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Family Connection Discretionary Grants
2012-Funded Comprehensive Residential
Family Treatment Projects
Final Cross-site Evaluation Report

June 22, 2016

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Contract #: HHP233201500039I
Order #: HHSP23337001T

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The following document contains the cross-site evaluation report of the 2012-Funded Comprehensive Residential Family Treatment Projects. This work was completed under Contract #: HHP233201500039I, Order #: HHSP23337001T. Questions on this document by James Bell Associates should be directed to Matthew R. McGuire, Contracting Officer's Representative, Children's Bureau, at matthew.mcguire@acf.hhs.gov or (202) 205-7270.

**Family Connection Discretionary Grants
2012-Funded Comprehensive Residential Family Treatment Projects**

Cross-site Evaluation Report

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Family Connection Discretionary Grants 2012-Funded Comprehensive Residential Family Treatment Projects

Final Cross-site Evaluation Report

This report is organized into several key sections that document process results for the five Family Connection grantees, which comprise the 2012-funded Comprehensive Residential Family Treatment Projects cluster. The Background and Overview section provides contextual information on the history of Family Connection discretionary grants and program areas and an overview of Comprehensive Residential Family Treatment Projects and implementation science literature. The Evaluation Approach details James Bell Associates' (JBA) development of logic models, process and outcome evaluation questions, data collection, and analysis procedures. The Process Evaluation Findings and Implementation Components sections synthesize process evaluations and organizational characteristics guided by implementation science. Outcome Evaluation Findings summarizes adult, child, and family-level findings; organizational and system-level findings; and cost study results. The report also includes several appendices to support the core text.

Section 1: Background and Overview

In September 2012, five grantees were awarded grants in the cluster area focused on implementing Comprehensive Residential Family Treatment (RFT) Projects. These 3-year grants supported RFT projects expanding the availability of effective and comprehensive residential treatment services for families involved with, or potentially served by, the child welfare system. Grantees conducted site-specific evaluations to improve processes and services and to demonstrate linkages between project activities and improved outcomes. Grantees also participated in a national cross-site evaluation documenting the progress and outcomes of each project and the five grantees (i.e., cluster).

Legislation Overview

In 2008, the Administration for Children and Families (ACF), Children's Bureau (CB) announced the availability of competitive grant funds authorized by the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351). This enabled the Secretary of the U.S. Department of Health and Human Services (HHS) to award competitive, matching grants of between 1 and 3 years to state, local, or tribal child welfare agencies and private/not-for-profit organizations to develop and implement programs to help children, who are in or at risk of entering into foster care, to reconnect with family members. This legislation was authorized for 5 years, thereby allowing for multiple rounds of awards. The first cohort included 24 Family Connection Discretionary Grants funded in September 2009 to implement Family-finding, Kinship Navigator, Residential Family Treatment, and Family Group Decision-making projects. Seven grantees were funded in 2011 as part of the Using Family Group Decision-making to Build Protective Factors for Children and Families cluster. The 2012-funded Comprehensive Residential Family Treatment Projects Discretionary Grants Program was one of three clusters funded in the third cohort of grants.¹ The other two clusters included seven Child Welfare/Temporary Assistance for Needy Families (TANF)

¹ HHS, Administration for Children and Families. (2012). *Family Connection Discretionary Grants*. Funding Opportunity Number: HHS-2012-ACF-ACYF-CF-0511 RFT.

Collaboration in Kinship Navigation Programs and five Combination Family-finding/Family Group Decision-making Projects. All grants were funded for 3 years.

Comprehensive Residential Family Treatment Projects expanded the availability of effective, comprehensive, residential treatment services for families involved with, or potentially served by, the child welfare system. Projects provided RFT services for primary caregivers, their minor children, and other family members to improve child and family outcomes. Projects used a family-centered service approach to address the complex, multiple needs of the target population, support the family unit, and provide a safe and healthy environment for family members. The projects were designed to identify and apply a range of effective, individualized services to support safety, permanency, and well-being for children and family members by improving parenting capacities and child functioning and well-being, and by decreasing underlying problems, such as parental substance use. Service providers were involved in the planning and coordination of comprehensive services to families in a culturally competent, gender-specific, and accessible manner. These projects were demonstration sites that other states and locales seeking to implement residential family treatment services for similar populations could look to for guidance, insight, and possible replication.

