment.

E. Child safety and permanency

In authorizing RPG, Congress had a primary interest in supporting the safety (reduced maltreatment) and permanency (reunification or other permanent placement) of children who experienced or who were at risk of experiencing maltreatment because of adult substance use issues. The cross-site evaluation used child welfare administrative data, obtained by projects, to measure outcomes in the safety and permanency domains.

1. Safety

Maltreatment rates, based on both substantiated and unsubstantiated reports, for children enrolled in the RPG5 and RPG6 projects decreased in the year following RPG5 and RPG6 entry compared to the year before enrollment. The incidence of reported maltreatment declined from 49 percent in the year before RPG5 and RPG6 enrollment to 16 percent in the following one-year period among a sample of 1,490 focal children (Table VI.6). This change represents a statistically significant 33 percentage point decrease. Rates of reported neglect, abuse, and other treatment all dropped significantly between these two periods. However, this may be partly because of drops in the rates of child maltreatment reports and substantiations following the COVID-19 pandemic, when children were no longer in school in person (CB, 2022, 2023).

Table VI.6. Change in the rates of reported maltreatment in the year before and after RPG5 and RPG6 enrollment

Variable	In year before RPG5 and RPG6 enrollment	In year after RPG5 and RPG6 enrollment	Change between years
Reports of any maltreatment (abuse, neglect, or other)[a]	49	16	-33*
Substantiated reports	34	8	-27*
Not substantiated or other reports[a]	20	9	-11*
Reports of abuse	14	6	-8*
Reports of neglect	31	9	-22*
Reports of other maltreatment	25	7	-17*

[a] Includes reports that received alternative responses or were unknown or reports for children who were not the subject of an allegation but in a household that received a CPS response for at least one child.

Note: Change scores could differ from the simple difference in the two time points because of rounding.

Safety data included focal children in each family. Sample included 1,490 children, based on the 15 projects that submitted the data for the years before and after RPG5 and RPG6 enrollment.

Any improvements in outcomes over time cannot be interpreted as caused by the RPG project.

* Statistically significant difference between time periods at the 0.05 level.

CPS = child protective services; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Administrative records in the years before and after RPG5 and RPG6 enrollment from state or county child welfare agencies, which projects obtained and submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

The magnitude of reductions in substantiated reports of maltreatment was larger than reports that were not substantiated or classified as other in the year following RPG5 and RPG6 enrollment. Specifically, substantiated maltreatment rates—when an incident of abuse or neglect as defined by state law was believed to have occurred (Child Welfare Information Gateway, 2013)—experienced a statistically significant decline of 27 percentage points from the year before RPG5 and RPG6 enrollment to the year after. The rates of maltreatment reports that were not substantiated or classified as other also decreased significantly, by 11 percentage points, as shown in Table VI.6.

Although the incidence of reported maltreatment decreased substantially among children in RPG5 and RPG6, a subset of children who were the subject of reports of maltreatment in the year before enrollment were also the subject of reports in the year following enrollment. Of the 725 children with maltreatment reports (substantiated or not substantiated) in the year before enrollment, 181 (25 percent) were the subject of one or more subsequent reports of maltreatment in the year following enrollment.

2. Permanency

Removals from the home decreased significantly from the year before RPG5 and RPG6 enrollment and the intervention year. A total of 360 eligible focal children, or 24 percent, were removed from their home in the year before RPG5 and RPG6 enrollment, as shown in Table VI.7. This number decreased to 105 children, or 7 percent, in the following year—a statistically significant decrease of 17 percentage points.

Despite this marked reduction, the seven percent of children removed from their homes was still higher than recent national averages. Fewer than one percent of children nationwide entered foster care in 2022 (CB, 2024). Therefore, even after enrollment, children in RPG5 and RPG6 continued to be removed from their homes at a higher rate than those in the national population, although this rate was significantly lower than before enrollment. This persistent high likelihood may be because children enrolled in RPG5 and RPG6 came from a higher-risk population, as intended by the legislation establishing RPG as well as by the grant recipients and their partners.

The rates of achieving permanency did not change significantly in the year following RPG5 and RPG6 entry compared to the year before enrollment. In the year before RPG5 and RPG6 enrollment, 360 children were removed from their homes and 250 of them, or 7 percent, achieved permanency outcomes (through reunification with family) by the time they enrolled in RPG5 and RPG6 that same year. As noted, 105 children were removed from their homes in the year after RPG5 and RPG6 enrollment. Fourteen of them, or 13 percent, achieved permanency during the year after enrollment, an improvement of 6 percentage points—although, this was not statistically significant. Similarly, the rate of children reunifying with their families increased 5 percentage points, from 7 percent in the year before enrollment to 11 percent in the year after RPG enrollment. But this also was not statistically significant.

Achieving permanency was still relatively rare in the year following entry into RPG5 and RPG6. Most children (87 percent) removed during this period had not achieved a permanent outcome—that is, reunification, adoption, or guardianship.

Table VI.7. Change in the percentage of children in out-of-home placements in the year before and after RPG5 and RPG6 enrollment

Removal or placement	In the year before RPG5 and RPG6 enrollment		In the year after RPG5 and RPG6 enrollment		Change between years
	Sample size	Percentage	Sample size	Percentage	
Removed from home	1,490	24	1,490	7	-17*
Achieved permanency	360	7	105	13	6
Reunified with family	360	7	105	11	5

Note: Change scores might not exactly match the simple difference in the two time points because of rounding.

Permanency data in this table included focal children in each case. Sample sizes were based on the 15 projects that submitted data for the year before and the year after RPG enrollment.

Any improvements in outcomes over time cannot be interpreted as caused by the RPG project.

* Statistically significant difference between time periods at the 0.05 level.

RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6.

Source: Administrative records in the year before and the year after RPG5 and RPG6 enrollment from state or county child welfare agencies, which projects obtained and submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

3. Summary of child safety and permanency outcomes

Rates of substantiated maltreatment declined significantly after families enrolled in RPG5 and RPG6, from 34 percent in the year before enrollment to 8 percent in the year after enrollment. Data show that this reduction in maltreatment was because of (1) removals of children from their home and placement in safer environments and (2) improvements among children who were never removed from their home before or after enrollment in RPG5 and RPG6.

Removals from the home were less common in the year after RPG5 and RPG6 enrollment than in the year before. Twenty-four percent of enrolled children were removed from their home in the year before RPG5 and RPG6 enrollment, while 7 percent of children were removed from their home in the year after entering RPG5 and RPG6. However, rates of achieving permanency were similar in the years before and after RPG5 and RPG6 entry.

F. Child well-being

In addition to promoting the safety and permanency of children, the RPG5 and RPG6 projects sought to enhance their well-being. The experience of maltreatment can have long-lasting effects for children (Institute of Medicine & National Research Council, 2013). The cross-site evaluation examined children's emotional and behavioral problems and sensory processing outcomes in the year before and after RPG5 and RPG6 entry.

1. Emotional and behavioral problems

The emotional and behavioral problems of focal children in RPG5 and RPG6 improved significantly from project entry to exit. Table VI.8 shows that, for emotional, behavioral, and total problems, there were statistically significant reductions in both the mean scores and the proportions of children characterized as high risk over time. All three scores (behavioral, emotional, and total) were above the national average of 50 at project entry but close to the national average at project exit. There were also significant reductions in the percentage of children in the high-risk category for all three scores. These results were based on a 28 percent response rate, or 271 children from 14 projects that submitted the data.

Table VI.8. Change in child well-being from RPG5 and RPG6 project entry to exit

Child well-being measure	Sample size	At project entry		At project exit		Change from project entry to exit	
		Mean score (SD)	Percentage in high-risk category	Mean score (SD)	Percentage in high-risk category	Change in mean score	Change in percentage in high-risk category
Emotional and behavioral problems (ages 1.5–18.0)							
Emotional problems	452	52.5 (12.2)	19	49.4 (12.5)	14	-3.1*	-5*
Behavioral problems	450	53.7 (12.5)	21	51.1 (12.4)	16	-2.6*	-5*
Total problems	450	53.6 (12.9)	23	50.2 (13.1)	17	-3.4*	-7*
Sensory processing (birth–36 months)	271	n.a.	29	n.a.	30	n.a.	1

Note: Emotional and behavioral problems were assessed using the CBCL; sensory processing was assessed using the ITSP. Higher scores on the CBCL indicated that the child had more problems.

The cross-site evaluation collected data from one focal child in each case. Sample sizes were based on the 15 projects that submitted the CBCL data and the 14 projects that submitted the ITSP data. Sample sizes varied by measure because caregivers reported on different subsets of children depending on the child's age. For example, the ITSP has a narrow age range (birth to 36 months), so a small number of children were analyzed for that measure. The sample sizes for the CBCL varied because of item-level nonresponse.

Any improvements in outcomes over time cannot be interpreted as caused by the RPG project.

* Statistically significant difference between time periods at the 0.05 level.

CBCL = Child Behavior Checklist; ITSP = Infant/Toddler Sensory Profile; n.a. = not applicable; RPG5 = Regional Partnership Grants, Cohort 5; RPG6 = Regional Partnership Grants, Cohort 6; SD = standard deviation.

Source: Administration of standardized instruments at project entry and project exit, including data submitted to the cross-site evaluation through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6. Results presented in this table were adjusted using nonresponse weights.

2. Sensory processing

The percentage of children with an atypical sensory processing assessment did not change significantly from project entry to project exit. Table VI.8 shows that, at project entry, 29 percent of the youngest focal children (ages birth to 3) that projects assessed as part of the cross-site evaluation were characterized as either under-responsive to stimuli (for example, they did not respond to audio, visual, or tactile stimulation) or over-responsive to stimuli. This percentage remained similar at project exit. These results were based on 271 children from 14 grant recipients that submitted the data, or a 32 percent response rate.

3. Summary of child well-being outcomes

Children's emotional and behavioral problems improved significantly from RPG5 and RPG6 project entry to exit. However, their sensory processing did not change.

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VII. RPG6 PROJECT SUSTAINABILITY PLANNING AND IMPROVEMENT

Sustainability is the continued implementation of a service or program and the continued achievement of benefits for children and families after a defined period of time (Moore et al., 2017).[52] Programs grapple with sustaining efforts over the long term so that the hard-won benefits of improved outcomes for children and families will persist after funding ends (Cutler, 2002; Schell et al., 2013). Furthermore, it is often the case that time and money is devoted to establishing evidence-based programs and interventions, while little attention is given to what happens after implementation (Birken et al., 2020; Nadalin Penno et al., 2019).

Creating and implementing sustainability plans is an important way to position programs for long-term success (Feinberg et al., 2008; Mancini & Marek, 2004). A major aim of RPG, as outlined in the RPG6 Notice of Funding Opportunity, is for grant recipients to develop a sustainability plan to continue offering services and interventions implemented during the grant period (ACF, 2019). Given that RPG projects are funded for five years, community needs could change during and after the grant period. To understand whether their services are meeting the needs of families , RPG projects are required to use data to continuously improve services and inform sustainability efforts.[53]

To examine sustainability plans and activities and understand the data used to monitor and improve services, the cross-site evaluation team surveyed all eight RPG6 grant recipients and their collaborating partners, including the child welfare agency, substance use treatment provider, and local evaluators (referred to in this chapter as RPG6 projects). Multiple respondents from all eight RPG6 projects completed the survey, including project directors and other partners who were familiar with ongoing sustainability planning and improvement activities. Survey responses reflect what was known at the end of the fourth year of the funding period and third year of implementation (summer 2023), when RPG implementation and sustainability planning were well underway. See Appendix G for the data collection procedures and analysis methods, and Box VII.1 for a discussion of limitations of the analyses.

Using data from the sustainability survey, qualitative data from site visit interviews[54] and semi-annual progress reports submitted by grant recipients over the course of their projects, this chapter examines sustainability planning activities and capacity to sustain RPG partnerships. The chapter describes the roles and affiliations of the survey respondents, projects' progress on

[52] The literature offers many conceptual and operational definitions of sustainability (Shediac-Rizkallah, 1998). This chapter defines sustainability in relation to the persistence of program benefits over time rather than the institutionalization of the program itself or community capacity building.

[53] All RPG6 projects collected and used data to monitor and improve their services using a continuous quality improvement (CQI) framework. CQI uses data to define a problem, identify possible strategies to address it, implement the selected strategy, monitor to determine whether it addresses the problem, and revise as needed (Daily et al., 2018). It was beyond the scope of the survey to delve into all elements of CQI. Thus, the findings focus on the current and planned use of data to improve services.

[54] The partnership study site visit interviews asked project directors and key partners about their plans to sustain their partnership and services. Project teams were in the third year of project implementation at the time site visit interviews were completed (See Chapter IV for partnership study findings).

sustainability planning, implementation supports and plans to improve services, and planned funding and resources to sustain services.

Box VII.1. Limitations

Three main limitations affect the generalizability of the findings described in this chapter: (1) survey response rates and nonresponse bias, (2) timing of the survey data collection relative to project implementation, and (3) variation in responses within a partnership.

First, members of RPG6 projects were nominated to complete the survey by project directors because they determined which respondents were knowledgeable about sustainability and improvement. Selection bias may have occurred if knowledgeable members of the project team were not invited to complete the survey. Furthermore, some invited respondents did not complete the survey, which may have led to nonresponse bias. These forms of bias can reduce the accuracy and representativeness of survey findings.

Second, most data were collected during the project's fourth year (versus the last year of RPG implementation). Any additional sustainability plans and activities that occurred after survey data collection were not captured in the findings.

Third, each RPG6 project team was represented by multiple survey respondents—ranging from three to seven respondents per team. The survey captured each respondent's individual viewpoint, which resulted in variation in agreement within the same project team on some items. To present findings systematically at the level of the RPG6 project team, agreement on different factors within the survey was determined by congruence of the project director's response with at least one other respondent on the project team.

A. Characteristics of survey respondents

Families served by RPG programs face co-occurring issues that require attention from multiple systems and service providers (Altshuler, 2005; Connell-Carrick, 2007; Drabble 2011). This array of systems and service providers was well-reflected among survey respondents. This section describes the background of the survey respondents who reported on RPG6 projects' efforts toward sustainability planning and program improvement. Respondents were asked about their role within their organization and the role of their organization in services offered by the RPG project.

1. Roles and organizations

RPG6 project directors identified the team members who were most knowledgeable about their project sustainability and improvement plans (47 respondents). The two most common roles of survey respondents were either RPG project staff or evaluators. Over one-quarter of survey respondents (28 percent) identified themselves as being part of the RPG grant recipient staff, with roles such as project coordinator, project manager, or program administrator. RPG project staff were often providers of services but also the lynchpin in coordinating services among partners. About one-quarter said their role was in evaluation, such as local independent evaluators or research managers (24 percent). Evaluation staff were most involved in the

ongoing examination of data for program improvement and in partnering with RPG project staff to evaluate the services offered to families. Another one-quarter of respondents reported that their role was a SUD treatment administrator (10 percent), a court or judicial agency staff member (10 percent), or a child welfare administrator (5 percent). These roles were consistent with the most common required RPG partners—substance use treatment, courts, and child welfare agencies. The remaining respondents reported a role that was in a different field, such as child development, health, or mental health administration.

Respondents were also asked to report their organization type. The organizations generally aligned with the kinds of roles held by survey respondents. Over one-half reported that their organization was a university or research and evaluation organization (26 percent) or a behavioral health services provider (26 percent). A smaller proportion of respondents reported organizations such as state or tribal government (14 percent), court or judicial agencies (12 percent), or child welfare services or health providers (12 percent).

2. Role of respondent organizations in RPG service offerings

Respondents reported on the role of their organization in the RPG project. Because one organization could hold multiple roles in delivering services to families, survey respondents reported all the roles their organization filled for the RPG project. Almost one-half of respondents reported that their organization served as the lead entity (43 percent) and more than one-quarter said their organization was a partner to the lead entity (26 percent). Respondents also said their organizations served in an advisory or planning role (29 percent), provided services directly to families (21 percent), provided referrals to RPG services (14 percent), or received the referrals (12 percent). Few respondents said their organizations contributed financial or in-kind resources to the RPG project (9 percent). However, as detailed in Chapter IV, the grant recipient organization was able to use RPG funding to pay for some services provided by other organizations involved in the project, most often substance use treatment.

B. Sustainability planning

Planning for sustainability is an important predictor of a program's survival (Feinberg 2008) and should occur throughout the life of the RPG project. Recognizing the importance of ongoing services and interventions, CB requires project teams to develop sustainability plans that identify which strategies and activities initiated under the grant should and can be sustained after the end of the project (ACF 2019). RPG project teams reported whether they planned to sustain the services implemented under the RPG6 grants and which services they planned to sustain.

1. Plans to sustain RPG projects

All eight RPG6 teams reported that they planned to sustain their project,[55] and seven out of eight teams said a moderate or extensive amount of planning had already occurred. However, more than one-half of the projects cited staffing challenges and lower referrals or enrollment than expected as central service-related barriers that could hinder sustainability. These survey findings aligned with the information that RPG6 grant recipients reported to CB in the semi-annual progress reports submitted in the third and fourth year of implementation as well as the site visit findings discussed in Chapter IV.

Grant recipients documented in their semi-annual progress reports their clear intentions to sustain RPG services by describing dedicated team meetings to work on sustainability strategies, including work to identify potential funding streams. The site visit interviews found that all eight RPG6 projects hoped to sustain their services and collaborations with partners. However, the interviews, which were conducted in the third year of implementation, found that two projects were unsure their partners had the capacity to continue working with them and another project was unsure whether its partners saw value in the collaboration beyond the funding period. Further, the findings showed that staff turnover was a continuous hurdle to planning for sustainability.

2. Using data to inform sustainability plans

Using data to guide decisions about which services to maintain is critical for sustainability planning. The survey asked respondents to report on the data or other information sources their RPG project reviewed to determine which services should be sustained (Table VII.1). Nearly all RPG projects (seven of eight projects) endorsed reviewing data on community needs to guide decisions about which services to sustain. Six RPG6 partnerships reported reviewing data on participant outcomes or service referrals as well as feedback from program staff to determine whether to sustain core services. More than half of the project teams endorsed examining enrollment and attendance or participant satisfaction to inform their planning. Half of projects looked at retention data (four of eight projects), and fewer than half looked at fidelity assessments (three of eight projects) or research literature (three of eight projects) to inform sustainability of services.

Table VII.1. Data and information sources for sustainability planning

Data or information source[a]	Number of RPG6 projects[b]
Community needs assessment	7
Feedback from program staff	6
Participant outcome data	6

[55] One of the RPG6 project directors reported in the sustainability survey that they would not sustain the project, but all other respondents from that project unanimously reported that they would. According to information from TA calls with this project team, the project director had discussed that the exact same set of partners and services would not be sustained but acknowledged that components of the project would be maintained beyond the end of funding. For these reasons, the project is included among the count of RPG6 projects that were planning to sustain the project.

Data or information source[a]	Number of RPG6 projects[b]
Referrals to services	6
Enrollment and attendance in services	5
Participant satisfaction	5
Retention in services	4
Fidelity assessments	3
Research literature	3

[a] Survey respondents could select multiple data sources, as applicable.

[b] The maximum value is eight RPG6 projects. An RPG6 project is included in the count if the project director and at least one other respondent from that project marked the same response.

Source: RPG Sustainability and Improvement Survey.

3. Determining services to sustain

Sustainability may involve the continuation of an original program or its components (Shea et al., 1996). Some RPG services are essential ingredients of a service approach focused on the whole family, including case management, high-quality SUD treatment, and a comprehensive service array of clinical treatment and related support services that meet the needs of each family member (National Center on Substance Abuse and Child Welfare, 2021). Respondents were asked to report on which services their RPG project planned to continue after the end of the grant period (Table VII.2). Almost all RPG6 projects planned to sustain at least one primary service and one supportive service (six of eight projects). The most common primary services that projects planned to continue were case management or service coordination and parent training and home visiting programs. For supportive services, at least four or more of the projects intended to continue screening or assessments, court or legal services, MOUD, or medical care or appointments.