The authorizing legislation sets aside funding for evaluation of Family Connection grantee activities. Within this charge, CB contracted with JBA to conduct a national, cross-site evaluation. The cross-site evaluation of the Comprehensive Residential Family Treatment Projects (under the Family Connection Discretionary Grants) was designed to determine the effectiveness of the five grants funded under this legislation in 2012. JBA may be referred to as JBA or the cross-site evaluation team in the remainder of this report.

In addition to participating in the national cross-site evaluation, each grantee was required to set aside funds and secure resources to conduct a local evaluation to assess its ability to reconnect children—who are in or at risk of entering foster care—with family members. CB set expectations for grantees to engage in a strong site-specific evaluation to improve their processes and services and demonstrate linkages between project activities and improved outcomes. Technical assistance (TA) was provided toward the conduct of site-specific evaluations as required in the program announcement. TA incorporated activities to address how site-specific evaluations also contributed to the national cross-site evaluation.

Comprehensive Residential Family Treatment Projects Overview

Comprehensive Residential Family Treatment Projects enable parents and their children to live in a safe environment for not less than 6 months. They also provide, on site or by referral, substance abuse treatment services, children’s early intervention services, family counseling, medical and mental health services, nursery and preschool, and other services designed to provide comprehensive treatment that supports the family. Facilities meet all state and local childcare and residential facility licensing requirements and have qualified staff and appropriate supervision.

RFT services tend to be in short supply as they are costly, complex, and disruptive to family life and may be resisted by family members who do not want to leave their current residence. However, these services are often the most effective resources for parents with co-occurring substance use and mental health disorders.

Projects focus on Child and Family Service Review (CFSR) Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate, with “home” being a designated treatment facility

that is designed to include as many minor children of the parent as possible. Safe and appropriate living arrangements should be available for minor children who are unable to reside in the treatment facility. Most, if not all, services are provided in the residential setting; any offsite treatment services are coordinated and integrated with the residential facility. To facilitate coordination and collaboration, all agencies connected to the facility support cross-system information sharing mechanisms.

Services for parents include, but are not limited to, mental health assessment and counseling, substance use assessment and counseling, parenting skills training, family counseling, continuing care and recovery support, and ancillary services. Children’s services include, but are not limited to, developmental and educational assessments and services, physical health assessments and services, mental health assessments and counseling, trauma assessments, family counseling, and other early intervention and preventive services. RFT projects and associated agencies may also provide supplemental and followup services for parents, children, and other family members. Supplemental services include alcohol and drug education and referrals for substance abuse, social, psychological, vocational, and medical services. The projects include case management to coordinate administrative and case services, assess and monitor parents and children, assist with community reintegration, and assist in accessing federal, state, and local resources.

The grantees funded in 2012 varied in terms of geographic location (see Table 1: Comprehensive Residential Family Treatment Projects and Locations). Two grantees—Amethyst, Inc., and Renewal House, Inc.—received funding to implement services as part of the 2009-funded cohort. Meta House, Inc., which received 2009 funds, was a key service provider for the State of Wisconsin Department of Children and Families. All grantees were private/not-for-profit service-providing organizations.

Table 1: Comprehensive Residential Family Treatment Projects and Locations

Grantee	Project Title	Location
Amethyst, Inc.	Recovery for Families: Protecting Children and Supporting Families	Columbus, Ohio
Meta House, Inc.	Offering Families Safety, Permanency, and Recovery Gains (OFFSPRG)	Milwaukee, Wisconsin
Queen of Peace Center	EMPOWERment Project (Enhancing Maternal and Child Permanency, Wellbeing, Safety and Recovery)	St. Louis, Missouri
Renewal House, Inc.	Footprints Project	Nashville, Tennessee
Susan B. Anthony Center, Inc.	Comprehensive Residential Family Treatment Project	Pembroke Pines, Florida

Frameworks Used to Organize Process Findings

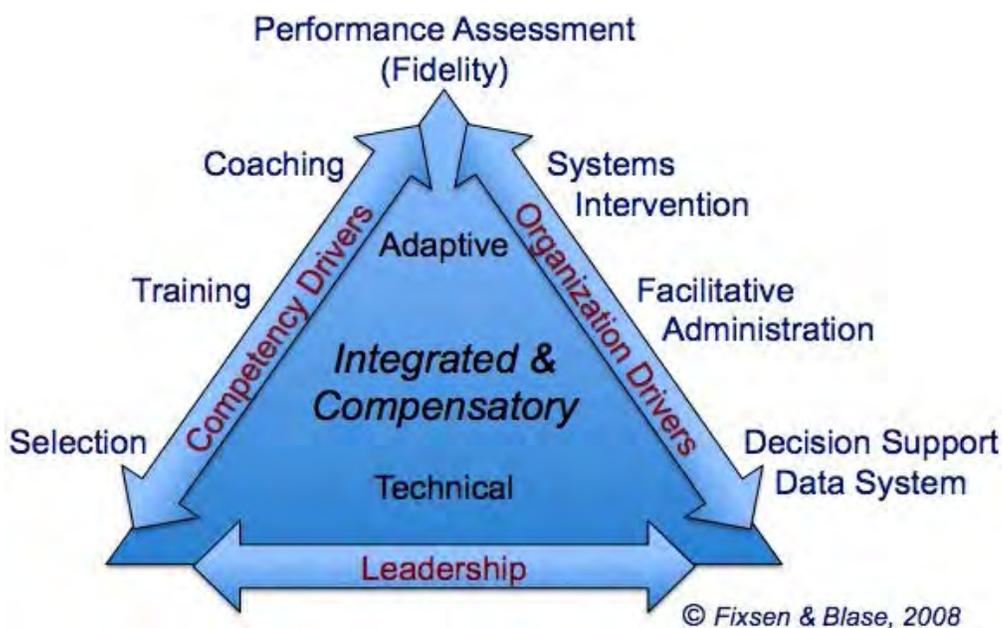
The national cross-site process evaluation was designed to describe critical portions of the developmental cycles, including design, implementation, maintenance, and sustainability. The cross-site evaluation adapted elements from the National Implementation Research Network (NIRN) Implementation Science²

² Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

and JBA’s Evidence-based Programming (EBP)³ frameworks to facilitate understanding the contextual factors that contribute to successful implementation of Family Connection grants.

While the NIRN framework highlights a range of stages, processes, and cycles regarding implementation, the cross-site process evaluation primarily focused on the intervention/innovation and implementation drivers aspects as they relate to the grant projects. The NIRN implementation science framework is based on a synthesis of implementation research findings across diverse fields. It assumes that implementation drivers are considered building blocks of the infrastructure required to support practice, organizational, and systems change. It also assumes that collectively, implementation drivers contribute to the successful implementation of innovative child welfare program models and practices by ensuring program model fidelity and sustainability (see Figure 1: NIRN Implementation Science Framework - Implementation Drivers).⁴

Figure 1: NIRN Implementation Science Framework - Implementation Drivers



³ James Bell Associates (2013). *Lessons learned through the application of implementation science concepts to Children’s Bureau discretionary grant programs*. Arlington, VA: Author.

⁴ Bertram, R. M., Blase, K. A., & Fixsen, D. L. (2014). Improving programs and outcomes: Implementation frameworks and organization change. *Research on Social Work Practice*. Advance online publication. doi:10.1177/1049731514537687.

Implementation drivers are integrated and compensatory and are organized into three categories.

Competency Drivers

- **Staff Selection.** Mechanisms to use to develop competence, confidence, and capacity through effective staffing practices.
- **Training.** Opportunities for project staff and partners to learn when, how, and with whom to use new skills and practices.
- **Consultation and Coaching.** Continuous guidance and encouragement as new skills are being used.
- **Performance Assessment.** Evaluation of staff members' performance and fidelity to the model.

Organization Drivers

- **Facilitative Administration.** Addressing institutional capacity to support staff implementing practices with fidelity through a prepared and supportive administrative environment.
- **Systems Intervention.** Collaborating and coordinating with key stakeholders.
- **Decision Support Data System.** Supporting continuous quality monitoring and improvement through evaluation.