Table VII.2. Plans for continuing RPG services

Type of service[a]	Number of RPG6 projects[b]
Primary services	
Case management or service coordination	5
Parent training and home visiting program	5
Support group or workshop	4
Therapy or counseling	4
Mentoring	3
Supportive services	
Screening or assessment	5
Court or legal	5
Medications for opioid use disorder	4
Medical care or appointment	4
Employment training	3
Financial or material support	3
Housing	2

Type of service[a]	Number of RPG6 projects[b]
Transportation	2
Child care	2
Academic education	1
At least one of the following primary services: Support group or workshop, therapy or counseling, parent training and home visiting program, or mentoring	6
At least one of the following supportive services: Housing, transportation, or child care	6

[a] Survey respondents could select multiple services, as applicable.

[b] The maximum value is eight RPG6 projects. An RPG6 project is included in the count if the project director and at least one other respondent from that project marked the same response.

Source: RPG Sustainability and Improvement Survey.

4. Contextual factors that may have affected sustainability planning

Community contexts may influence decisions to sustain programs. RPG projects reported on several external factors that could have affected sustainability planning, including changes in substance use patterns in their service areas; media reports about child welfare and substance use; and child welfare and substance use policies at the federal, state, and local levels. Six of the eight RPG6 teams reported that the pattern of substance use had increased or not changed in their service area since first receiving RPG6 funds, suggesting that perceptions of rising or static substance use may have reinforced their plans to sustain the partnerships. Respondents rated the extent to which media reporting on child welfare and substance use affected sustainability planning (positively, negatively, or not at all). Six RPG6 projects said that media reporting affected their partnerships somewhat positively or not at all. The majority of projects (five of eight) reported that child welfare and substance use federal policy affected them positively, while state and local policies affected the most partnerships either somewhat positively (three projects) or not at all (three projects).

C. Implementation supports to improve RPG services

Existing implementation supports and regular data monitoring are crucial ingredients for continuously improving existing services (Permanency Innovations Initiative Training and Technical Assistance Project, 2016) and helping programs operate more efficiently, which improves their ability to sustain their efforts over the long term (Scheirer & Dearing, 2011). Survey respondents reported on their projects' existing implementation supports, such as leadership teams and processes to resolve service delivery issues, and their use of data to improve service provision.

1. Established implementation supports

Respondents reported the extent to which specific supports were in place, whether fully or partially, to support ongoing program implementation. RPG6 projects typically had strong teams and collaborations to support these efforts. Nearly all projects reported having a team fully in place that was responsible for managing the implementation of RPG services (seven of eight

projects). Projects also largely had an interagency collaboration for implementation either fully in place (four of eight projects) or partially in place (three of eight projects). Most RPG projects also established processes to resolve barriers to service implementation, such as inadequate referrals or inadequate staff training (six of eight projects), and nearly all had a process fully or partially in place to assess service quality (seven of eight projects).

2. Use of data to improve service provision

Using data to guide decisions about how to improve program services can facilitate strong service implementation and inform decisions about what services to continue, change, or eliminate (Permanency Innovations Initiative Training and Technical Assistance Project, 2016). Projects analyzed a range of data for program monitoring and improvement (Table VII.3). RPG projects most often analyzed data on barriers to enrollment and engagement, referrals, retention, and program participation. Less than one-half of the projects analyzed data related to staff turnover or partner collaboration issues, although these were often named as barriers in the site visit data (see Chapter IV). Projects were asked to report on the types of data they shared with program directors, frontline staff, or the broader community. RPG6 teams tended to share the same kinds of data that they used for monitoring and improvement—barriers to enrollment, referrals into services, retention and participation in services, and participant outcomes (Table VII.3). However, projects that analyzed data on fidelity appeared to share those data less often.

Table VII.3. Data elements used for program monitoring and improvement

Data source[a]	Number of RPG6 projects analyzing data[b]	Number of RPG6 projects sharing data
Barriers to enrollment or engagement	8	6
Referrals into service	7	6
Participant retention	7	6
Participation in services	7	6
Participant feedback	6	5
Participant outcomes	6	6
Screening for service eligibility	6	5
Fidelity monitoring	5	3
Participant needs assessment	5	5
Referrals to other services	4	4
Staff turnover	3	2
Local partner collaboration issues	3	2
Local, state, or tribal support	2	2

[a] Survey respondents could select multiple data sources, as applicable.

[b] The maximum value is eight RPG6 projects. An RPG6 project is included in the count if the project director and at least one other respondent from the same project marked the same response.

Source: RPG Sustainability and Improvement Survey.

D. Planned implementation supports for sustaining RPG services

While building on existing implementation supports and data-informed program improvement during the grant period, sustainability planning must also account for how these kinds of supports will be maintained. Survey respondents reported on their planning for leadership, implementation processes, and collection and use of data for the services offered beyond the grant period.

1. Planned implementation supports

RPG6 projects made mixed progress on planning implementation supports following the grant period, with more planning done on identifying leadership and less progress on laying out procedures for teams to follow. Three-quarters of RPG6 projects identified an organization to lead the partnership after RPG6 funding ended, such as the lead entity, a partner organization, or a collaborative leadership of at least two partners. Similarly, three-quarters of RPG6 projects had a team either partially or fully in place for managing implementation of the sustained RPG services and a process to resolve barriers to implementation of the sustained RPG services. Project teams made less progress on planning a process to assess quality of the sustained RPG services—only three projects had this partially or fully in place, whereas four teams were not planning for it at all at the time of the survey.

2. Plans for data collection to improve service provision

In addition to planning leadership and processes to continue services, planning for the collection and use of data is important so that project leaders can make good decisions and continuously improve the quality of their service offerings (Permanency Innovations Initiative Training and Technical Assistance Project, 2016). Respondents indicated whether they planned to collect various types of data after RPG6 funding ended and the progress made toward identifying how data would be collected, stored, organized, and shared (Table VII.4). The types of data RPG6 projects most often planned to collect unsurprisingly fell into similar categories as those they already analyzed for monitoring and service improvement (Table VII.3): enrollment, participation, and referrals into services. Over one-half of RPG6 projects (five of eight projects) planned to continue collecting data on participant feedback, needs, outcomes, and eligibility screening. One-half of the projects also reported that they planned to continue collecting data for fidelity monitoring and on referrals to other services.

RPG6 projects were not as far along with planning their processes for using these data. Projects planning to collect data on participant enrollment and participation in services made the most progress in determining how the data would be collected, stored, and analyzed (ranged from three to five projects). However, for the remaining data sources, three or fewer project teams made progress on determining how the data would be used. For projects planning to collect data on fidelity and referrals to other services, no progress was made in determining how the data would be collected, used, and stored. Across all data elements, projects made very little progress on determining how any of the data sources would be shared.

Table VII.4. Data collection planning after end of grant period

Data source	Number of RPG projects planning to collect data[a]	Number of RPG projects with plans for how data will be:[b]			
		Collected	Stored	Organized	Shared
Enrollment	6	5	4	4	1
Participation in services	6	3	4	3	0
Referrals into service	6	3	2	2	0
Participant feedback	5	2	3	1	0
Participant needs assessment	5	2	3	2	0
Participant outcomes	5	2	3	1	0
Screening for service eligibility	5	2	3	3	1
Fidelity monitoring	4	0	0	0	0
Referrals to other services	4	0	0	0	0

[a] The maximum value is eight RPG6 projects. An RPG6 project is included in the count if the project director and at least one other respondent from that project marked the same response.

[b] Survey respondents could select multiple responses for how far along plans were, as applicable.

Source: RPG Sustainability and Improvement Survey.

E. Funding and resources to sustain RPG services

Programs must pay attention to and explore a variety of financial strategies and revenue streams to sustain their direct services and implementation supports after the end of a project (Permanency Innovations Initiative Training and Technical Assistance Project, 2016). Although implementation supports and data-driven decision making are important for sustaining services, funding is also a critical element necessary for organizations to sustain services. Survey respondents reported on activities to plan and prepare for financing RPG services beyond the grant period and the funding sources identified to make that possible.

1. Plans for funding sustained services

Most RPG6 projects engaged in activities to plan and prepare for financing after the grant ended. Five projects reported that they had at least partially or fully determined annual costs to sustain RPG services. Six projects reported that they identified or partially identified possible funding sources for personnel and other resources that were necessary to carry out RPG services. However, securing financing to sustain RPG services was not as far along—only one project reported securing financing for services after the end of the RPG funding period.

RPG6 projects made marginal progress on leveraging existing partnerships and identifying new partners to finance services after the end of their RPG funding. Two projects reported that planning and preparations to extend or renew partnerships were underway, but no project teams had completed this activity. Similarly, work was underway on two project teams to identify new organizations to work with. No other teams had made progress on this dimension.

2. Funding sources

Establishing a financial base for a program is critical to its sustainability (National Center for Substance Abuse and Child Welfare, n.d.). Funding to sustain RPG services can come from a number of sources, including federal, state, or local governments. Survey respondents were asked whether their organizations would contribute financial resources after RPG6 funding ended. For half of the projects, at least one partner organization within the project team planned to contribute financial support after RPG6 funding ended. The same partner organizations from within these four project teams also reported that they planned to contribute in-kind resources, including staff time, office space and supplies, program materials, and computers and communication technology. The remaining four projects did not have partners that planned to contribute financial resources after RPG6 funding ended.

In identifying potential sources of funding to pay RPG project staff, seven projects noted that their organizations planned to use state funding sources. Site visit interviews with the RPG6 projects (see Chapter IV) reflected the same intentions as reported in the survey. Interview data showed that project teams were exploring state funding, such as that available through state child welfare or behavioral health agencies. However, staff interviewed as part of the site visits described barriers to establishing state funding, such as state staff turnover, challenging bureaucracy, or a lack of political will.

Two RPG projects planned to use federal funding sources to maintain services, and one project planned to use local resources.[56] RPG6 projects did not plan to use other sources of funding to potentially pay staff, such as foundations or fundraising.

F. Summary

All eight RPG6 projects planned to sustain their services, and seven of them accomplished a moderate amount of sustainability planning at the time of the survey. Most projects had identified an organization to lead the partnership after RPG6 funding ended and had made substantial progress in determining which services to continue and data to collect about those services. However, the projects made less progress on plans to sustain funding for the services.

RPG6 projects had strong implementation supports and data collection infrastructure in place, suggesting the capacity to continue services after RPG6 funding ended. Most projects had a team in place to manage RPG services, a process to resolve barriers to implementing services, and a process to assess service quality. Additionally, most projects reported that they analyzed data to inform program improvement and shared data with staff, partners, and the community.

Although only one project had a funding source in place, seven projects planned to use state funding sources (versus federal, local, or other sources) to pay staff and sustain services. For one-half of the RPG6 projects, respondents reported that their organizations planned to contribute financial and in-kind resources beyond the RPG6 funding period.

[56] Although only two RPG6 projects planned to use federal funding for sustaining services, four of the eight RPG6 grant recipients were funded under the seventh cohort of RPG projects in 2022. However, each RPG project funded under separate rounds is intended to be a stand-alone project and not a way to support a previous set of services from a different round of funding.

VIII. INTRODUCTION TO RPG PROJECTS FUNDED IN 2022 (RPG7)

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

This chapter introduces the RPG7 cohort, made up of 18 5-year RPG projects funded in September 2022, first summarizing their activities during the planning period. Next, the chapter describes the people projects planned to serve, the services they planned to offer, the entities involved in the partnerships, and planned features of their required local evaluations. Information in this chapter reflects what projects reported after 14 months of the grant (November 2023).[57] At that point, all grant recipients had concluded their planning period and begun full implementation of their projects, with CB approval. Several of the partnerships were still making final decisions about their planned services or their evaluation designs. Information for the chapter is drawn from the funding applications submitted by RPG7 projects; the federally required semi-annual progress reports completed by grant recipients; grant recipient profiles; RPG7 projects' implementation and evaluation plans; and notes from meetings with grant recipients, their local evaluators, federal staff, and TA liaisons, which were held on a regular schedule from October 2022 through November 2023.

A. Planning period

During the planning period, HHS expected grant recipients to prepare for program implementation, their local evaluation, and their participation in the cross-site evaluation. Common activities the partnerships completed during their planning year included (1) holding steering committee meetings; (2) establishing lines of communication between the project and evaluation teams and specifying roles for all team members; (3) refining the focal population and criteria for eligibility; (4) outlining recruitment and enrollment procedures and protocols with referral partners; (5) building lead entities' and key partners' capacity and readiness for implementation and evaluation; (6) refining and strengthening local evaluation designs; (7) creating databases and processes for securely collecting and storing participant data for local use; (8) working to secure IRB approvals and data sharing agreements with the state; and (9) hiring project staff to implement the program.

Each grant recipient chose the length of their planning period. One project had a five-month planning period; seven projects had a six-month planning period; two projects had a nine-month planning period; and eight projects had a one-year planning period. This differs from RPG6 projects, which all had a one-year planning period.

[57] For information summarizing the types and number of partners in each RPG project, this chapter also uses data from the April 2024 semi-annual progress reports completed by grant recipients.

1. Group-based supports for RPG7 projects during the planning period

HHS led three group-based events to support RPG7 projects during their planning period. First, HHS held a 90-minute orientation webinar with the 18 RPG7 projects in November 2022, shortly after the grants were awarded. Second, HHS hosted a two-day virtual kickoff meeting on February 28 and March 1, 2023. Third, HHS led a two-day virtual annual grant recipient meeting with the three active RPG cohorts in May 2023 (RPG5, RPG6, and RPG7 cohorts).

Outside of these meetings, the TA team presented webinars and made virtual spaces available for grant recipients to share their experiences. NCSACW staff facilitated meetings, called communities of practice, for the active RPG5, RPG6, and RPG7 projects. These small-group meetings, which were held virtually, brought together projects with similar focal populations or service delivery methods to discuss common issues or opportunities. In addition, Mathematica's cross-site evaluation team, including the cross-site evaluation liaisons, held trainings and peer learning calls for the active RPG5, RPG6, and RPG7 projects on topics relevant to the cross-site evaluation; the trainings and calls also helped build local evaluation capacity. For example, the cross-site evaluation team held an interactive peer learning call on using data to support evaluation monitoring and problem-solving, and another interactive call on comparison group recruitment. Mathematica also released several prerecorded trainings for RPG projects on the data collection and submission requirements of the cross-site evaluation.

2. Supports for individual RPG7 projects during the planning period

In addition to group-based activities, the TA teams provided focused one-on-one TA to each RPG7 project, including program and local evaluation staff. The project-specific TA included monthly calls, site visits, and additional supports as needed. Throughout the planning period, the federal TA teams held monthly one-hour calls with selected members of each RPG7 project to cover updates, questions, and concerns about the program and the evaluation. From February through October 2023, the federal TA teams held a site visit with each project. The purpose was to offer additional TA as grant recipients finalized their implementation and evaluation plans. The cross-site evaluation liaison planned evaluation-focused sessions during the site visits. Common topics were how participants would flow through program services from enrollment through completion; the local evaluation design; and planned data collection procedures. Meanwhile, the change liaison planned sessions on program-focused topics such as walking through how participants would move from referral to program enrollment.

3. Implementation and evaluation plans

HHS expected projects to refine their programs and local evaluations during the planning period. For example, projects finalized their data collection procedures, executed (1) data sharing agreements with state agencies to obtain administrative data, and (2) memoranda of understanding with formal partners.

To formalize their final plans and ensure HHS approval, the grant recipients' planning period culminated in a project implementation and evaluation plan. Each grant recipient produced the

plan on behalf of the partnership and submitted it to their federal project officer for review. Each project's federal project officer asked the change liaison and cross-site evaluation liaison for each site to review the plans. Projects submitted their implementation and evaluation plans on a rolling basis, depending on the length of their planning period. HHS approved the implementation and evaluation plans between March and November 2023.

B. Focal populations

RPG projects work with families in which adults have a suspected or diagnosed SUD, and children are at risk of maltreatment. Children might have substantiated reports of maltreatment, or they might already have been removed from their homes and placed in foster care, or they might not have experienced maltreatment but are at risk for it. Projects typically define the population they intend to serve more narrowly based on the needs of their communities and a consideration of who would benefit from their planned services. As shown in Table VIII.1, the RPG7 projects narrowed their service population by planning to enroll families with children within specific age ranges and degrees of involvement with the child welfare system.

Four projects planned to enroll pregnant women, with 1 project solely focusing on this population, 1 focusing on enrolling prenatal women with children up to age 2, and 2 focusing on enrolling prenatal women with children up to age 5. Three projects planned to enroll families with children whose ages ranged from birth to early adolescence (up to age 12). Ten projects intended to include families with children whose ages ranged from birth to 17 or 18. Finally, 1 project planned to focus on serving families with children between the ages of 9 and 21.

Six projects planned to focus on families in three categories of child welfare involvement (namely, those at risk of child welfare involvement because of parental substance use, those with an active child welfare case, and those seeking reunification after a child was removed from the home). Seven other projects planned to focus on two of the categories: four planned to focus on families with an open child welfare case and families seeking reunification, and three planned to focus on families with an open child welfare case and those at risk of child welfare involvement. The remaining five projects planned to focus on just one category of child welfare involvement. Two of these focused on those with an open child welfare case, two focused on families at risk of child welfare involvement, and one focused on families seeking reunification.

Table VIII.1. RPG7 planned focal populations

State and grant recipient	Age of child at enrollment	Status of child welfare system involvement at enrollment		
		At risk of involvement with child welfare	Child welfare involvement, child at risk of removal from home	Child welfare involvement, child removed from the home
Alaska: Cook Inlet Tribal Council Inc.	0–17		X	X
Connecticut: State of Connecticut Department of Children and Families	Prenatal–5	X	X	X
Florida: Broward Behavioral Health Coalition Inc.	Prenatal	X		
Illinois: Centerstone of Illinois Inc.	0–17		X	X
Illinois: Youth Network Council, dba Illinois Collaboration on Youth	0–17		X	
Iowa: Florence Crittenton Home of Sioux City	9–21			X
Iowa: Judiciary Courts for the State	0–8	X	X	X
Kentucky: Mountain Comprehensive Care Center	0–17		X	X
Louisiana: Volunteers of America Southeast Louisiana Inc.	0–12		X	
Missouri: CPR of the Ozarks	0–18	X	X	X
Missouri: Preferred Family Healthcare Inc.	0–17	X		
New York: Montefiore Medical Center	0–17	X	X	
Oklahoma: Oklahoma Department of Mental Health and Substance Abuse Services	Prenatal–2	X	X	X
Pennsylvania: Health Federation of Philadelphia	Prenatal–5	X	X	
Tennessee: Helen Ross McNabb Center	0–5	X	X	X
Tennessee: Tennessee Department of Mental Health and Substance Abuse Services	0–18		X	X
West Virginia: Prestera Center for Mental Health Services Inc.	0–18	X	X	X
Wisconsin: Meta House Inc.	0–17	X	X	

Note: This information reflects grant recipients' plans as of November 2023. For some grant recipients, the description of their intended population may evolve over time as their plans change.

Sources: Calls between Mathematica and grant recipients, local evaluators, federal project officers, and programmatic TA providers that took place from October 2022 through November 2023; grant recipient profiles; and projects' semi-annual progress reports.

C. Planned services and service recipients

HHS requires RPG applicants to propose specific, well-defined, high-quality program services and activities that are supported or informed by evidence. However, there is no specified program model that partnerships must implement. Instead, grant recipients design their RPG projects to meet the needs of their states or communities and the populations that they plan to serve. They do this by offering a range of direct services, usually in one or more of the following categories: (1) case management or service coordination; (2) screening or assessment; (3) parenting or family strengthening, through methods such as a parenting curriculum or family problem-solving; (4); trauma or mental health treatment; (5) SUD treatment; (6) coaching or mentoring from a peer with experience recovering from SUD; (7) transportation; and (8) financial or material supports.