Leadership Drivers

- Defining and addressing adaptive and technical challenges; aligning intervention model with the project mission, values, and vision; establishing clarity of roles, responsibilities, and communication patterns; and making informed decisions to guide and support implementation.

Implementation science literature also recognizes the multi-level influences on the successful implementation of child welfare projects and practices. Core implementation components, organizational components, and influence factors work together to create implementation outcomes. Social, economic, and/or political influence factors either promote or obstruct how well core implementation components operate. As such, JBA also included a qualitative assessment of the internal and external factors influencing grantees' implementation outcomes in the cross-site evaluation to better understand the contextual factors that impacted project implementation.

Several key assumptions of the NIRN framework do not apply to these funded projects, which, in turn, challenge the applicability of the framework to the implementation experiences of Family Connection grantees. While the NIRN framework was developed to foster successful replication of evidence-based practices in human service practice settings, Family Connection grantees were funded to implement and evaluate promising practices (i.e., Comprehensive Residential Family Treatment Projects) that are typically not as well established or rigorously evaluated. Additionally, while it assumes that programs have the resources and capacity to engage in an exploration phase (during which community stakeholders engage in a collaborative planning and problem solving process), CB grantees often operate under short timeframes for planning, adapting, implementing, and evaluating their projects.

Due to the specific funding requirements and limited start-up period afforded CB grantees, JBA (2013) adapted the NIRN Implementation Science framework for a set of CB discretionary grantees to help document their experiences and identify successful implementation strategies for federally funded projects. The resulting EBP framework is tailored directly toward CB grant projects, and thus takes into account the nuances of operating under federal guidelines and regulations. The implementation factors (which are comparable to the implementation drivers in the NIRN framework) are identified and contribute most significantly to effective project implementation. The EBP implementation factors

assessed through the cross-site process evaluation are organized by the two distinct phases within the lifespan of CB-funded projects (i.e., project planning and implementation).

Phase 1: Conceptualization and Planning. Grant applications are developed in response to funding announcements. This process includes documenting a clear need for the proposed services, identifying project champions, developing partnerships, and creating an evaluation plan. In combination, these implementation factors should contribute to improved project plans, strengthen grant proposals, and lead to an increased readiness for implementation per the following three steps:

- Identifying, adapting, or designing a program
- Planning for program evaluation
- Building community partnerships and commitment

Phase 2: Project Implementation. Projects are expected to be implemented, adapted, and maintained. In combination, the Phase 2 implementation factors listed below are expected to contribute to improved project implementation, participant outcomes, and systems of care.

- Implementing effective participant recruitment and retention strategies
- Hiring/assigning project staff members with relevant skills and qualities
- Providing intensive initial and ongoing staff training
- Providing ongoing staff supervision, support, and evaluation
- Implementing a high-quality program evaluation
- Empowering and sustaining project champions
- Initiating a purposeful approach to change/making program changes
- Engaging in proactive sustainability efforts

Table 2: NIRN Implementation Science Framework and Parallel JBA Concepts illustrates the relationship between the concepts of NIRN Implementation Science and JBA’s EBP framework.

Table 2: NIRN Implementation Science Framework and Parallel JBA Concepts

Implementation Science Component	Evidence-based Programming Component
Intervention/Innovation	<ul style="list-style-type: none"> • Identifying, adapting, or designing a program • Planning for program evaluation • Implementing effective participant recruitment and retention strategies
Selection	<ul style="list-style-type: none"> • Identifying, adapting, or designing a program • Involving extended family members
Training	<ul style="list-style-type: none"> • Providing intensive initial and ongoing staff training
Coaching	<ul style="list-style-type: none"> • Providing ongoing staff supervision, support, and evaluation
Performance Assessment (Staff Evaluation)	<ul style="list-style-type: none"> • Implementing a high-quality program evaluation
Leadership	<ul style="list-style-type: none"> • Empowering and sustaining project champions
Decision Support Data System (Program Evaluation)	<ul style="list-style-type: none"> • Implementing a high-quality program evaluation • Making program changes
Facilitative Administration	<ul style="list-style-type: none"> • Engaging in proactive sustainability efforts
Systems Intervention	<ul style="list-style-type: none"> • Building community partnerships and commitment
Influence Factors	<ul style="list-style-type: none"> • No parallel JBA concept

Note: Some EBP concepts are aligned with more than one Implementation Science component.