The RPG7 project teams planned to use the grant to offer families an array of services spanning two or more of these categories (Table VIII.2). Fourteen grant recipients planned to offer a wide service array, spanning at least five of the service categories. All 18 RPG7 projects planned to provide case management or service coordination. Fifteen planned to offer screening or assessment, whereas 13 planned to provide parenting or family strengthening supports. Thirteen planned to provide trauma or mental health treatment. Twelve planned to provide SUD treatment.

Most grant recipients planned on serving the adult (such as through SUD treatment or peer support groups) and/or the family unit (such as through a family-centered therapeutic intervention, parenting training, or home visiting focused on both children and caregivers). Nine planned to serve children directly through, for example, trauma-informed cognitive behavioral therapy or referrals to other services.

In their grant applications, the RPG7 projects named a total of 54 specific program models they planned to implement. They generally listed well-defined or manualized programs, curricula, or practices. Individual projects named between 1 and 16 program models to offer adults, families or children (Appendix Table A.1). Three grant recipients proposed 10 or more service models, often combining multiple program models and multiple service domains into a comprehensive treatment approach. Overall, most of the models addressed trauma and mental health care (22 models), parent training or family strengthening (13 models), and treatment of substance use disorder (8 models). The model that the most projects planned to deliver was the Nurturing Parenting Program. It is a parenting course for families with a parent in recovery from SUD. Eight of the 18 projects planned to offer it.

Table VIII.2. Planned services and service recipients for RPG7 projects

State and lead entity	Intended recipients of services	Types of RPG services planned							
		Case management or service coordination	Screening or assessment	Parenting/family strengthening	Trauma or mental health treatment	SUD treatment	Peer coaching, mentoring, or support	Transportation	Financial or material supports
Alaska: Cook Inlet Tribal Council Inc.	Adult, family, child	X	X	X	X		X	X	
Connecticut: State of Connecticut Department of Children and Families	Adult, family	X	X	X	X	X			
Florida: Broward Behavioral Health Coalition Inc.	Adult	X	X				X		
Illinois: Centerstone of Illinois Inc.	Adult, family, child	X	X	X	X		X		
Illinois: Youth Network Council, dba Illinois Collaboration on Youth	Adult, family, child	X	X	X				X	X
Iowa: Florence Crittenton Home of Sioux City	Child, family	X	X		X	X	X		
Iowa: Judiciary Courts for the State	Family	X	X						
Kentucky: Mountain Comprehensive Care Center	Adult, child	X	X	X	X	X	X	X	X
Louisiana: Volunteers of America Southeast Louisiana Inc.	Adult, family	X	X	X	X	X	X	X	X
Missouri: CPR of the Ozarks	Adult, family, child	X	X	X	X	X		X	
Missouri: Preferred Family Healthcare Inc.	Adult, family	X	X	X	X	X	X	X	X
New York: Montefiore Medical Center	Adult	X	X	X	X				X
Oklahoma: Oklahoma Department of Mental Health and Substance Abuse Services	Adult	X				X			
Pennsylvania: Health Federation of Philadelphia	Adult, family	X	X	X	X	X			X
Tennessee: Helen Ross McNabb Center	Adult, family, child	X	X	X	X	X		X	X
Tennessee: Tennessee Department of Mental Health and Substance Abuse Services	Adult, family, child	X	X	X	X	X		X	X
West Virginia: Prestera Center for Mental Health Services Inc.	Adult, family	X				X	X	X	
Wisconsin: Meta House Inc.	Adult, family, child	X		X	X	X	X		

Note: This information reflects grant recipients' plans as of November 2023. The description of some grant recipients' services and their intended recipients may evolve over time as their plans change. Adult = adult-only services (such as SUD treatment), Child = child-only services (such as play therapy), Family = the family unit or parent-child dyad (such as home visiting focused on parent and child).

Sources: Calls between Mathematica and grant recipients, local evaluators, federal project officers, and programmatic TA providers that took place from October 2022 through November 2023; grant recipient profiles; and projects' semi-annual progress reports.

D. Partnerships

In RPG projects, services are typically planned and implemented through partnerships that include the grant recipient, other public agencies, and other community service providers. Collaboration is an inherent part of the RPG funding stream and is often the means through which lead entities gain community support, identify eligible families, and offer them the variety of services outlined above. As required by the legislation, partners for RPG7 must include the state child welfare agency responsible for administering the state plan under Title IV-B or Title IV-E of the Social Security Act, and the state agency responsible for administering the substance use prevention and treatment block grant provided under Subpart II of Part B of Title XIX of the Public Health Service Act 42 U.S.C. 629(f)(2)(A). If the partnership serves children in an out-of-home placement, the collaboration must include the Juvenile Court or Administrative Office of the Courts that oversees the administration of court programs that address the population of families who come to the attention of the court due to child abuse or neglect.

As expected, all RPG7 partnerships included the state or local child welfare agency (for 17 projects, the agency was a partner to the grant recipient organization, and for 1 project, the agency was the grant recipient organization), and all but one partnership included the state or local substance use or mental health system agency (for 15 projects, the agency was a partner to the grant recipient organization, and for 2 projects, the agency was the grant recipient organization) (Table VIII.3). Court or judicial systems involved in child welfare dependency cases were involved as partners on 14 projects.

As of April 2024, the RPG7 cohort included 190 partner organizations across the projects, ranging from 5 to 31 per project, including the grant recipient agencies.[58] The different project designs were responsible for some of the variation across projects. Some projects required a wider network of supports than others; some preexisting partnership structures were stronger than others; and the availability of community services and supports varied.

[58] RPG projects began implementing programs on a rolling basis as their implementation plans were approved, and partnership composition continued to evolve as implementation began. To summarize the composition of partnerships after at least six months of program implementation for each project, this report draws on data from the April 2024 semi-annual progress reports.

Table VIII.3. Type and numbers of organizations involved in RPG7 projects

	AK	CT	FL	IL-C	IL-ICOY	IA-FC	IA-JC	KY	LA	MO-CPR	MO-PFH	NY	OK	PA	TN-DMHSAS	TN-HRM	WV	WI	Total: Organizations	Total: RPG7 projects
State or local child welfare agency	1	1	2	1	1	1	1	1	1	1	1	2	1	2	1	1	1	1	**21**	**18**
State or local substance use or mental health agency	1	1	1	1	1	1	1	1	1		1	2	1	1	1	1	1	1	**18**	**17**
Courts	1	1		4		1	2	1	1	3	3		1		1	1	1	1	**22**	**14**
Other state or local government agency		2		2					1						2				**7**	**4**
SUD and/or mental health treatment provider		1	1	1	2	1		1	9	7	2		3	3	2	1	2	1	**37**	**15**
Child and family social services organization	1			6	4	1		2	1	3	1			1	1	1			**22**	**11**
University (including university-based local evaluators)				2			1	1	3			2	2				1		**12**	**7**
Private evaluator (non-university)	1	1	1		1	1			1	1				1	1			1	**10**	**10**
Health care				3			1		2	3			1						**10**	**5**
Other types		4	3	12	1		1	3	4	4			1						**33**	**9**
Number of organizations	**5**	**11**	**8**	**32**	**10**	**6**	**7**	**10**	**24**	**22**	**8**	**6**	**10**	**8**	**9**	**5**	**6**	**5**	**190**	**-**

Note: This information reflects grant recipients' plans as of April 2024. The description of some grant recipients' services or local evaluation design may evolve over time as their plans change. IL-C = Centerstone; IL-ICOY = Youth Network Council, dba Illinois Collaboration on Youth; IA-FC = Florence Crittenton Home of Sioux City; IA-JC = Judiciary Courts for the State of Iowa; MO-CPR = CPR of the Ozarks; MO-PFH = Preferred Family Health; TN-DMHSAS = Department of Mental Health and Substance Abuse Services; TN-HRM = Helen Ross McNabb Center.

Sources: Grant recipient profiles; projects' implementation and evaluation plans; grant applications; calls between cross-site evaluation TA liaisons and grant recipients held from October 2022 through November 2023, and projects' semi-annual progress reports.

E. Local evaluations

HHS requires projects to conduct local evaluations to learn more about the implementation and outcomes of their unique set of services. RPG7 project teams proposed local impact or outcome evaluations and process evaluations as part of their funding applications, and during the planning period, they worked to refine and finalize their plans. Plans for the local impact or outcome evaluations are described in Table VIII.4.

Evaluation designs. HHS asked the projects to propose impact evaluation designs that featured treatment and comparison groups. The treatment group received RPG services, and the comparison group did not. Projects identified a comparison group that was intended to be similar to the treatment group, so that the comparison group could represent what would have happened to people in the treatment group if they had not received RPG services. As of November 2023, 15 of the 18 projects had proposed impact evaluations, using either a quasi-experimental design (QED) or randomized controlled trial (RCT). In a QED, the treatment and comparison groups are assigned by a nonrandom process, such as self-selection or staff assignment, whereas in an RCT, the treatment and comparison groups are formed using a random process. Ten RPG7 projects planned to use a QED for their local impact evaluation, and five proposed an RCT. The remaining three projects proposed outcome evaluations, which descriptively examine the change in outcomes for the treatment group over time. The projects planned to enroll between 100 and 415 families into their evaluation (across program and comparison groups).

Services tested. The RPG7 local evaluations were generally designed to measure the impact of the new services that projects added by using RPG funds. Projects that added, for example, a home visiting model to business-as-usual offerings designed evaluations to assess the effectiveness of the new home visiting piece. RPG7 projects implementing a combination of services planned to assess the impact of the combination. Fifteen projects planned to test their RPG services by comparing a treatment group, which was offered the usual standard of care plus the new RPG services, to a comparison group of similar families who were not receiving the full array of RPG services.[59]

Future reports to Congress will share findings on services delivered by RPG7 projects, participant characteristics, and participant outcomes.

[59] For nine projects, the comparison group received business-as-usual child welfare, behavioral health, and/or SUD treatment services. (One of these nine projects planned to have a second comparison group that receives a subset of the RPG services.) Five projects planned to provide the comparison group with a subset of the program group's RPG services, but not the full array. One project planned to offer the comparison group a different evidence-based program than the one offered to the program group.

Table VIII.4. Summary of RPG7 projects' planned local evaluations

State and grant recipient organization	Local evaluation design			Services tested		Enrollment goal for evaluation (number of families)		
	RCT	QED	Outcome	Treatment group	Comparison group	Treatment	Comparison	Total
Alaska: Cook Inlet Tribal Council Inc.			X	Nurturing Parenting for Families in Substance Abuse Treatment and Recovery: a trauma-informed, evidence-based program that uses psychoeducational and cognitive behavioral approaches with parents and children; intensive case management; peer recovery support; family contact (visitation) support; and optional services including a trauma support group and community-based activities for the family	Not applicable	100	Not applicable	100
Connecticut: State of Connecticut Department of Children and Families	X			Multidimensional Family Therapy and Recovery, an intensive, home-based approach to outpatient behavioral health treatment that serves the family unit and incorporates components to address parental substance use, co-occurring mental health problems, family functioning, and healthy relationships	Business-as-usual outpatient behavioral health treatment	114	114	228
Florida: Broward Behavioral Health Coalition Inc.		X		Home visiting services, including prenatal and parenting education; stress management; care coordination; screenings for perinatal depression, intimate partner violence, tobacco use, substance use, and child development; an individualized plan of care; a family support plan; Broward Healthy Start Coalition Behavioral Health Program model from a peer and services specialist; and peer navigation approach that uses motivational interviewing to engage mothers in the recovery process and other needed services, including substance use treatment	Business-as-usual home visiting and the Broward Healthy Start Coalition Behavioral Health Program from a peer and services specialist	105	105	210

State and grant recipient organization	Local evaluation design			Services tested		Enrollment goal for evaluation (number of families)		
	RCT	QED	Outcome	Treatment group	Comparison group	Treatment	Comparison	Total
Illinois: Centerstone of Illinois Inc.	X			Nurturing Parenting Program for Families in Substance Abuse Treatment and Recovery and trauma-informed cognitive behavioral therapy for the family's children	Strengthening Families Program, an evidence-based program focused on family skill building, and trauma-informed cognitive behavioral therapy for the children in the family	150	150	300
Illinois: Youth Network Council, dba Illinois Collaboration on Youth			X	Standard child welfare case management services through Intact Family Services, enhanced with a recovery coordinator for specialized case management	Not applicable	384	Not applicable	384
Iowa: Florence Crittenton Home of Sioux City			X	Emergency shelter housing and at least one of the following services: Attachment, Self-Regulation, and Competency (ARC); enhanced therapeutic supervised visits between children in congregate care and their families, kin, or foster families; Teaching Family Model; and cognitive behavioral therapy models	Not applicable	415	Not applicable	415

State and grant recipient organization	Local evaluation design			Services tested		Enrollment goal for evaluation (number of families)		
	RCT	QED	Outcome	Treatment group	Comparison group	Treatment	Comparison	Total
Iowa: Judiciary Courts for the State	X			A new Family Resource Center (FRC) that (1) screens children for medical and developmental risks; (2) conducts a comprehensive child assessment (with social, medical, and developmental history, a medical exam, and developmental or psychological assessment) and develops a treatment plan, with clinicians receiving tele-mentoring support to develop the plan; and (3) refers families to services based on the treatment plan	All FRC services offered to the treatment group except tele-mentoring support for the clinicians	100	100	200
Kentucky: Mountain Comprehensive Care Center		X		Intensive outpatient program for SUD treatment, including integrated mental health care, trauma-informed care, case management, recovery peer supports, parenting and life skills training, and continuing care (services during early recovery and maintenance stages)	Business-as-usual SUD services, including residential, outpatient, and drug court programs. Some comparison group families might not receive any services.	200	200	400
Louisiana: Volunteers of America Southeast Louisiana Inc.		X		Residential SUD services and after-care services, along with community-based, outpatient SUD services, care coordination, and peer support	Group 1: Business-as-usual residential SUD and after-care services offered by another service provider Group 2: Same community-based, outpatient SUD services, care coordination, and peer support as the treatment group, but no residential SUD services or after-care services	120	Group 1: 120 Group 2: 30	Group 1: 240 Group 2: 150

State and grant recipient organization	Local evaluation design			Services tested		Enrollment goal for evaluation (number of families)		
	RCT	QED	Outcome	Treatment group	Comparison group	Treatment	Comparison	Total
Missouri: CPR of the Ozarks		X		Family support specialist guides family through services based on their needs, using home visiting, comprehensive treatment planning, parent education, and screenings and assessments; additional needs-based services could include SUD treatment, anger management classes, employment assistance, additional parent education, skills education, individual and family therapy, and case management	Business-as-usual basic treatment planning, parent education classes, anger management classes, drug testing, SUD assessment, SUD treatment, teen parenting classes, independence skills training for teens, individual therapy, and family therapy	140	90	230
Missouri: Preferred Family Healthcare Inc.	X			Core services (trauma-informed, comprehensive, strength-based screening and assessment of needs; enhanced case management from a family peer advocate; parenting support; peer recovery mentoring; SUD treatment; two evidence-based programs called Living in Balance and Helping Men/Women Recover; and the Stress Management and Resiliency Training program); additional needs-based services could include financial and transportation assistance and access to employment and job-training or skill-building services	All core services offered to the treatment group except the Stress Management and Resiliency Training program	88	88	176
New York: Montefiore Medical Center	X			Father-specific parenting education and employment training program, case management, Motivational Enhancement Therapy, and contingency management	Business-as-usual community and SUD treatment services	160	80	240

State and grant recipient organization	Local evaluation design			Services tested		Enrollment goal for evaluation (number of families)		
	RCT	QED	Outcome	Treatment group	Comparison group	Treatment	Comparison	Total
Oklahoma: Oklahoma Department of Mental Health and Substance Abuse Services		X		Training and support for behavioral health treatment providers to (1) implement Parent-Child Assistance Program and Family Care Plans, and (2) build a collaborative cross-system implementation team to strengthen referral pathways (including to birthing hospitals)	Business-as-usual services from behavioral health and substance use treatment providers and birthing hospitals	75	75	150
Pennsylvania: Health Federation of Philadelphia		X		Peer recovery services, Mothering from the Inside Out integrated with Child-Parent Psychotherapy, and residential SUD treatment	All services offered to the treatment group except peer recovery services	90	60	150
Tennessee: Helen Ross McNabb Center		X*		Prenatal plans of safe care and family-centered treatment using practices including Seeking Safety, Eye Movement Desensitization and Reprocessing, Nurturing Parenting Program, Circle of Security, and Child-Parent Psychotherapy	Business-as-usual SUD treatment services	100	100	200
Tennessee: Tennessee Department of Mental Health and Substance Abuse Services		X		HOMEBUILDERS, which provides intensive in-home family preservation services	Business-as-usual family preservation services	115	100	215
West Virginia: Prestera Center for Mental Health Services Inc.		X		Wraparound services from a care coordinator, peer recovery coach, and/or a family therapist, with services including Seeking Safety, eco-systemic structural family therapy, and motivational interviewing	Business-as-usual child welfare, behavioral health, and SUD treatment services	180	75	255

State and grant recipient organization	Local evaluation design			Services tested		Enrollment goal for evaluation (number of families)		
	RCT	QED	Outcome	Treatment group	Comparison group	Treatment	Comparison	Total
Wisconsin: Meta House Inc.		X		Recovery-supportive housing program for women and their children, including intensive child and family services, peer support services, and Meta House's business-as-usual outpatient SUD treatment program	Meta House's business-as-usual outpatient SUD services	72	72	144

Notes: * = The grant recipient is conducting a quasi-experimental design using only administrative data; dba = doing business as; QED = quasi-experimental design; RCT = randomized controlled trial; SUD = substance use disorder. This information reflects grant recipients' plans as of November 2023. The description of some grant recipients' services or local evaluation design may evolve over time as their plans change.

Sources: Grant recipient profiles; projects' implementation and evaluation plans; grant applications; calls between cross-site evaluation TA liaisons and grant recipients held from October 2022 through November 2023; projects' semi-annual progress reports.

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Appendix A

Previous Reports to Congress About RPGs

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Table A.1. Previous reports to Congress about RPG cohorts

RPG cohort	Report title	Year submitted to Congress
RPG1	Targeted grants to increase the well-being of and to improve the permanency outcomes for children affected by methamphetamine or other substance abuse: First annual report to Congress[a]	2012
RPG1	Targeted grants to increase the well-being of and to improve the permanency outcomes for children affected by methamphetamine or other substance abuse: Second annual report to Congress[a]	2013
RPG1	Targeted grants to increase the well-being of and to improve the permanency outcomes for children affected by methamphetamine or other substance abuse: Third annual report to Congress[a]	2014
RPG1	Targeted grants to increase the well-being of and to improve the permanency outcomes for children affected by methamphetamine or other substance abuse: Fourth annual report to congress[a]	2017
RPG2	2012 Regional Partnership Grants to increase the well-being of and to improve the permanency outcomes for children affected by substance abuse: First annual report to Congress	2014
RPG2	2012 Regional Partnership Grants to increase the well-being of and to improve the permanency outcomes for children affected by substance abuse: Second annual report to Congress	2015
RPG2, RPG3	2012 and 2014 Regional Partnership Grants to increase the well-being of and to improve the permanency outcomes for children affected by substance abuse: Third annual report to Congress	2016
RPG2, RPG3	2012 and 2014 Regional Partnership Grants to increase the well-being of and to improve the permanency outcomes for children affected by substance abuse: Fourth annual report to Congress	2019
RPG2	2012 Regional Partnership Grants to increase the well-being of and to improve the permanency outcomes for children affected by substance abuse: Fifth annual report to Congress	2020
RPG3, RPG4	2014 and 2017 Regional Partnership Grants to increase the well-being of and to improve the permanency outcomes for children affected by substance abuse: Sixth report to Congress	2021
RPG4, RPG5, RPG6	Regional Partnership Grants to increase the well-being of and to improve the permanency outcomes for children affected by substance abuse: Seventh report to Congress	2023
RPG4, RPG5, RPG6	Regional Partnership Grants to increase the well-being of and to improve the permanency outcomes for children affected by substance abuse: Eighth Report to Congress	2024

[a] A separate contractor prepared the reports to Congress for RPG1, which concluded before the cross-site evaluation began with RPG2.