By incorporating concepts detailed in both the NIRN Implementation Science and JBA's EBP frameworks into the cross-site evaluation, the cross-site evaluation team was able to draw out and develop a detailed description of the key components of successful implementation, including the programmatic, organizational, and contextual factors that facilitated enhanced project performance among the five grantees. Identifying these practices assisted in making the link between project implementation and outcomes, and will aid future grantees in efforts to implement RFT services effectively within federal grant parameters.

Section 2: Evaluation Approach

An informative and rigorous cross-site evaluation addressed process and outcome questions at the parent/child/family and organizational/systems levels for the Family Connection Comprehensive Residential Family Treatment Projects cluster. A cluster logic model was developed as a key step in planning the evaluation design. The following sections provide details on logic model development and the approach to the process and outcome evaluations.

For purposes of this cross-site evaluation, “parent” was defined broadly to include a biological parent, foster parent, adoptive parent, kinship caregiver, or other primary caregiver. “Child” included infants, children, and youth up to age 18. “Family” may have included immediate, biological family; extended family and other kin; other significant adults; or community members.

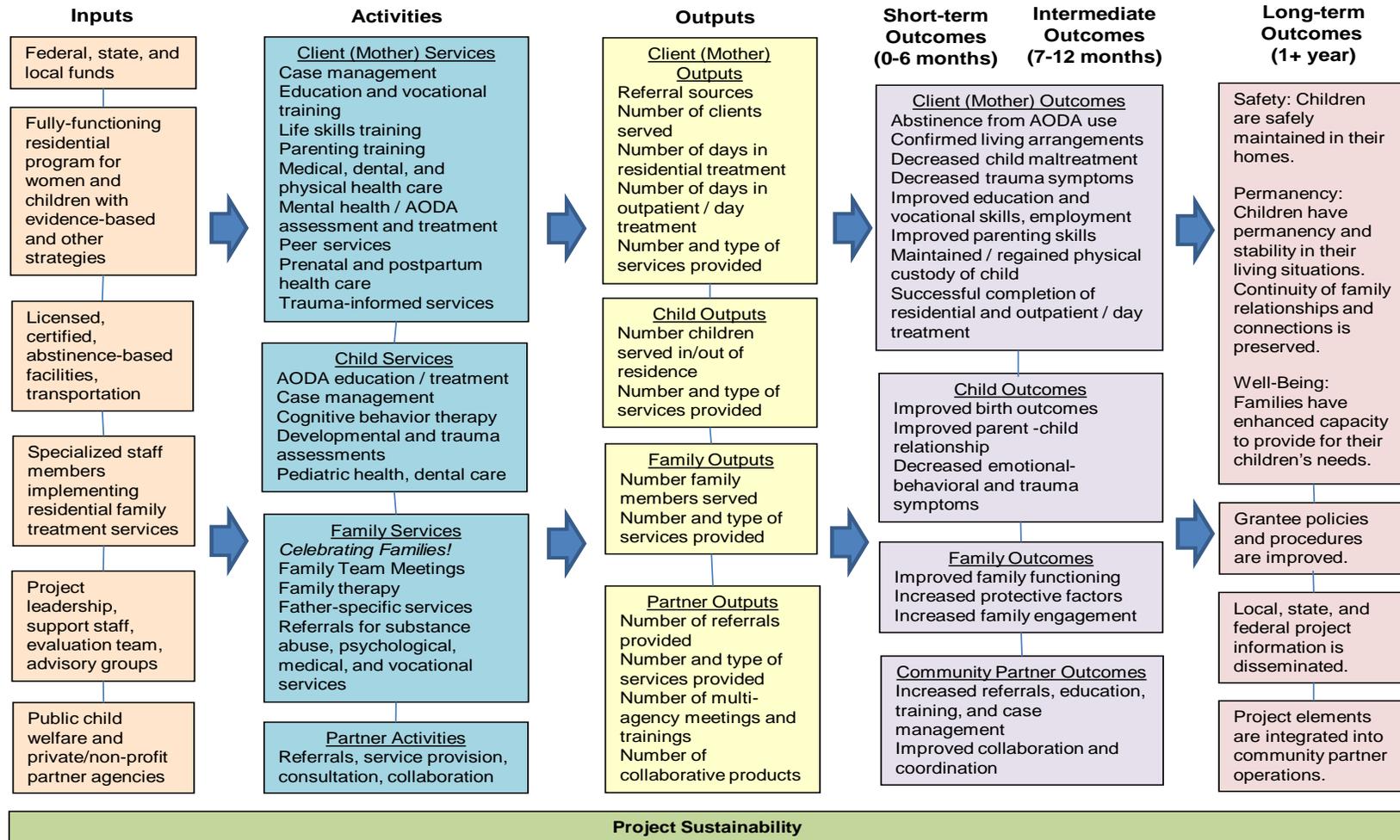
Logic Model for Comprehensive Residential Family Treatment Projects