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Appendix B

Data Sources

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Projects submit some data to the cross-site evaluation contractor, and the contractor collects additional data from grant recipients and their partners. The time frame covered by the data varies by their source and the RPG cohort. This appendix describes the data sources and the time frames used in this report.

1. Data that grant recipients submit for the cross-site evaluation

Grant recipients, their partners, or local evaluation contractors provide several types of data used by the cross-site evaluation and discussed in this report:

- **Semi-annual progress reports.** HHS requires grant recipients to submit written progress reports twice a year. The semi-annual progress reports describe the partner agencies and their activities, project implementation, and successes and challenges experienced by the projects during each six-month reporting period.
- **Enrollment and services.** Grant recipients or their partner agencies enter data on the people they have enrolled and the services those people receive into a federally approved, secure data collection system built for the cross-site evaluation.[60] The system is known as the RPG Evaluation Data System (RPG-EDS).
- **Outcomes from standardized instruments and administrative data.** Grant recipients and their evaluators also upload to RPG-EDS data on family and child outcome measures. Projects collect outcome data by administering standardized data collection instruments to adults in families enrolled in the RPG cross-site evaluation at enrollment (baseline) and project exit (follow-up). They also request administrative data on enrolled children or adults from the relevant child welfare and substance use treatment agencies in their states. For the cross-site evaluation, HHS asked grant recipients to collect administrative data across the enrolled adults' and children's lifetimes, but some grant recipients only collect data for the year before enrollment in RPG through project exit.

2. Data collected by the cross-site evaluation contractor

The cross-site evaluation team collects additional data to enable closer examination of how the partnerships function and implement their RPG projects. First, the cross-site evaluation team reviews the RPG grant applications and implementation plans, along with project summaries that the partnerships develop during the first year of each grant. These documents were available for all three cohorts. In addition, the team collects the following data:

- **Sustainability survey.** The team administered a sustainability survey to a representative from the RPG6 grant recipient and from each partner organization identified by the grant recipient. The survey included questions along five broad topics (1) organizational characteristics, (2) plans for sustaining RPG project, (3) implementation supports to improve and maintain RPG services, (4) funding and resources for sustainability, and (5) the federal,

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

state, and local context. The survey was administered once during the grant period. The cross-site evaluation team used statistical methods to analyze the resulting data.

- **Site visits.** To better understand partnerships between child welfare and substance use treatment agencies, the team conducted site visits with each project once during the grant period. Using protocols approved by Office of Management and Budget to guide their discussions, team members met one-on-one or in small groups with leaders and staff members from the grant recipient and partner agencies. The team members talked with representatives from child welfare and substance use treatment agencies, including directors, managers, administrators, supervisors, and direct service staff. The team conducted qualitative analyses of the field notes and summaries from the visits. The site visits were conducted virtually in six of the RPG6 projects, and in person with the two projects that participated in the parent interviews (see below).
- **Parent interviews.** To learn more about the parents enrolled in RPG services, two RPG6 projects participated in a pilot of qualitative data collection activities, including in-depth interviews and focus groups. Using semi-structured protocols to guide their discussions, team members met with 16 parents who had a current or previous open child welfare case and substance use issue. Eight parents participated in in-depth interviews designed to understand the factors over time that led to their substance use and child welfare system involvement. Eight parents participated in focus groups designed to understand their experiences in services provided by the two projects. The team conducted qualitative coding of the transcripts from these interviews to identify overarching themes from the data.

3. Time frame and grant recipients' data contributions by data source

As shown in Table B.1, the timespan that the data cover differs by cohort and data source. For RPG5, data cover a period of about four years, from March 2019 through May 2023, for most data sources. For RPG6 projects, the data cover about three and a half years, from October 2020 through March 2024, for most data sources.[61] For RPG7 projects, the data in this report extend from October 2022 through March 2024.[62]

Most grant recipients contributed the expected data to the cross-site evaluation. Because the RPG7 cohort members are earlier in their grant cycle, they had participated in fewer data activities as of 2024.

[61] Data collection for the cross-site evaluation began after each cohort's planning period. RPG5 grant recipients had a 5-month planning period for their local evaluation, and RPG6 grant recipients had a 12-month planning period.
[62] Data collection for the cross-site evaluation for RPG7 began after the cohort's planning period, which ranged from 6 to 12 months.

Table B.1. Number of grant recipients providing data, by source and cohort

Data source	Number of grant recipients (Time covered by data)		
	RPG5	RPG6	RPG7
Total number of grant recipients	10	8	18
Data collected by grant recipients			
Semi-Annual Progress Reports	10 (October 2018–March 2023)	8 (October 2018–March 2024)	18 (October 2022–March 2024)
Enrollment data	10 (March 2019–May 2023)	7 (October 2020–March 2024)	n.a.
Service data	10 (March 2019–May 2023)	7 (October 2020–March 2024)	n.a.
Standardized instruments	10 (March 2019–May 2023)	7 (October 2020–March 2024)	n.a.
Administrative data: child welfare	10 (Enrolled child's lifetime, or one year before enrollment in RPG to project exit)	5 (Enrolled child's lifetime, or one year before enrollment in RPG to project exit)	n.a.
Administrative data: substance use treatment	5 (Enrolled adult's lifetime, or one year before enrollment in RPG to project exit)	3 (Enrolled adult's lifetime, or one year before enrollment in RPG to project exit)	n.a.
Data collected by cross-site evaluation contractor			
Site visits	n.a. [a]	8 (Conducted winter/spring 2023)	n.a.
Sustainability survey	n.a.	8 (Conducted summer 2023)	n.a.
Parent interviews	n.a.	2 (Conducted winter/spring 2023)	n.a.

[a] Findings from the RPG5 site visits were presented in the Eighth Report to Congress.

Note: n.a. = not applicable.

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Appendix C

Outcomes

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This appendix provides technical information about the data and methods used to summarize results on participants' outcomes. The cross-site evaluation team used these data to describe the status of adults and children when they enrolled in in RPG5 and RPG6 projects (Chapter II) and how their outcomes changed over time (Chapter VI). The appendix has three sections:

- Section A describes participants' outcome data used in this report (data elements obtained through standardized instruments and administrative records).
- Section B describes how these data were prepared for the purposes of the analyses.
- Section C gives information on how the outcome data were analyzed in the report, with additional technical details on: (1) how the baseline analyses in Chapter II were conducted; (2) how individuals with both baseline and follow-up data from standardized instruments differed from individuals with only baseline data; (3) the approach for calculating nonresponse weights; (4) the analytic approach for comparing baseline and follow-up outcomes in Chapter VI; and (5) sensitivity analyses used to assess the robustness of the benchmark results presented in Chapters II and Chapter VI.

A. Description of the outcome data

To understand key outcomes of interest, the cross-site evaluation team used a comprehensive set of common data elements that RPG 5 and RPG6 projects collected about adults and children. At program entry and exit, RPG projects administered standardized child and adult assessment instruments to adults. Projects also obtained: (1) administrative child welfare data for all children for the period from birth through the end of the grant, and (2) data on substance use treatment for enrolled adults from age 18 through the end of the grant. Not all RPG projects were able to obtain these data. The data used for this report were based on projects' cumulative outcome data through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

An RPG case consists of the group of individuals who enroll in an RPG project together. An RPG case can be, but is not always, the same as the family unit. Although RPG cases could include more than one child, projects collected standardized assessment data on only one focal child in each case and established a rule for selecting that child. This enabled HHS to obtain detailed information on child well-being outcomes in each RPG case without placing excessive burdens on projects or families. Projects obtained administrative data for all children in a case.

1. Data from standardized instruments

Projects administered standardized instruments to obtain information on child and adult well-being (family functioning) and adult substance use. The biological parent of the focal child in the case was the intended reporter for all domains; he or she would provide information on the well-being of the focal child and on their own well-being at baseline and follow-up. In many cases, the biological parent was the individual in the case who was engaged in substance use treatment and, therefore, was the reporter on substance use. However, in some cases, the biological parent was not involved in substance use treatment; in these situations, a separate

individual in the case who was involved in this type of programming provided information on substance use. The cross-site evaluation labels the individual providing information about substance use outcomes as the recovery domain adult (RDA). Additionally, in some cases, the biological parent was not the primary caregiver of the focal child (defined as the individual who had primary responsibility of care for the child in the 30 days prior to data collection). In these situations, the person who was the primary caregiver of the focal child completed the instruments on child well-being. The cross-site evaluation labels these individuals the child well-being reporter (CWR). The CWR could be different individuals at enrollment and exit data collection.

The standardized instrument data collected by projects to inform the cross-site evaluation were intended to be administered to the appropriate members of the case at program entry (enrollment) and at program exit (either successful completion of the program or dropout). The default rules for data collection stated that projects should complete baseline data collection within 30 days of enrollment, and again within 30 days of case closure (regardless of whether the case closed as a result of successful program completion or program dropout). However, some projects used modified versions of these rules (occasionally using a wider enrollment window or a longer period before attempting follow-up data collection after a person did not complete programming).

a. Instruments to assess adult recovery

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

- **Adult substance use.** The cross-site evaluation used the 10 questions in the drug/alcohol use subscale[63] of the ASI-SR, a widely used tool in the addiction field, to measure the extent and severity of substance use by adults in RPG. Examples of questions include: "How many days have you used more than one substance (including alcohol) in the past 30 days?" and "In the past 30 days, how many days have you experienced drug problems?" Along with indicating the use of alcohol and other drugs, the ASI has been shown to be predictive of substance use disorder (Rikoon et al., 2006). However, the results of the instrument alone are not enough to establish this diagnosis, and it was not used for that purpose in the cross-site evaluation.
- **Adult symptoms of trauma.** Experiences of trauma are strongly predictive of subsequent substance use issues (National Child Traumatic Stress Network, 2008) and create their own difficult problems for families and programs to address. The cross-site evaluation measures adult trauma symptoms using the TSC-40 as one measure of adult recovery from substance

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

use issues. The TSC-40 measures aspects of post-traumatic stress and other symptom clusters in adults who have experienced traumatic experiences as children or in adulthood. It is a self-administered questionnaire with items covering six subscales: (1) anxiety, (2) depression, (3) dissociation, (4) Sexual Abuse Trauma Index, (5) sexual problems, and (6) sleep disturbance. The items can also be combined into a total score. Adults answer questions such as, "How often have you experienced each of the following in the last two months?" by reporting how often they have had symptoms such as "headaches," "sadness," or "anxiety attacks."

b. Instruments to assess family functioning

Family functioning can be affected by parents' mental health and parenting attitudes. Substance use issues can cause or result from mental health problems such as depression (Grant & Harford, 1995). Issues with parents' mental health and their parenting abilities are linked to the risk of child maltreatment and poor child outcomes (Budd et al., 2006; Dubowitz et al., 2011; Sidebotham et al., 2001).

The cross-site evaluation collects data on adult mental health and parenting attitudes to assess family functioning.

- **Depressive symptoms.** The cross-site evaluation measures adult depressive symptoms using the Center for Epidemiologic Studies Depression Scale (CES-D), a 12-item short form (Radloff, 1977). The CES-D is a screening tool assessing the presence and severity of depressive symptoms over the past week. Respondents are asked to rate how often each of the items (for example, "I was bothered by things that usually don't bother me") applied to them in the past week. Respondents with a score of 15 or higher are categorized as having "severe" depressive symptoms.
- **Parenting attitudes.** When parents have negative attitudes about parenting—in particular, when they have unrealistic expectations for their children—it can produce frustration and anger and raise the potential for child abuse and neglect. The Adult Adolescent Parenting Inventory-2 (Bavolek & Keene, 1999) was developed to distinguish the parenting attitudes of parents who did and did not mistreat children. It has five subscales: expectations of children, parental empathy toward children's needs, use of corporal punishment, parent–child family roles, and children's power and independence. The cross-site evaluation used this measure to describe those attitudes about parenting and understand the number of biological parents who expressed attitudes that put their children at risk of maltreatment.

c. Instruments to assess child well-being

The experience of maltreatment has comprehensive and lasting implications for children (Institute of Medicine & National Research Council of the National Academies, 2013). The RPG program seeks not only to maintain or increase children's safety and their permanency within their family, but also to improve their well-being. The standardized instruments that the cross-site evaluation used to assess child well-being include: (1) the Infant/Toddler Sensory

Profile (ITSP) (Dunn, 1999, 2002), which measures sensory processing difficulties of children in RPG projects; and (2) the Child Behavior Checklist (CBCL), which measures children's emotional and behavioral problems.

- **Children's emotional and behavioral problems.** Children's emotional and behavioral problems are associated with caregiver substance use (Behnke & Smith, 2013), caregiver well-being, and parenting stress and skills (Neece et al., 2012). The cross-site evaluation used the CBCL to measure children's emotional and behavioral problems, including internalizing (for example, anxiety or depression) and externalizing (for example, attention or aggression) problems and total problems (a combination of the two categories and the category of other problems). There are two versions of the CBCL—one for preschool-age children (ages 1.5 to 5.0) (Achenbach & Rescorla, 2000) and one for school-age children (ages 6 to 18) (Achenbach & Rescorla, 2001).
- **Sensory processing.** Sensory processing—the way the brain takes the information from the senses and turns it into appropriate behavioral responses—is one of the areas shown to be affected by prenatal substance exposure (Chasnoff et al., 2010). Children who have difficulties processing sensory information or responding to the information with appropriate behavior are considered to have sensory processing disorder. They often have difficulties performing everyday tasks and exhibit elevated emotional and behavioral problems and lower levels of adaptive social behaviors (Ben-Sasson et al., 2009). The cross-site evaluation used the ITSP (Dunn, 1999; 2002) to examine sensory processing difficulties of children in RPG. The ITSP reveals whether children are over- or under-responsive to stimuli, both of which indicate sensory processing difficulties and can be detrimental to children's well-being. These children are characterized as being at high risk of having a sensory processing disorder. The ITSP can be used with children whose ages range from newborn to 36 months.

2. Administrative data

In addition to the standardized instrument data, projects obtained administrative data on a common set of elements reflecting child welfare and substance use treatment. Specifically, projects obtained data on reported incidents of child maltreatment, removals from the home and subsequent placements, and adult participation in state-funded substance use treatment. Data on maltreatment and removal were available for all children in a case, and enrollment data on state-funded substance use treatment were available for all adults in the case in their lifetime. The baseline and follow-up outcomes were defined as child maltreatment and removal or adult participation in substance use treatment in the year before program enrollment and the year immediately following enrollment.

- **Safety.** A key desired outcome for RPG projects is the safety of children involved in the child welfare system—that is, the absence of maltreatment. Project teams worked with state and/or local child welfare agencies to obtain child welfare data for all children served in their RPG projects. Data elements were:
  - Whether an enrolled child had a record with child protective services.

  - Information about the types of allegations of abuse or neglect reported (and whether the reports were substantiated) for children enrolled in RPG5 and RPG6, such as dates, maltreatment type (such as physical, emotional, or sexual abuse, or neglect), and the disposition of the allegation (such as substantiated, unsubstantiated, indicated, or reason to suspect).

- **Permanency.** As they did with safety data, state and/or local child welfare agencies provided projects with administrative data on permanency (removals from the home and foster care placements) for all children enrolled in RPG. These data provide information on whether a child has been removed from their home in a given period (for example, within the past year or before RPG enrollment). For those who have been removed, data show information about the removal, including dates, where the child was placed, and whether the child was discharged—and, if so, when and why (such as reunification with parents).
- **Substance use treatment.** For all adults enrolled in RPG projects, projects requested administrative data about their participation in publicly funded substance use treatment before, during, and after participating in RPG. Requested data elements included dates of service, substances used at admission and frequency of use, date of discharge, and reason for discharge (such as completing treatment or leaving against advice).

3. Data used in the report

The data used for this report are based on projects' cumulative uploads of outcome data through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

B. Preparing the data

The data preparation steps for this report varied depending on the data source.

1. Preparing the standardized instrument data

The cross-site evaluation team used the scoring manuals for each instrument to create scale scores for each outcome. In most cases, the scale scores are a sum or average of responses to individual items. These sums or averages represent a composite, or an underlying construct of interest (for example, "externalizing behavior problems" is a construct measured by the CBCL).

The scale scores were then transformed into norm scores. The norm scores were obtained by comparing the observed scale scores to scores for demographically similar individuals in a normative sample (for example, comparing scale scores to scores for children of the same age and sex). The norm scores therefore allow for a comparison of the RPG sample of children and adults to a large national sample of typical adults or children, or a comparison population. In particular, they can reveal whether a child's or adult's scores on a given trait or attitude are better or worse than those of a hypothetical average individual in the normative group.

Tables C.1 (instruments to assess adults) and C.2 (instruments to assess children) present descriptive statistics for each construct assessed in all standardized instruments. The tables show the number of items contributing to each scale, the possible score ranges, and sample means and

standard deviations, calculated using all available data. The information in these tables can differ slightly from the information presented in Chapters II and VI, because the analyses in those chapters used different criteria to determine who was in the sample.

These summary tables include Cronbach's alphas to illustrate the reliability of the standardized instrument constructs. Higher values represent measures that are more reliable assessments (that is, they have less measurement error) of an underlying construct. In general, both adult and child outcome measures represent internally consistent or reliable assessments of the underlying construct of interest.

In addition to creating scale and norm scores for each construct of interest from the standardized instrument data, the cross-site evaluation team placed individuals into risk categories based on their scores on the instruments, using definitions of risk articulated in the instruments' scoring manuals. The high-risk category reflects the group of children or adults who have elevated or extreme scores on the measure, which corresponds to concerning symptoms or behaviors captured by a given measure.

2. Preparing the administrative data

The cross-site evaluation team used three sources of administrative data to inform three outcome domains: (1) safety (maltreatment) data, (2) permanency (removal and placement) data, and (3) recovery (participation in state-funded substance use treatment) data. Fifteen projects obtained safety and permanency data from their state and/or local child welfare agencies, and eight projects obtained recovery data from state agencies keeping records on substance use.

Specifically, projects gave these organizations lists of individuals they had enrolled (either all children or enrolled adults, as appropriate), and asked the organizations to provide information on those individuals. If the organization had data about those individuals, the data were shared with the project. The safety data shared with projects contained information on the dates of maltreatment investigations, the type of maltreatment, and whether the report was substantiated. The permanency data returned to projects contained information on dates of removal and placement into different settings, and whether a removal ultimately resulted in a permanent placement. The recovery data provided to projects included information on dates of enrollment into substance use treatment and program completion (if applicable).

Using the administrative data, the cross-site evaluation team created person-level indicator variables for whether a given incident occurred in a particular period. For example, the team created indicator variables for whether a child had an incident of substantiated maltreatment in the year before RPG enrollment. The cross-site evaluation team created indicator variables for all administrative data outcomes and focused on (a) the one-year periods before and after RPG enrollment; and (b) lifetime for children (from birth to enrollment) and adults (from age 18 to enrollment) for the purpose of all administrative data analysis.

Table C.1. Descriptive statistics and reliability estimates for adult outcome measures at project entry and exit

Measures	Instrument	Possible score range	Number of items	Project entry				Project exit			
				n	M (SD)	Reported score range	Cronbach's alpha	n	M (SD)	Reported score range	Cronbach's alpha
Depressive symptoms	CES-D	0–36	12	2,172	7.63 (8.04)	0-36	0.93	1,249	5.67 (7.36)	0-36	0.93
Parenting skills											
Inappropriate expectations for child	AAPI	1–10	7	2,113	5.86 (1.59)	1-10	0.60	1,208	5.55 (1.78)	1-10	0.64
Lack of empathy for child	AAPI	1–10	10	2,113	6.45 (2.07)	1-10	0.79	1,208	6.59 (2.43)	1-10	0.89
Values corporal punishment	AAPI	1–10	11	2,113	5.69 (1.87)	1-10	0.85	1,208	5.73 (1.89)	1-10	0.88
Treats child like an adult peer, not a child	AAPI	1–10	7	2,113	5.71 (2.04)	1-10	0.76	1,208	5.34 (2.15)	1-10	0.81
Oppresses child's independence	AAPI	1–10	5	2,113	6.20 (2.36)	1-10	0.61	1,208	6.51 (2.33)	1-10	0.64
Adult substance use											
Drug use	ASI	0–1	13	2,058	0.08 (0.12)	0-0.9	0.59	1,223	0.04 (0.07)	0-0.6	0.44
Alcohol use	ASI	0–1	6	2,106	0.07 (0.14)	0-1.0	0.74	1,238	0.05 (0.10)	0-0.9	0.56
Childhood/adult trauma symptoms	TSC-40	1–120	40	1,775	27.96 (20.51)	0-110	0.94	1,046	20.68 (18.74)	0-114	0.94

Notes: M = mean; n = number of individuals; SD = standard deviation.

Source: RPG administration of standardized instruments for adult outcomes, including data submitted through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6. Depressive symptoms were assessed using the Center for Epidemiologic Studies Depression Scale (CES–D); parenting skills were measured using the Adult Adolescent Parenting Inventory–2 (AAPI–2); adult substance use was measured using the Addiction Severity Index, Self–Report form (ASI–SR); and childhood/adult trauma symptoms were assessed using the Trauma Symptoms Checklist (TSC–40).

Table C.2. Descriptive statistics and reliability estimates for child well-being measures at program entry and exit

Measures[a]	Instrument	Possible score range	Number of items	Project entry				Project exit			
				n	M (SD)	Reported score range	Cronbach's alpha	n	M (SD)	Reported score range	Cronbach's alpha
Sensory processing											
Low threshold raw score	ITSP 0 to 6 months	17–85	17	313	73.20 (8.03)	42-85	0.75	46	74.41 (7.71)	48-85	0.70
Low threshold raw score	ITSP 7 to 36 months	23–115	23	197	98.27 (12.28)	34-115	0.84	271	96.62 (14.63)	31-115	0.89
Emotional and behavioral problems											
Emotional problems	CBCL_PS	29–100	36	488	49.97 (13.08)	29-82	0.90	250	45.40 (12.84)	29-80	0.89
Emotional problems	CBCL_SA		32	543	56.43 (13.57)	33-100	0.92	297	52.61 (13.63)	33-88	0.92
Behavioral problems	CBCL_PS	28–100	24	488	50.42 (13.99)	28-92	0.94	250	46.27 (12.98)	28-95	0.94
Behavioral problems	CBCL_SA		35	542	58.13 (13.06)	33-89	0.94	283	54.82 (12.73)	33-84	0.92
Total problems score	CBCL_PS	24–100	99	487	50.57 (14.24)	28-90	0.91	250	45.73 (13.19)	28-82	0.90
Total problems score	CBCL_SA		109	542	58.21 (14.02)	24-94	0.90	283	53.84 (14.87)	24-86	0.91

Notes: M = mean; n = number of individuals; SD = standard deviation.

Source: RPG administration of standardized instruments for measuring child well-being, including data submitted through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6. Sensory processing was assessed using the Infant/Toddler Sensory Profile (ITSP), and emotional and behavioral problems were assessed using the Child Behavior Checklist Preschool (PS) or School Age (SA) forms.

C. Analytic approaches used to describe outcome data

1. Baseline analysis for Chapter II

For each measure of interest based on the standardized instrument data, this report presents the mean and standard deviation of each outcome–along with the proportion of individuals in the high-risk category—as descriptive statistics in Chapter II. The benchmark approach in the body of the report uses nearly all available standardized instrument data (after excluding a small number of foster parent respondents from the analysis, because the analysis concentrates on the family of origin) and administrative data for focal children or RDAs in the families. The cross-site evaluation team also conducted sensitivity analyses varying the criteria for which families to include in the analysis, and the results were similar even with more restrictive criteria. (The upcoming section on sensitivity analyses has more information on the approaches and the robustness of the findings.)

For the administrative data, the cross-site evaluation reports the percentage of individuals who experienced a given incident both in the year before RPG enrollment and at any time throughout their lifetime before enrollment. For example, the cross-site evaluation presents the percentage of focal children with substantiated maltreatment reports in a given year, using all available administrative data provided by projects.

2. Comparing individuals with and without follow-up data for Chapter VI analyses

To understand whether individuals included in the pre-post change analysis differed from those who did not have follow-up data, the cross-site evaluation team compared the demographics and baseline measures for individuals who had both baseline and follow-up data from each standardized instrument to those for individuals with baseline data only for each of the standardized instruments. The analyses excluded the small number of individuals with follow-up data who did not have baseline data. To understand the degree to which the sample contributing to the pre-post analysis could be generalized to the broader RPG5 and RPG6 sample, analysts conducted independent t-tests to determine whether there were statistically significant differences between the two groups on demographics and baseline measures. Chapter VI summarizes these findings, which are covered in more detail here. The differences in these samples are shown separately for each outcome domain that uses standardized instruments: (1) substance use and adult trauma; (2) family functioning; and (3) child well-being.

a. Substance use and adult trauma

Recovery domain adults with and without standardized assessment data. Assessment data on RDAs were available for 1180 and 990 adults for the ASI-SR and TSC-40, respectively; 49 percent had both baseline and follow-up data for the ASI-SR, and 51 percent had both baseline and follow-up data for the TSC-40. Tables C.3 and C.4 show the results of comparisons between individuals with both baseline and follow-up data and those without follow-up data for the ASI-SR and TSC-40, respectively.

The two groups were similar in age, employment status, and relationship status, but different in other demographic characteristics (Table C.3). Compared with those who had follow-up data, adults without follow-up data were less likely to be women and more likely to be men (ASI-SR and TSC-40); less likely to be non-Hispanic Black (ASI-SR and TSC-40) or Hispanic/Latino (ASI-SR); less likely to have some postsecondary education (ASI-SR and TSC-40) and more likely to only have some high school education (ASI-SR); and less likely to receive public assistance (TSC-40).

For outcome measures at baseline, there were significant differences between the two groups in severity of drug or alcohol use or in trauma symptoms. Adults without follow-up data were more likely to be in the high-risk category for alcohol or drug use and trauma symptoms than those with follow-up data were (Table C.4).

Table C.3. Demographics for adults reporting on substance use who did and did not have follow-up standardized instrument data (ASI-SR, TSC-40)

Characteristics	ASI-SR			TSC-40		
	Adults with follow-up data	Adults without follow-up data	Difference in means or percentages	Adults with follow-up data	Adults without follow-up data	Difference in means or percentages
Average age in years (SD)	33.5 (52.6)	33.5 (32.8)	-0.0	34.1 (57.4)	34.0 (36.3)	0.1
Sex						
Female	89.3	86.4	3.0*	89.7	86.4	3.3*
Male	10.7	13.6	-3.0*	10.3	13.6	-3.3*
Race and ethnicity						
White, non-Hispanic	8.1	7.0	1.1	8.2	8.8	-0.6
Black or African American, non-Hispanic	3.6	1.9	1.7*	4.1	1.9	2.1*
Hispanic or Latino	15.2	10.8	4.5*	16.5	13.2	3.3
American Indian or Alaska Native (AIAN)	1.8	1.4	0.4	2.0	1.7	0.4
Other race	86.5	89.7	-3.3*	85.7	87.6	-1.9
Highest level of education						
Some high school	24.6	29.0	-4.4*	23.4	26.8	-3.4
High school diploma/GED	36.1	37.4	-1.4	35.9	39.3	-3.4

Characteristics	ASI-SR			TSC-40		
	Adults with follow-up data	Adults without follow-up data	Difference in means or percentages	Adults with follow-up data	Adults without follow-up data	Difference in means or percentages
Some postsecondary education	33.3	28.2	5.1*	34.5	28.3	6.2*
Bachelor's degree or higher	6.1	5.3	0.7	6.3	5.6	0.6
Family's largest income source						
Wage or salary	33.4	34.9	-1.5	33.2	35.5	-2.2
Public assistance	39.1	35.4	3.6	38.8	32.8	6.0*
Other income	13.0	14.3	-1.3	12.0	14.4	-2.4
No income	14.5	15.3	-0.8	16.0	17.4	-1.3
Employment status						
Full-time employment	23.9	25.7	-1.8	23.8	24.9	-1.1
Part-time employment	12.9	11.4	1.5	12.6	12.4	0.2
Self-employed	2.4	1.9	0.5	2.3	1.9	0.4
Unemployed	35.5	37.1	-1.5	36.9	38.1	-1.2
Not in the labor force	25.3	24.0	1.3	24.4	22.7	1.7
Relationship status						
Single (never married)	65.0	63.0	2.0	64.4	62.4	2.1
Married	15.5	17.3	-1.8	15.3	18.6	-3.2
Divorced or separated	19.5	19.8	-0.3	20.2	19.1	1.1
Number of adults	**1,123-1,182**	**935-968**		**975-990**	**764-785**	

Notes: ASI-SR = Addiction Severity Index, Self-Report Form (McLellan et al., 1992), TSC-40 = Trauma Symptoms Checklist-40 (Briere & Runtz, 1989).

SD = standard deviation.

* Significantly different from zero at the .05 level, two-tailed test.

Source: RPG Enrollment and Service Log data submitted through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

Table C.4. Baseline measures for adults reporting substance use who had and did not have follow-up standardized instrument data

Baseline measure of substance use	Adults with follow-up data	Adults without follow-up data	Difference in percentages
ASI			
Substance use			
Drug use			
Percentage in high-severity category for drug use	19.0	26.2	-7.2*
Alcohol use			
Percentage in high-severity category for alcohol use	8.3	11.5	-3.1*
Percentage in high-severity category for use of drugs or alcohol or both	23.6	33.5	-9.9*
TSC-40			
Adult trauma symptoms			
Percentage in high-risk category	33.7	38.7	-5.0*
Number of adults for ASI-SR	1,127-1,163	914-943	
Number of adults for TSC-40	985	785	

Notes: ASI-SR = Addiction Severity Index, Self-Report Form (McLellan et al., 1992), TSC-40 = Trauma Symptoms Checklist-40 (Briere & Runtz, 1989).

* Significantly different from zero at the .05 level, two-tailed test.

Source: RPG baseline administration of standardized instruments, including data submitted through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

b. Family functioning

Biological parents with and without follow-up standardized assessment data. Data on biological parents were available for 1,191 and 1,135 adults for the AAPI and CES-D, respectively; 47 percent had both baseline and follow-up data for the AAPI, and 59 percent had both baseline and follow-up data for the CES-D. Tables C.5 and C.6 show the results of comparisons between adults with both baseline and follow-up data and those without follow-up data.

The two groups were similar in most demographic characteristics except for race/ethnicity and education level (Table C.5). Compared with those who had follow-up data, adults without follow-up data were more likely to be in the Other race category (AAPI and CES-D) and less likely to be non-Hispanic White (AAPI), non-Hispanic Black (AAPI and CES-D), or Hispanic/Latino (AAPI and CES-D); less likely to have some postsecondary education, and more likely to only have some high school education (AAPI and CES-D).

For outcome measures at baseline, there were significant differences between the two groups in depressive symptoms and parenting attitudes (Table C.6). Compared with those who had follow-up data, adults without follow-up data had higher levels of depressive symptoms and lower scores (that is, lower risk) on two AAPI subscales: treats child like an adult peer, not a child; and oppresses child's independence.

Table C.5. Demographics for biological parents with and without follow-up standardized instrument data in RPG cases (AAPI, CES-D)

Characteristics	AAPI			CES-D		
	Biological parents with follow-up data	Biological parents without follow-up data	Difference in means or percentages	Biological parents with follow-up data	Biological parents without follow-up data	Difference in means or percentages
Average age in years (SD)	33.6 (53.7)	32.4 (7.7)	1.2	33.5 (52.4)	32.2 (7.6)	1.3
Sex						
Female	89.3	87.5	1.7	89.7	87.6	2.1
Male	10.7	12.5	-1.7	10.3	12.4	-2.1
Race and ethnicity						
White, non-Hispanic	8.4	5.2	3.2*	8.1	6.9	1.2
Black or African American, non-Hispanic	3.7	1.9	1.9*	3.6	1.9	1.7*
Hispanic or Latino	15.6	9.2	6.4*	15.0	10.9	4.1*
American Indian or Alaska Native (AIAN)	1.8	1.6	0.2	1.7	1.6	0.1
Other race	86.1	91.4	-5.3*	86.6	89.7	-3.1*
Highest level of education						
Some high school	24.5	28.5	-4.1*	24.5	29.3	-4.8*
High school diploma/GED	36.2	37.3	-1.1	36.1	37.8	-1.7
Some postsecondary education	33.2	29.0	4.3*	33.2	28.1	5.1*
Bachelor's degree or higher	6.1	5.2	0.9	6.2	4.9	1.4
Income source						
Wage or salary	34.1	33.9	0.2	33.6	34.9	-1.2
Public assistance	38.4	37.3	1.1	38.7	35.5	3.2
Other income	12.7	13.5	-0.8	13.2	14.2	-1.0
No income	14.7	15.3	-0.5	14.5	15.5	-1.0
Employment status						
Full-time employment	24.4	24.8	-0.4	24.2	25.4	-1.1
Part-time employment	13.0	10.6	2.4	12.8	11.2	1.5
Self-employed	2.2	2.1	0.1	2.2	1.9	0.4
Unemployed	35.4	37.4	-1.9	35.3	37.4	-2.1
Not in the labor force	25.0	25.2	-0.2	25.4	24.1	1.3
Relationship status						
Single (never married)	64.0	62.6	1.4	64.2	62.9	1.3
Married	15.6	17.3	-1.7	15.6	17.6	-2.1
Divorced or separated	20.4	20.1	0.3	20.2	19.5	0.8
Number of adults	**1,092-1,135**	**954-978**		**1,137-1,191**	**962-981**	

Notes: AAPI = Adult Adolescent Parenting Inventory-2 (Bavolek & Keene, 1999), CES-D = Center for Epidemiologic Studies Depression Scale (CES-D), 12-item short form (Radloff, 1977).

SD = standard deviation.

* Significantly different from zero at the .05 level, two-tailed test.

Source: RPG baseline administration of standardized instruments, including data submitted through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

Table C.6. Baseline measures for biological parents with and without follow-up standardized instrument data

Family functioning	Mean (SD)			Percentage of adults in high-risk category		
	Biological parents with follow-up data	Biological parents without follow-up data	Difference in means	Biological parents with follow-up data	Biological parents without follow-up data	Difference in percentages
CES-D						
Depressive symptoms	7.1 (7.7)	8.3 (8.4)	-1.2*	18.6	22.6	-4.0*
AAPI						
Inappropriate expectations for child	5.9 (1.6)	5.8 (1.6)	0.0	12.9	12.0	0.9
Lack of empathy for child	6.5 (2.1)	6.4 (2.0)	0.1	34.7	32.0	2.7
Values corporal punishment	5.7 (1.9)	5.6 (1.8)	0.1	17.3	14.2	3.1
Treats child like an adult peer, not a child	5.8 (2.1)	5.6 (2.0)	0.2*	20.9	16.9	4.0*
Oppresses child's independence	6.3 (2.4)	6.1 (2.3)	0.2*	34.9	30.8	4.1*
Number of adults (CES-D)	**1,191**	**981**				
Number of adults (AAPI)	**1,135**	**978**				

Notes: AAPI = Adult Adolescent Parenting Inventory-2 (Bavolek & Keene, 1999), CES-D = Center for Epidemiologic Studies Depression Scale (CES-D), 12-item short form (Radloff, 1977).

SD = standard deviation.

* Significantly different from zero at the .05 level, two-tailed test.

Source: RPG baseline administration of standardized instruments, including data submitted through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

c. Child well-being

Focal children with and without follow-up data from standardized assessments. Data on children's well-being were available for 271 and 452 focal children for the ITSP and CBCL, respectively. Almost one-third (32 percent) of children with ITSP assessments had both baseline and follow-up data, and 28 percent of children with CBCL assessments had both baseline and follow-up data. Tables C.7 and C.8 show the results of comparisons between children with both baseline and follow-up data and those without follow-up data.

The two groups of children were different in all demographic characteristics except for residence at enrollment (Table C.7). Compared to those with follow-up data, children without follow-up data were older (ITSP), a higher percentage were boys (CBCL), and they were more likely to be in the Other race category and less likely to be non-Hispanic Black or Hispanic/Latino (ITSP).

For outcome measures at baseline, the two groups had significant differences in emotional or behavioral problems but were similar in sensory processing (Table C.8). Children without follow-up data on CBCL had higher levels of emotional or behavioral problems and total problems than those with follow-up data.

Table C.7. Demographics of focal children with and without follow-up child standardized instrument data (ITSP, CBCL)

Characteristics	ITSP			CBCL		
	Children with follow-up data	Children without follow-up data	Difference in means or percentages	Children with follow-up data	Children without follow-up data	Difference in means or percentages
Average age in years (SD)	0.2 (0.5)	0.5 (0.7)	-0.3*	6.9 (4.3)	7.1 (4.4)	-0.2
Age by category						
Younger than 1	84.1	63.7	20.3*	n.a.	n.a.	n.a.
1 to 4	15.9	36.2	-20.3*	38.9	36.6	2.3
5 to 8	n.a.	n.a.	n.a.	27.7	28.3	-0.7
9 or older	n.a.	n.a.	n.a.	33.4	35.1	-1.7
Sex						
Female	51.3	45.0	6.3	52.4	45.9	6.5*
Male	48.7	55.0	-6.3	47.6	54.1	-6.5*
Race and ethnicity						
White, non-Hispanic	12.7	13.0	-0.3	9.2	9.3	-0.0
Black or African American, non-Hispanic	12.7	5.0	7.6*	1.1	1.0	0.1
Hispanic or Latino	34.7	23.1	11.6*	12.8	13.3	-0.5
American Indian or Alaska Native (AIAN)	4.5	1.7	2.8	0.7	1.4	-0.7
Other race	70.1	80.3	-10.1*	89.0	88.3	0.7
Residence at enrollment						
Private residence	88.6	87.0	1.5	95.4	93.6	1.8
Foster or group home	0.0	0.0	0.0	0.0	0.3	-0.3
Treatment facility, shelter, or correctional facility	11.4	13.0	-1.5	4.2	5.4	-1.2
Other residence	0.0	0.0	0.0	0.4	0.7	-0.2
Number of children	**268–271**	**238–240**		**444–452**	**571–579**	

Notes: ITSP = Infant/Toddler Sensory Profile (ITSP) (Dunn, 1999, 2002), CBCL = Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2001).

SD = standard deviation; n.a. = not applicable.

* Significantly different from zero at the .05 level, two-tailed test.

Source: RPG Enrollment and Service Log data submitted through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

Table C.8. Child well-being at RPG enrollment for focal children with and without follow-up data from standardized instruments

Child well-being at baseline	Mean (SD)		Difference in means	Percentage of children in high-risk category		Difference in percentages
	Children with follow-up data	Children without follow-up data		Children with follow-up data	Children without follow-up data	
ITSP						
Sensory processing	n.a.	n.a.	n.a.	29.9	30.8	-0.9
CBCL						
Emotional problems	52.1 (13.8)	54.4 (13.6)	-2.3*	23.9	30.4	-6.5*
Behavior problems	53.1 (14.1)	55.6 (13.9)	-2.5*	26.5	29.2	-2.7
Total problems	53.0 (14.9)	55.9 (14.3)	-2.9*	29.2	33.1	-3.9
Number of children (ITSP)	**271**	**240**				
Number of children (CBCL)	**452**	**577-579**				

Notes: ITSP = Infant/Toddler Sensory Profile (ITSP) (Dunn, 1999, 2002), CBCL = Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2001).

n.a. = not available.

Source: RPG baseline administration of standardized instruments, including data submitted through May 19, 2023, for RPG5 and through March 15, 2024, for RPG6.

d. Summary of all comparisons of individuals with and without follow-up data

Individuals with and without follow-up data differed from each other on some demographic characteristics and outcome measures at project entry. Generally, adults without follow-up data were less likely to be non-Hispanic Black or Hispanic/Latino; more likely to have lower levels of education; and more likely to score in the at-risk range on measures of drug or alcohol use, trauma symptoms, and depressive symptoms, but reported lower levels of negative parenting skills and attitudes, compared with those with follow-up data. Compared to those with follow-up data, children without follow-up data on the ITSP were younger and less likely to be non-Hispanic Black or Hispanic/Latino; more children without follow-up data on the CBCL were boys, and a higher percentage of children without follow-up data on the CBCL had more emotional or behavioral problems.

D. Nonresponse weights for pre-post analysis for Chapter VI

To describe the changes in outcomes of those who received RPG services, the ideal approach would be to compare outcomes for the full population of eligible individuals enrolled in the RPG from baseline (program entry) to follow-up (program exit). The cross-site evaluation team could have used administrative data to conduct this analysis, which includes all eligible RPG participants enrolled in the projects that submitted the data. (Eligibility to be included in the pre-post analysis is defined as being enrolled for at least one year at the end of the grant period.) However, the sample that had observed data on standardized instruments at both baseline and follow-up was unlikely to represent the full population of individuals enrolled in RPG. First, the percentage of eligible individuals with standardized instrument scores at both baseline and follow-up was relatively low, with response rates ranging from 28 to 51 percent across instruments. Second, as shown in the tables in this appendix, those with and without standardized instrument data at follow-up differed on some demographic characteristics and on outcome measures at project entry. Therefore, to reduce nonresponse bias for the outcome estimates, the cross-site evaluation used nonresponse weights to statistically adjust the analysis of the observed data. A description of the process for generating and using these weights follows.

Instrument-specific weights. The cross-site evaluation created separate nonresponse weights at the individual level for each standardized instrument. There were several reasons for creating individual-level instrument-specific weights. First, each instrument that measures child well-being does not apply to all children; for example, ITSP can be used only for children from birth to age 36 months. Second, not all projects used the full battery of instruments examined in the cross-site evaluation. Third, focal children, biological parents, and RDAs and CWRs (when different from the biological parents) were each associated with a different set of standardized instruments. The variation in the population eligible for each instrument meant creating separate weights for each instrument. The variables used to calculate nonresponse weights were demographic variables; baseline measures of outcomes; and variables from baseline administrative data (safety, permanency, and recovery), which differ slightly for the focal children, biological parents, and RDAs.

Procedure for computing sampling weights. There were four steps followed in creating the weights.

1. Preparing the data. The first step in the weighting procedure was to prepare the data for the sample of interest. For each instrument, the cross-site evaluation team identified the subset of the participant sample (focal child, biological parent, RDA, or CWR) that was potentially eligible to complete the assessment at both time points. That is, the team identified the subset of participants who: (1) had been enrolled in RPG long enough for a follow-up assessment; (2) were age-eligible for both the baseline and follow-up assessments (this applied to the focal child outcomes measured using the standardized instruments); and (3) were enrolled in an RPG project that collected data using a given standardized instrument. A subset of projects did not administer all standardized instruments.

For the subset of individuals eligible for assessment by a given standardized instrument, the cross-site evaluation team focused on a specific list of variables: (1) demographic characteristics; (2) administrative data; and (3) baseline and follow-up data from each instrument.

2. Identifying predictor variables. The next step was to identify the appropriate set of variables associated with completing a follow-up assessment for a given standardized instrument. In addition to considering all variables observed at baseline as potential predictors, the cross-site evaluation team identified all two-way interactions in the pool of covariates that were potentially significant in predicting the response variable. They accomplished this using the chi-square automatic interaction detector (CHAID) algorithm (Kass, 1980). They implemented this step using a SAS procedure called HPSPLIT.

3. Estimating an initial nonresponse weight for the instrument. For each standardized instrument, the cross-site evaluation team conducted stepwise logistic regression to estimate each individual's propensity to complete the follow-up assessment. This analysis used as its dependent variable whether an individual had both baseline and follow-up data for a given instrument. The cross-site team used demographic variables, baseline administrative data, baseline standardized assessment scores, and any two-way interactions identified via CHAID in Step 2 as predictors of this outcome. Using the final model, the team estimated a propensity score for each individual (the predicted probability that the person would have both baseline and follow-up data for a given instrument). The inverse of this propensity score (based on the final model for respondents) was then used as the initial weight for the nonresponse analysis.

4. Adjusting the initial weight. The team refined the weights from Step 3 to better represent the eligible sample of interest. Although the inverse propensity score serves as a starting point for the weights, the sum of the weights for an instrument must equal the total number of eligible individuals, and the inverse propensity scores do not satisfy this requirement.

To make the inverse probability weight $w_{inv,i}$ sum to the full baseline sample size associated with each instrument measure, the cross-site evaluation team applied a simple ratio adjustment factor $\frac{n}{\sum w_{inv,i}}$ to the inverse probability weight for each respondent, where n is the full sample size, n_r is the number of respondents, and the ratio-adjusted weight is renamed as $w_{adj,i}$, such that

$$(1) \quad \sum_{i=1}^{n_r} \left(\frac{n}{\sum w_{inv,i}}\right) w_{inv,i} = \sum_{i=1}^{n_r} w_{adj,i} = n$$

After adjusting the ratio, the individual weights sum to the size of the intended population. However, in the process, a small number of observations ended up having extreme weights (either very small or very large), which can lead to large variances in sample estimates of interest. To address this concern, the cross-site evaluation team used a weight-trimming procedure to identify and reduce large weights. The procedure, which is also used in the National Assessment of Educational Progress (2021), compares each observation's weight

relative to the average squared weight of all other observations in the sample, and adjusts all weights accordingly, effectively pulling extreme weights toward the sample average. This iterative procedure eventually produces a revised or final set of weights without any outliers, in which the sum of all weights equals the size of the intended population of interest.

E. Analysis of change from baseline to follow-up

For standardized instrument analyses, the report presents baseline means and standard deviations, follow-up means and standard deviations, and a change score, which is the difference in means. The statistics calculated for all analyses of a given instrument included the nonresponse weights described earlier. The inferential assessment of whether the differences in the scores between baseline and follow-up differed significantly from zero (that is, the paired t-test analyses) included these weights.

The cross-site evaluation team used a comparable approach to report on the administrative data for focal children or RDAs in the cases. Chapter VI presents the prevalence of a given outcome (for example, incidence of maltreatment) in the pre-intervention year and the intervention year, along with the change in the prevalence rates between these two periods (Table VI.3, Table VI.6, and Table VI.7). Again, the team used a paired t-test to assess whether the changes in individual categories were significantly different from zero. However, it was unnecessary to use nonresponse weights for the administrative data, given that there are complete data on these outcomes for the eligible sample. All inferential tests used a Type I error rate (alpha) level of 0.05 (two-tailed) to describe a result as statistically significant.

F. Benchmark versus sensitivity analyses

As noted, the main or benchmark approach for presenting RPG5 and RPG6 baseline statistics or pre-post change results used all available data for a given standardized outcome of interest and administrative data for the focal child or RDA. The cross-site evaluation tested the sensitivity of the observed results by:

a. Including all children or enrolled adults in the case for administrative data (including multiple children or adults in the case).
b. Limiting the sample to only individuals who had baseline assessments within a 30-day window around the enrollment date.
c. Limiting the sample to only the first instance of individual outcome measures, for the small subset of individuals who had outcome data in multiple cases, such as a focal child who was associated with two separate cases (for example, associated with two biological parents enrolled separately).
d. In addition, the cross-site evaluation team assessed the extent to which the analysis of standardized instrument changes over time was sensitive to the use of nonresponse weights.

In all of these analyses, the findings from the sensitivity analyses were similar to the findings of the benchmark analyses, suggesting that the benchmark findings are robust.

1. Baseline statistics

The findings from the sensitivity analysis about the baseline statistics were similar to the benchmark findings for the baseline analysis reported in Chapter II:

a. *Baseline administrative data for all children or adults in a case.* When the analysis of administrative data was expanded to include all children and adults in a case, the sample increased about 26 percent for adults and 94 percent for children compared to the sample size for the benchmark analysis.

b. *Baseline standardized assessment within a 30-day window around the enrollment date.* When the analysis of standardized instruments was limited to individuals whose baseline measure was close enough to the enrollment date, about 86 percent of all baseline assessments were maintained in the analysis (range = 86 to 91 percent across all standardized instruments).

c. *First instance of individual outcome at baseline.* This analysis included 95 percent of the records used in the benchmark analysis (range = 94 to 95 percent across all standardized instruments).

In sum, this suggests that the approaches used to define the benchmark sample and for the baseline analysis in Chapter II did not play a substantive role in the interpretation of the findings, because the sensitivity results largely replicated the findings.

2. Pre-post comparisons

The sensitivity analyses for the pre-post comparison analyses were almost identical to the benchmark pre-post analyses reported in Chapter VI:

a. *Baseline and follow-up administrative data for all children or adults in a case.* This analysis was not weighted because we did not have missing data for administrative data. When the analysis of administrative data was expanded to include all children and adults in a case, the sample increased to about 125 percent for adults and 197 percent for children of the sample size for the benchmark analysis. All contrasts had the same sign and same statistical significance as the benchmark analysis results in Chapter VI.

b. *Baseline and follow-up standardized assessments within a 30-day window around the enrollment date.* Nonresponse weights were applied for this analysis. When the pre-post change analysis was limited to the subset of individuals whose baseline measure was close enough to the enrollment date, about 12 percent of observations were dropped (ranging from 4 to 20 percent across instruments). Comparisons had the same sign and same statistical significance as the weighted results in Chapter VI for all outcome measures except for a change in the percentage in the CBCL high-risk category for behavioral problems (which was not statistically significant in this sensitivity analysis but was statistically significant in the benchmark analysis).

c. *First instance of individual outcome at baseline and follow-up.* Nonresponse weights were applied for this analysis. When the sample was limited to the first instance of assessments for individuals who were part of more than one case, 95 percent of the records in the

benchmark analysis were included in this analysis (that is, 3 to 7 percent of records were in multiple cases, across instruments). Comparisons had the same sign and same statistical significance as the weighted results in Chapter VI for all outcome measures except for a change in the percentage in the high-risk category for CBCL behavioral problems (which was not statistically significant in this sensitivity analysis but significant in the benchmark analysis).

d. *Sensitivity to nonresponse weights.* In addition, the benchmark pre-post analysis that incorporated nonresponse weights (reported in Chapter VI) and a sensitivity analysis that ignored the nonresponse weights were comparable. Comparisons had the same sign and same statistical significance as the weighted results in Chapter VI for all outcomes except for two outcome measures: change in the percentage in high-risk category for the CBCL behavioral problems subscale (which was not statistically significant in unweighted analysis but significant in the benchmark weighted analysis) and change in the percentage in the high-severity category for the AAPI subscale on valuing corporal punishment (which was statistically significant in unweighted analysis but not significant in the benchmark weighted analysis).

These sensitivity results suggest that the approaches taken to define the benchmark sample and the approach for the pre-post analysis did not play a substantive role in the interpretation of the findings. The benchmark results presented in Chapter VI appear to be robust relative to these alternate definitions of the analytic sample and analytic approach.

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Appendix D

Latent Class Analysis

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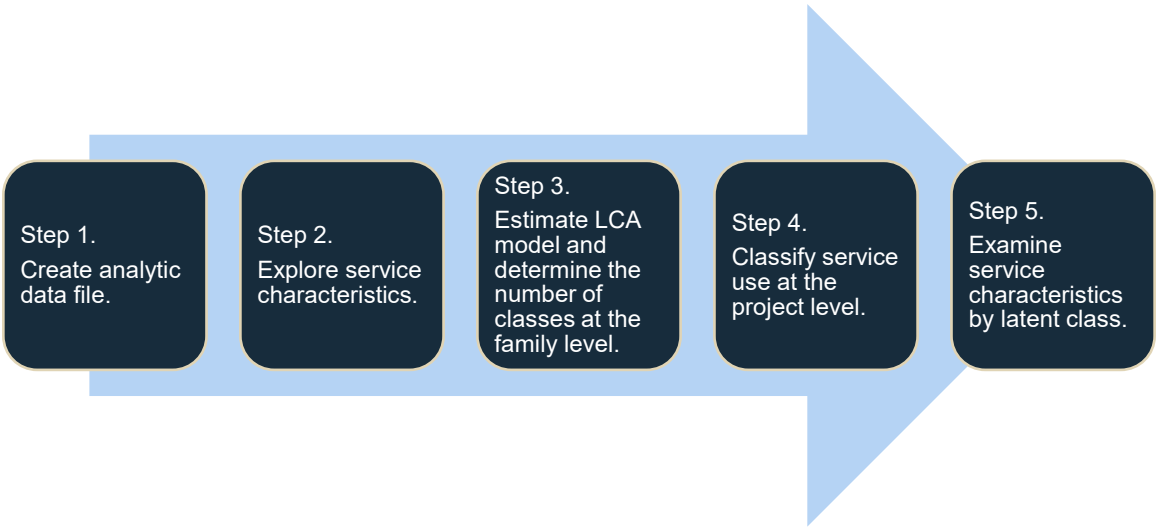
Latent class analysis (LCA) is an analytic method that identifies and categorizes clusters (classes) of similar cases for data observed as a series of categorical response values (Linzer & Lewis, 2011). (Box 1 provides definitions of key concepts.) The goal of LCA is to determine whether a given data set contains only one population or a mixture of several populations that can be uncovered by examining patterns in the observed variables. In this sense, LCA is similar to cluster analysis, which groups together observations (for example, individuals, families, projects, and so on) into latent classes based on underlying similarities. LCA assumes that the latent classes uncovered from the observed data are mutually exclusive and exhaustive.

Box D.1. Key definitions of LCA

- **Categorical variable**: a variable that has a limited and fixed number of possible values. Examples include service location (client's place of residence, residential treatment facility, other location, or phone). A categorical variable that takes on values 0 and 1 is called a **binary variable**.
- **Observed variable**: a variable measured directly in the data. Observed variables might or might not be categorical.
- **Latent variable**: an unobserved variable inferred based on observed data. For example, an individual's personality (unobserved) is a latent variable that analysis can derive from items (observed) on a personality scale survey.

The cross-site evaluation team conducted LCA to examine the patterns of service delivery and group RPG5 and RPG6 projects that provided similar services to enrolled families. The approach for using LCA in the service analysis involved five steps, as illustrated in Figure D.1 and described below.

Figure D.1. Steps for analyzing services data using a latent class analysis



A. Create an analytic data file (step 1)

First, the cross-site evaluation team created an analytic data file that included the variables of interest and aggregated to the family level, because projects typically designed services to serve the families as a unit. The analytic sample in the LCA model included 17 of the 18 RPG5 and RPG6 projects[64] with families that received at least one of the primary service types (that is, case management or service coordination, parenting, therapy, support group, or mentoring). The analysis excluded any families that did not meet this criterion.

B. Explore service characteristics (step 2)

The second step explored different characteristics of service provision to identify patterns or trends of participants' service use. During this exploratory phase, numerous models were considered to identify which variables to include in the LCA model and to understand the relationship between the variables and the latent classes. The preliminary LCA models began with the final model used with an earlier cohort of projects (HHS, 2025). Analyses were conducted using Stata (StataCorp, 2023) and Mplus (Muthén & Muthén, 1998–2017).

Table D.1 highlights four models (three preliminary models and one final model) worth noting and the service characteristic variables included in the models. This table shows the progression of analytic decisions made to include and exclude variables based on the descriptive statistics and variation in the data by latent class. A description of each model follows:

- **Model 1** included relevant service characteristics that could potentially distinguish groups of families' service receipt. A previous LCA model with the RPG4 cohort motivated the selection of these variables and included the five primary service types and an indicator for families that received services from a peer mentor. This model identified three latent classes.
- **Model 2** dropped the peer indicator from the model, given the indicator did not help distinguish classes and resulted in a three-class model.
- **Model 3** added an indicator for a supportive service that was particularly critical to two projects' service offerings, medical services, which resulted in a five-class model.
- **Model 4** is the final LCA model. This model was the similar to Model 3 but estimated a four-class model.

Table D.1. Indicators included in the LCA models and the number of latent classes

Indicator	Model 1	Model 2	Model 3	Final model
Case management or service coordination	X	X	X	X
Support group or workshop	X	X	X	X
Therapy	X	X	X	X
Parenting training or home visiting program	X	X	X	X

[64] The analysis excluded one project because it did not provide services data.

Indicator	Model 1	Model 2	Model 3	Final model
Mentoring	X	X	X	X
Peer providers	X			
Medical services			X	X
Number of latent classes in the model	3	3	5	4

C. Estimate LCA model and determine the number of classes at the family level (step 3)

This step included refining the LCA model using a series of fit statistics, which aids in determining the number of latent classes in the model. The team selected an upper limit of eight classes and the resulting models included one to eight latent classes. The rationale for having an upper limit of eight latent classes is based on the number of variables included in the model balanced with the need to keep the number of classes manageable and interpretable. Examining a large range of classes provided a good starting point to see how the fit statistics changed for each model iteration, which allowed for model refinement.

1. Latent class model estimation

The following key concepts were considered in estimating an LCA model: parsimony, model fit, and interpretability.

- **Parsimony.** A parsimonious model explains the data with the minimum number of classes and still achieves a good fit. It is important to employ the parsimony principle to select the model with the fewest number of classes that is statistically and substantively meaningful (Masyn, 2013).
- **Model fit.** Evaluating model fit included examining the relative fit and classification diagnostics, as described below.
  - **Relative fit.** Examining the relative fit involved comparing the model's representation of the data to another model's representation using the following two criteria: inferential and information criteria.
    - **Inferential criteria.** This LCA analysis used inferential tests to compare nested models, which include the Lo-Mendell-Rubin Adjusted Likelihood Ratio Test (LMR-LRT) and the Bootstrap Likelihood Ratio Test (BLRT). These tests compare neighboring class models (that is, it tests the null model to the more parsimonious model). A statistically significant *p*-value suggests the higher-class model fits the data significantly better than the model with one fewer class (Masyn, 2013; Nylund, Asparouhov, & Muthén, 2007). In this LCA, the LMR-LRT and the BLRT were helpful to determine which models not to select. These inferential criteria suggested that larger class models fit the data better than smaller-class models. However, based on the information criteria described below, smaller-class models were preferred over larger-class models. Applying the parsimony principle resulted in selecting a model with fewer classes that still obtains a good fit.

- **Information criteria**. This analysis relied on the most commonly used information criteria, the Bayesian Information Criterion (BIC). When evaluating information criteria, the model with the lowest value of relative fit to the model suggests the best fitting model (Nylund et al., 2007). In addition to the value of the BIC, the team examined the diminishing gains in model fit (Masyn, 2013). Specifically, calculating both the change and difference in change in the BIC from one model to the next neighboring model to assess the largest drop in BIC value. Small changes in the BIC between two adjacent models indicate diminishing benefit for selecting higher-class (that is, more complex) models. Conversely, large changes in the BIC suggest that higher-class models can still provide sufficient information gain to justify additional complexity. The team selected the number of classes that had the largest difference in change in BIC.

– **Classification diagnostics** assessed the degree of class separation. The classification diagnostic used in this analysis is relative entropy, which is an index that examines the accuracy of classification for the entire sample across the latent classes and falls between 0 and 1, where higher values of entropy indicate better classification of observations into latent classes (Clark & Muthén, 2009). Standard practice considers entropy values that are 0.80 or higher as high (Ram & Grimm, 2013). This LCA used entropy as a guide after examining the information and inferential criteria.

- **Interpretability.** Once the relative fit and classification diagnostics were satisfied, the priority was models that were easily interpretable. The pattern of item-response probabilities (as described in Box 2) was reviewed for high homogeneity and class separation. Homogeneity is the extent to which individuals within a latent class are likely to provide the same observed responses (Collins & Lanza, 2010), and is considered to be high if the class-specific item-response probabilities are greater than 0.70 or less than 0.30 (Masyn, 2013). Class separation is the extent to which the overall pattern of the item-response probabilities clearly distinguishes the latent classes (Collins & Lanza, 2010). Theory and background knowledge of the service delivery also provided context in interpreting the latent classes.

Box D.2. Item-response probability

Item-response probability is the probability that a family had a specific value for an observed categorical variable (the expression for having a specific value is "endorsed an observed item"). The analysis produced this probability for each family and observed categorical variable, with values ranging from 0 to 1. Values closer to 0 indicate a family is not likely to endorse the item; values closer to 1 indicate a family is likely to endorse the item. Item-response probabilities were used to form the basis for interpreting latent classes. These probabilities can facilitate comparisons between classes to assess the distinctness (or uniqueness) of each class.

2. Determine the number of latent classes

This section describes a summary of the relative fit and classification diagnostics for Models 1 through 4, provided in Tables D.2, D.4, and D.6. In addition, this section provides the item-response probabilities for each of the four models in Tables D.3, D.5, and D.7 and explains how

the cross-site evaluation team refined each model and eliminated indicators to achieve the final LCA model.

Table D.2. shows the fit statistics for Model 1 for up to seven latent classes. In this model, the inferential criteria (LMRT and BLRT) and BIC do not point to a specific solution. The model did not reach a minimum BIC in the first eight classes. The difference in change in BIC indicates a three-class model is the preferred model.

Table D.2. Fit statistics for Model 1

Number of latent classes	Log likelihood	BIC	Change in BIC	Difference in change in BIC	*p*-value of BLRT	*p*-value of LMRT	Entropy
1	-7578.50	15203.21			-	-	-
2	-7008.31	14116.75	-1086.45		0.000	0.000	**0.96**
3	-6781.29	13716.62	-400.13	**686.32**	0.000	0.000	0.84
4	-6645.68	13499.31	-217.31	182.82	0.000	0.000	0.90
5	-6527.12	13316.12	-183.19	34.12	0.000	0.000	0.86
6	-6458.75	13233.29	-82.82	100.37	0.000	0.000	0.86
7	-6422.88	13215.47	-17.83	65.00	0.000	0.000	0.87

Note: BIC = Bayesian Information Criterion; BLRT = Bootstrap Likelihood Ratio Test; LMRT = Lo-Mendell-Rubin Adjusted Likelihood Ratio Test. Bolded values indicate the preferred model given the fit index.

In each model, when determining which characteristics to retain, the team treated the five primary service types as one group because of the importance of the kinds of services RPG projects provided to families. The team eliminated one characteristic at a time to observe changes in the item-response probabilities. However, this appendix does not present every iteration of the model.

When considering which indicators to explore in Model 1, the cross-site evaluation team evaluated the item-response probabilities from the three-class model presented in Table D.3.

Table D.3. Model 1 item response probabilities and percentage of families in each class

Indicator	Class 1	Class 2	Class 3
Case management or service coordination	0.689	0.680	**0.803**
Support group or workshop	**0.008**	**0.051**	**0.289**
Therapy or counseling	**0.295**	0.648	**1**
Parenting training or home visiting program	**0.230**	**0.214**	**1**
Mentoring	**1**	**0.076**	**0**
Peer provider	**1**	0.300	**0**
Percentage of families in each class	20%	52%	28%

Note: The analysis includes families that received at least one of the primary services. Bolded values indicate an item-response probability that is greater than 0.70 or less than 0.30. Percentage of families in each class might be more than 100 percent due to rounding.

Source: Regional Partnership Grant-Evaluation Data System data, March 1, 2019, through May 19, 2023, (RPG5) and October 1, 2020, through March 15, 2024 (RPG6).

Table D.4 shows the fit statistics for Model 2 for up to seven classes. Fit statistics disagree on the best model. The BIC reached a minimum value at the five-class solution, just slightly lower than the four-class solution. The difference in the change in BIC suggests a three-class model. The *p*-value for the BLRT and LMRT suggests a six-class model fits better than a seven-class model. Given that fit statistics disagree, the parsimony principle supports the three-class model.

Table D.4. Model 2 fit statistics

Number of latent classes	Log likelihood	BIC	Change in BIC	Difference in change in BIC	*p*-value of BLRT	*p*-value of LMRT	Entropy
1	-5453.14	10944.56			-	-	-
2	-5275.47	10635.14	-309.42		0.000	0.000	0.52
3	-5161.45	10453.03	-182.11	**127.31**	0.000	0.000	0.74
4	-5108.65	10393.35	-59.68	122.43	0.000	0.000	0.71
5	-5085.67	**10393.33**	-0.02	59.66	0.000	0.000	0.78
6	-5074.78	10417.46	24.13	24.15	**0.000**	**0.000**	0.77
7	-5071.89	10457.61	40.16	16.03	0.100	0.044	0.82
8	-5071.79	10503.34	45.73	5.57	0.990	0.6784	**0.86**

Note: BIC = Bayesian Information Criterion; BLRT = Bootstrap Likelihood Ratio Test; LMRT = Lo-Mendell-Rubin Adjusted Likelihood Ratio Test. Bolded values indicate the preferred model given the fit index.

Table D.5 shows the item-response probabilities for the three-class model for Model 2. Removing the peer indicator did not distinguish the classes and led to additional model exploration.

Table D.5. Model 2 item response probabilities and percentage of families in each class

Indicator	Class 1	Class 2	Class 3
Case management or service coordination	**0.74**	**0.014**	**0.761**
Support group or workshop	**0.014**	**0**	**0.07**
Therapy or counseling	**0.896**	**0**	0.432
Parenting training or home visiting program	0.608	**1**	**0**
Mentoring	**0.038**	0.621	0.441
Percentage of families in each class	58%	6%	37%

Note: The analysis includes families that received at least one of the primary services. Bolded values indicate an item-response probability that is greater than 0.70 or less than 0.30.

Source: Regional Partnership Grant-Evaluation Data System data, March 1, 2019, through May 19, 2023, (RPG5) and October 1, 2020, through March 15, 2024 (RPG6).

Models 3 and 4 added an indicator for medical services because two projects primarily focused their service provision on this service, which RPG projects typically considered a supportive service. Table D.6 shows the fit statistics for Models 3 and 4, which suggest that a four-, five-, or six-class model are all plausible choices. The BIC reached a minimum value at five classes (Model 3), but the difference in change in BIC points to a four-class model (Model 4). The statistically insignificant *p*-values for the BLRT and LMRT suggest a seven-class model over an eight-class model. Based on the parsimony principle, the cross-site evaluation team did not

consider a seven-class model, but they evaluated both the five- and four-class models. Model 3 explored the five-class model solution, with the item-response probabilities described in Table D.7.

Table D.6. Model 3 and Model 4 fit statistics

Number of latent classes	Log likelihood	BIC	Change in BIC	Difference in change in BIC	*p*-value of BLRT	*p*-value of LMRT	Entropy
1	-6438.93	12923.80			-	-	-
2	-6122.97	12345.44	-578.35		0.000	0.000	0.80
3	-5812.37	11777.83	-567.61	10.74	0.000	0.000	0.89
4	-5744.08	11694.82	-83.01	**484.60**	0.000	0.000	0.80
5	-5697.04	**11654.33**	-40.50	42.52	0.000	0.000	0.75
6	-5671.59	11657.01	2.68	43.18	0.000	0.000	0.78
7	-5653.39	11674.19	17.18	14.50	**0.000**	**0.000**	0.87
8	-5644.37	11709.73	35.54	18.36	0.010	0.007	0.84

Note: BIC = Bayesian Information Criterion; BLRT = Bootstrap Likelihood Ratio Test; LMRT = Lo-Mendell-Rubin Adjusted Likelihood Ratio Test. Bolded values indicate the preferred model given the fit index.

The item-response probabilities for the five-class model for Model 3 in Table D.7 indicate multiple indicators have high item-response probabilities in multiple classes. This suggests that the classes were not distinct from one another. Furthermore, when examining the proportion of families in each class, there is a small proportion of families in two of the classes (1 percent of families in Class 1 and 7 percent of families in Class 3). Importantly, the indicator for medical services stands out as a defining characteristic of Class 5.

Table D.7. Model 3 item response probabilities and percentage of families in each class

Indicator	Class 1	Class 2	Class 3	Class 4	Class 5
Case management or service coordination	**0**	**0.853**	**0.903**	0.679	**0**
Support group or workshop	**1**	**0.012**	**0.010**	**0.032**	**0**
Therapy or counseling	**0.014**	**0.96**	0.362	**0.848**	**0**
Parenting training or home visiting program	**0**	**1**	**0.012**	0.348	**0.788**
Mentoring	**0.025**	**0**	0.589	**0.076**	0.490
Medical services	**0**	0.548	**0.013**	**0.012**	**1**
Percentage of families in each class	1%	18%	25%	49%	7%

Note: The analysis includes families that received at least one of the primary services. Bolded values indicate an item-response probability that is greater than 0.70 or less than 0.30.

Source: Regional Partnership Grant-Evaluation Data System data, March 1, 2019, through May 19, 2023, (RPG5) and October 1, 2020, through March 15, 2024 (RPG6).

Table D.8 presents the item-response probabilities of the four-class model for the final model, Model 4. These probabilities reveal specific services for each latent class and can help identify the meaning of the classes. Looking across the classes, certain indicators stand out as defining elements of only one class. For example, parenting training and home visiting services have a

strong association with Class 3, whereas medical services strongly associated with Class 2 (both have a value of 1). For each of those classes, these indicators define the types of services projects in that class provide: Class 3 focused almost exclusively on parenting training and home visiting services, and Class 2 centered on medical services. One service type, case management or service coordination, strongly associated with both Class 1 and Class 3. These services were common across different kinds of projects as they sought to help families identify and receive other needed services. Therapy services defined Class 4, though the strength of the association was not as high as those seen in Class 3.

After multiple iterations and refinements of the number of LCA models, Model 4 was selected as the final model. The parsimony principle supports this model, which fits the data well while using the fewest number of classes. Families are fairly evenly distributed across the four classes, with the exception of Class 2, in which medical services define the class.

Table D.8. Model 4 item response probabilities and percentage of families in each class

Indicator	Class 1	Class 2	Class 3	Class 4
Case management or service coordination	**0.887**	**0**	**0.770**	0.606
Support group or workshop	**0.008**	**0**	**0.010**	**0.100**
Therapy or counseling	0.481	**0**	**0.910**	**0.795**
Parenting training or home visiting program	**0.082**	**0.790**	**1**	**0**
Mentoring	0.556	0.500	**0**	**0.014**
Medical services	**0.007**	**1**	0.307	**0.019**
Percentage of families in each class	32%	7%	32%	28%

Note: The analysis included families that received at least one of the primary services or at least one service medical support services. Bolded values indicate an item-response probability that is greater than 0.70.

Source: Regional Partnership Grant-Evaluation Data System data, March 1, 2019, through May 19, 2023, (RPG5) and October 1, 2020, through March 15, 2024 (RPG6).

D. Classify service use at the project level (step 4)

Once a final model was selected, RPG5 and RPG6 projects were classified based on the association of their families with each of the classes.

To identify projects' class membership, the probability that each family belongs to each class was calculated, based on services the families received using the six binary indicators in Model 4. The pattern of how each family responds to an indicator determined the probability of class membership. For example, a family that had service encounters in case management and therapy or counseling was more likely to belong to Class 3. Similarly, a family that had service encounters in medical services was likely

Box 3. Class membership probability

Class membership probability is the probability that a family belongs to a specific class. This probability takes on values from 0 to 1.

Values closer to 0 indicate a family is not likely to be a member of that latent class; values closer to 1 indicate a family is likely to be a member of that latent class.

to be a member of Class 2. The analysis assigned families to the class with the highest predicted probability.

The predicted probabilities at the family level were then aggregated to the project level. Projects were assigned to a class by identifying in which class the majority of families likely belonged. For example, if one project had 20 percent of families predicted to be in Class 1, 50 percent of families predicted to be in Class 2, and 30 percent of families predicted to be in Class 3, this project would be classified in Class 2 because it had the highest proportion of families predicted to be in that class.

Table D.9 shows the percentage of families that belonged in each class for each project based on the predictions from Model 4. Overall, the majority of families for each project (90 percent or more) fell into one class, resulting in straightforward class assignments. One notable exception to this is Project C in the table. More than 95 percent of this project's enrolled families belonged to Class 3 or Class 4, but neither class accounted for a majority of families. To be consistent with the majority vote approach, this project was classified in Class 3, but noted in Chapter III that this project did not fit as easily into either class, which affected the analysis and conclusions.

Table D.9. Percentage of families in each class, by project and overall

Project	Class 1	Class 2	Class 3	Class 4
A	80	0	0	20
B	88	0	0	12
C	5	0	49	47
D	4	0	0	96
E	1	0	0	99
F	62	0	3	35
G	1	96	2	0
H	0	0	95	5
I	0	0	0	100
J	0	0	98	2
K	2	0	41	58
L	0	0	82	18
M	66	0	15	19
N	97	0	0	3
O	60	0	0	40
P	97	0	0	3
Q	0	54	20	26
Total	**27**	**7**	**34**	**32**

Note: The analysis included families that received at least one of the primary services or at least one service provided by a peer.

Source: Regional Partnership Grant-Evaluation Data System data, March 1, 2019, through May 19, 2023, (RPG5) and October 1, 2020, through March 15, 2024 (RPG6).

Aggregating the predicted probabilities at the project level yielded the following groups:

1. Class 1: Seven projects that provided case management services.
2. Class 2: Two projects that provided medical care and parenting services.
3. Class 3: Four projects that provided parenting and therapy services.
4. Class 4: Four projects that provided therapy services.

E. Examine service characteristics by latent class (step 5)

After grouping projects into latent classes, further analyses were conducted to describe patterns of service receipt within latent class, as presented in Chapter III.

Appendix E

Methods for Collecting and Analyzing Site Visit Data

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A. Topics for interviews with RPG staff and partners

In site visit interviews conducted in winter 2023 with RPG6 staff and partners, the cross-site evaluation team examined the partnerships developed through the RPG program—between child welfare agencies, substance use treatment providers, and (where applicable) the courts.[65] Table E.1 lists the main interview topics.

Table E.1. Topics for site visit interviews with RPG staff and partners

Topic	Learning objective
Partnership composition and roles	• Who the key partners from child welfare agencies, substance use treatment providers, and courts or other entities were, and what their overall roles were
Developing shared goals and implementation plans	• Roles of key partners from child welfare and substance use treatment systems (and courts or other entities, where applicable) in developing project plans • Project goals and degree of alignment with organizational goals • Planning successes and challenges
How partners worked together to achieve goals	• Roles and responsibilities of key partners in providing referrals and coordinating service delivery • Extent and purpose of communication between partners, particularly child welfare agencies and substance use treatment providers • Strategies for and challenges with making decisions and resolving differences with partners
Facilitators and barriers to working together	• Presence of factors respondents believed affect collaboration between child welfare agencies and substance use treatment providers, and whether the factors were a strength, barrier, both, or neither for their collaboration: – History of working together – Leadership support – Resources and funding – Staff time and turnover – Competing timelines and priorities – Capacity to serve participants – Cross-system staff training – Partners' ability to meet (in person or virtually) – Local policy context
Perceptions about progress toward interagency collaboration	• How the partnership or project helped families • How the partnership or project could better support families • Whether partners were interested in continuing past the project period

Note: Key partners include the lead entity.

[65] The team obtained limited information on the courts' influence on RPG projects and partnerships between child welfare agencies and substance use disorder treatment providers; thus, courts were not a focus in Chapter V.

B. Interview respondents

The cross-site evaluation team aimed to interview all RPG6 project directors and lead contacts at partners from child welfare agencies and substance use treatment providers. When substance use treatment providers were awarded grants, the team aimed to hold at least two interviews—one with the child welfare agency leaders and one with the leaders at the substance use treatment provider. If another type of agency received the grant, the team aimed to hold at least three interviews—one each with leaders from the RPG project, the child welfare agency, and the substance use treatment partner. Some projects had multiple partners from child welfare agencies or multiple partners from substance use treatment agencies, including partners in different jurisdictions. In these instances, interviewers asked the most knowledgeable partners to participate in interviews but did not attempt to talk to all child welfare or substance use treatment partners. For six of the projects, the team also interviewed supervisors and/or direct service staff delivering RPG substance use treatment services to hear a range of perspectives. For two projects, the team interviewed a court partner.

The team conducted 41 interviews with 57 RPG staff or partner respondents from across the eight RPG6 projects. Child welfare staff in six of the projects and substance use treatment providers in all eight projects participated in interviews (Table E.2). In one project, a child welfare contact could not be identified; in another, a child welfare contact declined the interview. Just under half (44 percent) of the respondents were from a lead entity, and the others were from a partner entity. About half of the interview respondents were directors, managers, or administrators; about 30 percent were direct services staff, and the rest were supervisors (Table E.2).

Table E.2. Number of partners and respondents interviewed

Type of entity	Number of projects in which entity participated in interviews	Total respondents interviewed across projects
Substance use treatment provider[a]	8	28
Child welfare agency	6	15
State agency (other than child welfare)[b]	3	6
Court	2	2
Youth advocacy organization	1	3
University research center	1	2
Family support services provider	1	1

[a] For this analysis, a substance use treatment provider refers to any implementing agency that offers recovery services (such as medically assisted treatment or residential treatment) to adults with substance use issues, and/or offers mental or behavioral health treatment or supports (such as intensive case management, assessments, wraparound care, peer mentorship, counseling, or therapy) to adults, children, or the family unit affected by substance use. The provider might also offer family strengthening or parenting supports or other services connected to the provider's mission (such as medical services). An entity offering any RPG substance use treatment, even if it mainly offers other services like medical care or court services, is considered a substance use treatment provider. For example, entities classified as substance use treatment providers include two university hospital clinics, a family treatment court program, and a family support service provider.

[b] One state agency was a judicial department, and two were substance use and mental health services departments.

Table E.3. Staff level of respondents who participated in site visit interviews

Staff level	Number of respondents interviewed
Director, manager, or administrator	29
Supervisor	11
Direct service staff	17
Total	57

C. Analysis approach

After completing all interviews for a project, interviewers used a write-up template to combine answers from respondents within a project. The template mapped to the interview protocols and covered all discussion topics in Table E.1. The interviewer noted any alignments or discrepancies between interview respondents. An experienced team member reviewed all write-ups for clarity and consistency.

To examine responses across projects, team members imported write-ups into NVivo[66] and qualitatively coded the raw data. The team then used analytic spreadsheets in Excel to find themes, thematically code the data, and tally project responses. If an interviewer did not ask project respondents a particular question, and respondents did not otherwise raise the topic, the team considered the response to that question missing. The team counted responses that aligned with the theme as supporting the theme, and counted any missing responses or responses that did not align as not supporting the theme. Thus, project counts presented in Chapter IV should be interpreted as the number of projects in which respondents discussed a theme when they were asked to or raised a theme themselves. An experienced team member reviewed analytic files to verify the accuracy of themes and counts. Team members discussed all areas of disagreement or complexity in developing themes and counts.

To analyze the degree of collaboration between staff from child welfare agencies and substance use treatment providers, two experienced team members examined raw data pertaining to (1) referral procedures and (2) interagency case management and case consultation. To classify the raw data by level of collaboration, they updated project definitions for each level of collaboration (no collaboration, communication, cooperation, or coordination) that were developed for the eighth report to Congress (HHS, 2025) to reflect the current data. They refined the criteria iteratively to capture the range of RPG6 responses and meaningful distinctions across levels. They then tallied the number of responses that aligned to the criteria for each level of collaboration.

To analyze the set of facilitators and barriers common to collaboration efforts by child welfare agencies and substance use treatment providers, cross-site team members categorized, for each project, responses to each factor as being (1) an overall facilitator, if respondents described using the factor to strengthen the partnership; (2) a barrier, if they described the factor as limiting or hindering their partnership; or (3) neutral, if the respondents did not think the factor materially

[66] NVivo is a data software used for coding and analyzing qualitative data. More information is available at https://lumivero.com/products/nvivo/

strengthened or hindered the partnership. Team members then counted the number of projects in which the factor was a facilitator, barrier, or neutral to the partnership and used the following criteria to classify the factor across projects:

- If "facilitator" was the most frequent response across projects (that is, if more projects described a factor as a facilitator than as a barrier or neutral), team members considered whether the factor was (a) a facilitator or (b) a facilitator with limitations. Team members classified the factor as a facilitator with limitations if many projects described the factor as helpful for the partnership overall, but at least half of them noted limitations that prevented them from benefiting from the factor more fully. If limitations were not commonly discussed, they classified the factor as only a facilitator.
- If barrier was the most frequent response across projects, team members classified the factor as a barrier for most projects.
- If a factor was *not* the most frequently cited as a facilitator or barrier across the eight projects included in this analysis, team members concluded the factor did not seem to have a major influence on the collaborations.

Using these criteria, each one of eight factors was classified as a facilitator, barrier, or facilitator with limitations. Chapter IV focuses on only the eight factors found to influence the partnership as a facilitator, barrier, or facilitator with limitations; the chapter excludes one factor (local policy context) that did not seem to influence the partnerships in the aggregate.

Appendix F

Methods for Collecting and Analyzing Data on Participant Experiences

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A. Data collection methods

The exploratory study used two data collection methods—in-depth interviews and focus groups—to learn more about the parents enrolled in RPG services who had a current or previous child welfare case and a substance use issue. The in-depth interviews gave some early insight into parents' perspectives on the factors that led to their substance use and child welfare involvement. The focus groups shed light on parents' experiences in RPG services.

Semi-structured interview guides and focus group discussion guides captured parents' descriptions of experiences leading to their substance use and child welfare involvement and RPG service experiences. Table F.1 lists the topics covered during the in-depth interviews. Table F.2 shows the topics covered in the focus groups.

Table F.1. Topics for the in-depth interviews

Topic	Description
Family and household composition	• Household members, family dynamics, housing stability
Relationships with others	• Relationships with family members (including their own children), peers, and service providers
Economic and financial stability	• Education, employment, and receipt of public benefits
Substance use and misuse	• History of substance use in the family and by the participant
Involvement with the child welfare system	• History of parents' involvement, from childhood to adulthood
Significant experiences and turning points	• Experiences and events thought to shape parents' beliefs and behavior, and how those experiences contributed to substance use and involvement with the child welfare system
Participation in RPG services	• Descriptions of enrolling in RPG services, types of services provided, coordination between child welfare agencies and substance use treatment providers, service approaches that make it easy or difficult to participate in RPG services, and recommendations to improve RPG services
Goals and aspirations	• Parents' goals and hopes for themselves and their family • RPG services that support setting and achieving goals

Table F.2. Focus group topics

Topic	Description
Enrollment in RPG	• Enrollment process • Parents' expectations for services
Participating in RPG services and interacting with partners	• Services received from RPG project, services received from RPG project partners, and coordination between child welfare agencies and substance use treatment providers
Facilitators and barriers to participation	• Approaches that make it easy or difficult for people to participate in RPG services
Participant needs and feedback on program	• The extent to which RPG services met parents' and families' needs and connected them to needed resources • Recommendations to improve RPG services

In addition, each discussion guide included questions to get parents' feedback on the study recruitment process and the use of in-depth interviews and focus groups in the cross-site evaluation. Their feedback will be combined with the cross-site evaluation team's notes about the study methods and processes to inform a larger-scale study with future RPG cohorts. The in-depth interviews lasted up to two hours, and the focus groups lasted up to one and a half hours. Box F.1 describes how the team made sure parents had access to supports during data collection.

Box F.1. Protecting participants

The cross-site evaluation team prioritizes study participants' rights and safety. Every team member received training on how to handle sensitive topics if parents raised them and how to connect parents to professional supports if needed. The cross-site evaluation team developed a tailored list of local resources with the help of each participating site. It included resources such as the local crisis hotline, child welfare reporting hotline, and domestic violence hotline. It also included the point of contact for the site so they could provide emotional or other support to a parent if needed. Parents were given written copies of the resource list and the study team could assist them with contacting a resource if needed. No parents requested support from the resources during data collection.

B. RPG6 project participation

This exploratory study included two RPG6 projects to test discussion guides and processes before using them with RPG7 projects. The two projects served families with child welfare cases and parents or caregivers with substance use issues, in alignment with the overall study eligibility criteria. Box F.2 describes the study eligibility criteria.

The two selected projects demonstrated a capacity to accommodate the in-depth interviews and focus groups and had sufficient participant enrollment. One project served families in a midwestern rural area, and one project served families in an eastern suburban area. To preserve anonymity, names and descriptions of the projects are not included in this report.

Box F.2. Study eligibility criteria

The cross-site evaluation team narrowed the sample criteria for the exploratory study because RPG projects span prevention and intervention services that may not include parents with direct experience with substance use or the child welfare system. To participate, parents had to meet all three of the following criteria:

- Be an adult parent or caregiver who was enrolled and actively participating in RPG6 services or who recently exited RPG6 services
- Current or previous open child welfare case as a parent
- Current or previous substance use issue

C. Participant recruitment and sample size

This exploratory study aimed to include nine parents in in-depth interviews and nine parents in focus groups across the two participating projects. Staff from the two participating RPG6

projects helped with initial outreach to potential respondents. The projects over-recruited to help achieve the target sample size.

Across the two projects, eight parents participated in in-depth interviews—five parents from one project and three parents from the other project. Seven of these parents were female. On average, parents were age 36 (ranged from 28 to 55); had 3 children (ranging from 2 to 6 children, which sometimes included a partner's children living in the home); and nearly all the children, except 2, were younger than age 13.[67]

Eight parents participated in a focus group—four parents from one project and four parents from the other project. To accommodate the schedules of the four parents in one site, they were asked the focus group questions in individual telephone interviews instead of a group setting.

D. Analysis approach

For the in-depth interviews, the cross-site evaluation team transcribed audio-recorded interviews and imported the full transcripts into NVivo. A codebook guided the first round of primary coding. In this round, the codes in the codebook were organized under specific topics interviewers asked about in the discussion guide and themes the team expected to emerge from the data based on the study research questions. However, the team also developed codes inductively—that is, as they emerged from the data. For example, coders found that existing substance use and treatment service codes did not adequately capture participants' narratives about their motivations to get sober and their progress in recovery. The coding team added the code *participant substance use recovery* to the codebook under the topic of substance use.

Before the first round, each coder independently coded the same in-depth interview transcript, and then the coders met as a group to review the codes they applied, address discrepancies between coders, and clarify code descriptions in the codebook. Team members repeated this process with a second in-depth interview transcript to ensure consistency. The remaining transcripts were divided between the coders, and an experienced team member spot-checked each coded transcript. The coding team met throughout the process to address questions and ensure intercoder reliability.

After primary coding was finished, the cross-site evaluation team ran reports in NVivo for each code in the codebook and exported the text into a Word document for analytic subcoding. Often, individual codes were related to a broader theme, so the team ran reports and included multiple codes at one time to examine them together and simplify the analytic subcoding. For example, analyzing how participants coped with adversity required examining the codes *coping strategies*, *participant needs*, and *services and supports* together. The team conducted analytic subcoding in an Excel spreadsheet to generate summaries for each parent interviewed, broken down by each life stage (childhood, adolescence, and adulthood) and by the study's research questions. Then

[67] Demographic information was not systematically collected due to the exploratory nature of this study. Some of the interview questions allowed us to informally gather some basic information about participants. No demographic information could be gathered from the focus group questions.

the coding team looked across the summaries to document emergent subthemes across the whole sample and to import supporting quotations from the text into the spreadsheet.

The cross-site evaluation team used a similar process to analyze the focus group results, except that one experienced team member led all coding and analysis, and a second team member reviewed the coding to ensure its accuracy. The parents who participated in an in-depth interview and those who participated in a focus group often reported similar experiences related to RPG services. Thus, when appropriate, their responses were combined to provide a more robust analysis of parent descriptions related to RPG services.

Appendix G

Methods for Collecting and Analyzing Sustainability Data

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This appendix describes the methods used to collect and analyze the data in Chapter VIII on RPG6 projects' sustainability. It includes a description of the data sources, details about conducting the sustainability survey, and data analysis procedures.

A. Data sources

The team used three data sources for the sustainability study: the semi-annual progress reports, site visit data, and a sustainability survey. The semi-annual progress reports and site visit data were used only to confirm or contextualize findings from the survey.

1. **Semi-annual progress reports.** HHS requires grant recipients to submit written progress reports twice a year. The semi-annual progress reports describe the partner agencies and their activities, how the grant recipient implemented the project, and successes and challenges the projects experienced during each six-month reporting period. For the purposes of the study, the cross-site team used only the semi-annual progress reports that RPG6 grant recipients submitted in April and October of 2022 and April and October of 2023. The analysis focuses on one question in the semi-annual progress reports, "Please summarize the status of your sustainability plans, including any progress made toward formalizing your plan, and any sustainability activities during this reporting period."
2. **Site visit data.** To deepen understanding of the partnerships between child welfare and substance use treatment agencies, the cross-site evaluation team conducted site visits with each RPG6 project once during the grant period. The site visits were virtual in six of the RPG6 projects, and in person in two projects. (Appendix E details the data collection methods for the site visit data described in Chapter IV.) The sustainability study focused on one line of questioning from the site visit interviews, "Do you intend to continue partnering with [partner organization] after the grant ends? If not, why not? If so, do you have the funding, staffing, and other resources in place to continue the partnership?"
3. **Sustainability survey.** The primary data source for the sustainability study was a survey that was administered in a web-based system to respondents from the eight RPG6 projects in summer 2023. The team administered the sustainability survey to a representative from the RPG6 grant recipient and from each partner organization the grant recipient identified. The survey was administered once during the grant period at a point when RPG6 projects had been operating for four years and in full program implementation for three years. The survey asked respondents to report on their work to plan for sustainability and improve their project.

B. Topics in the sustainability survey

The sustainability and improvement survey asked about five broad topics (1) organization characteristics, (2) plans for sustaining the RPG project, (3) implementation supports to improve and maintain RPG services, (4) funding and resources for sustainability, and (5) the federal, state, and local context. Taken together, the survey assessed measures of sustainability planning, sustainability capacity, and financial stability.

To develop the sustainability survey, the team adapted items from previous surveys administered to RPG grant recipients, used items from other data sources such as the semi-annual progress reports, and adapted survey items and subscales scales from established measures of sustainability:

- Guide to Developing, Implementing and Assessing an Innovation (Permanency Innovations Initiative Training and Technical Assistance Project, 2016). The guide names 10 key elements of sustainability planning that, when developed systematically, function as strong implementation practices. The sustainability and improvement survey included questions related to seven of the key elements, including (1) planning for sustainability, (2) using data and information, (3) building relationships and creating partnerships, (4) tracking and monitoring data and other information, (5) demonstrating effects and sharing results, (6) creating and changing systems, and (7) identifying a range of funding and financing. The survey did not ask questions related to the other key elements, including (8) focusing on outcomes, (9) clarifying a vision of success, and (10) engaging leadership.
- Program Sustainability Assessment Tool (Calhoun et al., 2014). This 40-item scale includes 8 subscales that measure a program's sustainability capacity. When completed in full, the assessment reveals sustainability strengths and challenges that can guide sustainability action planning. The sustainability and improvement survey did not include subscales or subscale items. However, the survey did have questions that were closely related to some items from the following subscales: (1) funding stability, (2) organizational capacity, (3) program adaptation, and (4) strategic planning. The survey did not ask questions reflecting the other four subscales: (5) environmental support, (6) partnerships, (7) program evaluation, or (8) communications.

The team pre-tested the sustainability survey in summer 2019 to assess the clarity and completeness of content and to estimate respondent burden. To conduct the pre-test, the team asked five project directors and evaluators from RPG3 to complete the survey. Based on their feedback in a debriefing interview, the team refined the survey for administration.[68]

C. Respondents to the sustainability survey

Survey respondents were staff at grant recipient and partner organizations. The project director saw these staff as the ones who knew the most about RPG6 project sustainability and improvement plans, regardless of their level of involvement in the planning.

Of the 73 respondents invited to complete the survey, 47 completed it, for a 64 percent response rate. The survey analysis encompassed the 42 respondents who reported that their project team planned to sustain the RPG6 project, and who answered follow-up questions. The number of respondents per RPG6 project ranged from three to seven. Seven RPG6 project directors completed the survey. The eighth RPG6 project director had no valid responses because they reported that the partnership would not be sustained, and by design, this response ended the

[68] The sustainability survey was intended to be administered to the RPG5 and RPG6 cohorts, but the public health emergency in 2020 prevented fielding of the survey. Thus, the RPG6 cohort was the first to complete the survey.

survey.[69] When project directors were missing responses, the team used responses from their project manager instead. Some of the 42 survey respondents did not answer or did not know the answer to a given survey question. In these cases, the findings were based on a smaller set of nonmissing survey responses.

D. Data analysis methods

The team used qualitative and descriptive quantitative methods to analyze the data contributing to the sustainability study.

1. **Semi-annual progress reports.** The team coded the semi-annual progress reports every six months as they arrived from grant recipients. The first step in coding the semi-annual progress reports was to use NVivo to organize the text responses to each question into their own code. The team focused on one question across a subset of the semi-annual progress reports submitted by RPG6 projects and exported a report from NVivo that produced all the responses to the sustainability question by grant recipient. The team systematically looked across the responses for each grant recipient and summarized the data across time points in an Excel sheet to summarize the plans for sustainability. Then the team looked at the summaries across all grant recipients to produce counts of items such as whether or not the grant recipients intended to sustain the project and what the common barriers to sustainment were.
2. **Site visit data.** The sustainability study used site visit data analyzed and reported in Chapter IV. The team employed standard qualitative analysis procedures to analyze and summarize site visit data, including coding raw data in NVivo and using analytic spreadsheets in Excel to identify themes and thematically code the data and tally project responses. The sustainability study only reports the site visit findings related to the intention of the RPG6 projects to continue working together. The focus of the site visits was not to explore sustainability in-depth, therefore few findings are presented from the site visit data. Appendix E details the analysis approach for the site visit data.
3. **Sustainability survey.** The team used basic descriptive methods to summarize the survey data. The analysis procedure included cleaning the data, constructing variables, and computing descriptive statistics. Cleaning the data involved verifying that the data values were within the expected ranges, finding any invalid numeric data values, and examining missing data to ensure the proportion of item-level missingness was not large enough to invalidate the response. Also, the team examined the text responses added into the "other, specify" fields in the survey and back-coded responses into existing categories in the survey or created a new category if there were more than five responses. Finally, to make the data easier to interpret, the team created a grant recipient–level indicator to report findings at the RPG project team level instead of the individual respondent level. However, items about the

[69] Based on information from technical assistance calls with this project team, the project director had discussed that the exact same set of partners and services would not be in place if the project were sustained, but acknowledged that components of the project would be maintained beyond the end of funding. For these reasons, the project is included in the count of RPG6 projects that were planning to sustain their services.

respondent's characteristics and organization were kept at the survey respondent level. After completing these data cleaning steps, the team produced descriptive statistics and created counts of individual respondents or the number of RPG projects endorsing a given item or topic.

Whenever possible, the team triangulated the three data sources to ensure consistency or to document any deviations; however, there was limited data from the semi-annual progress reports and site visits that focused explicitly on sustainability. Due to the small quantity of data available from these data sources on this topic, there were few opportunities for comparing findings across them.

Appendix H

Program Models Proposed by RPG7 Projects

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Table H.1. Program models that RPG7 projects proposed to implement (by project)

Program model	AK	CT	FL	IL-C	IL-ICOY	IA-FC	IA-JC	KY	LA	MO-CPR	MO-PFH	NY	OK	PA	TN-DMH SAS	TN-HRM	WV	WI	Total
Parent training and family strengthening																			
1-2-3 Magic															1				1
24/7 Dads												1							1
Active Parenting Now															1				1
Active Parenting of Teens															1				1
Celebrating Families																		1	1
Circle of Security																1		1	2
Early Pathways																		1	1
Mothering from the Inside Out														1					1
Nurturing Parenting Program	1			1				1	1	1	1					1		1	8
Strengthening Families Program				1															1
Teaching Family Model						1													1
Therapeutic Supervised Visitation						1													1
Trust-Based Relational Intervention											1								1
Substance use disorder treatment																			
Comprehensive Opioid Response with Twelve Steps								1											1
Contingency Management												1							1
Helping Men Recover											1								1
Helping Women Recover											1								1
Living in Balance								1			1								2
Matrix Model								1		1									2
Matrix Model Family Program								1											1
Relapse Prevention Therapy					1				1										2

Program model	AK	CT	FL	IL-C	IL-ICOY	IA-FC	IA-JC	KY	LA	MO-CPR	MO-PFH	NY	OK	PA	TN-DMH SAS	TN-HRM	WV	WI	Total
Trauma and behavioral health care																			
Attachment Regulation and Competence						1													1
Beyond Trauma										1									1
Child-Parent Psychotherapy														1		1			2
Cognitive Behavior Therapy				1		1			1	1					1			1	6
Dialectical Behavior Therapy									1	1								1	3
Eye Movement Desensitization and Reprocessing										1						1			2
Filial Therapy																		1	1
Intensive Therapeutic Anger Management Program										1									1
Mindfulness-Based Cognitive Therapy						1				1									2
Moral Reconation Therapy										1									1
Motivational Enhancement Therapy												1							1
Motivational Interviewing			1		1				1		1				1		1	1	7
Multidimensional Family Therapy and Recovery		1																	1
Narrative Cognitive Behavior Therapy										1									1
Parent-Child Interaction Therapy										1									1
Play Therapy																		1	1
Rational Emotive Behavior Therapy															1				1
Reunification Therapy										1									1
Seeking Safety								1		1					1	1		1	5
Solution-Focused Brief Therapy									1										1

Program model	AK	CT	FL	IL-C	IL-ICOY	IA-FC	IA-JC	KY	LA	MO-CPR	MO-PFH	NY	OK	PA	TN-DMHSAS	TN-HRM	WV	WI	Total
Stress Management and Resiliency Training											1								1
Trauma-Focused Cognitive Behavioral Therapy						1				1									2
Case management or service coordination																			
HOMEBUILDERS															1				1
Parent-Child Assistance Program											1		1						2
Strengths, Needs, Abilities and Preferences Profile										1									1
Solution-Based Case Work					1														1
Team Decision Making	1																		1
Wellness Recovery Action Planning			1																1
Wraparound																	1		1
Screening or assessment																			
American Society of Addiction Medicine Criteria											1								1
Screening, Brief Intervention, and Referral to Treatment			1																1
Other																			
Individual Placement and Support											1								1
Into the Future										1									1
Total	**2**	**1**	**3**	**3**	**3**	**6**	**0**	**6**	**6**	**16**	**10**	**3**	**1**	**2**	**8**	**5**	**2**	**10**	**87**

Note: This information reflects grant recipients' plans as of November 2023. Some grant recipients' services may evolve over time as their plans change.

IA-FC = Florence Crittenton Home of Sioux City; IA-JC = Judiciary Courts for the State of Iowa; IL-C = Centerstone; IL-ICOY = Youth Network Council dba Illinois Collaboration on Youth; MO-CPR = CPR of the Ozarks; MO-PFH = Preferred Family Health; TN-DMHSAS = Department of Mental Health and Substance Abuse Services; TN-HRM = Helen Ross McNabb Center.

Source: Grant recipient profiles; information provided by grant recipients to the cross-site evaluation team.

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