A cluster-level logic model was developed to depict common elements in the projects’ functioning and anticipated impacts (see Figure 2: Comprehensive Residential Family Treatment Projects Logic Model). Project evaluators, directors, other interested project staff members, and CB Federal Project Officers were provided an opportunity to review and comment. Revisions were based on grantee and stakeholder feedback.

The logic model helped structure the cross-site evaluation, providing a map of the key project activities along with the expected outputs and outcomes. It was designed to facilitate a clear understanding of what services were implemented, what goals were to be achieved, what data were collected in the evaluation, and how data were used. The logic model provides a graphic representation of the inputs, activities, outputs, and outcomes listed in grantee applications, logic models, evaluation plans, and other evaluation-related documents.

- **Inputs** fell within the categories of human (e.g., staff members), service (e.g., evidence-based and promising practices), fiscal (e.g., federal and other funding), technical (e.g., computers, telephones), and community (e.g., community agencies and organizations, advisory boards).
- **Activities** included service models; services and activities for parents, children, and families; staff training and coaching activities; and collaboration efforts.
- **Outputs** included number of parents, children, and families served along with outputs related to services, training and education, case plans, and meetings.
- **Outcomes** were divided into short-term, intermediate, and long-term. Generally, short-term outcomes could be found from 0 to 6 months, intermediate outcomes from 6 to 12 months, and long-term outcomes from 12 months forward. The timing of outcomes varied, depending on the focus and structure of the projects. Short-term outcomes all contributed to more common intermediate outcomes. Long-term outcomes related to child safety, parents maintaining custody, children avoiding foster care re-entry and multiple placements, and improved capacity of the family to meet children’s needs.

Figure 2: Comprehensive Residential Family Treatment Projects Logic Model



Note: Client, child, and family services are examples of grantee project's holistic cadre of services. Services in italics are evidence-based.

Cross-site Evaluation Questions

This section provides an overview of the cross-site evaluation questions. Process evaluation questions address key areas of intervention, implementation, and influence factors. Outcome questions address potential findings in the areas of safety, permanency, and well-being for adults, children, and family, along with organizational-system level outcomes.

Process Evaluation Questions

A process evaluation was designed to describe critical portions of the developmental cycle related to design, implementation, maintenance, and sustainability. Questions incorporating key CB interests and implementation science components were addressed for the process evaluation.

Intervention

- *What are the characteristics of the children, parents, and families being served?*
- *What are the service models, interventions, and activities implemented by the projects?*
- *What amount and mix of services are provided to parents, children, and families receiving residential family treatment services?*

Implementation

- *How do project leaders promote, guide, and sustain effective project implementation?*
- *How do grantees select, develop, and sustain staff's ability to effectively implement project services?*
- *What is the quality of service implementation in regard to timeliness, fidelity, and administration?*
- *How do the projects pursue continuous quality improvement as a way to improve services?*
- *To what extent do projects collaborate with key partners, particularly child welfare agencies, to serve children and families?*

Influence Factors

- *What challenges and facilitators do projects experience in implementing services?*

Outcome Evaluation Questions

An outcome evaluation was conducted to determine the effectiveness of projects in producing outcomes related to safety, permanency, and well-being. As applicable, long-term parent, child, and family-level outcomes were labeled by CFSR measures. CFSR outcomes and items were used as an organizing framework for outcomes; a CFSR was not conducted with grantees, nor were they expected to conduct one. The outcome evaluation also addressed several other organizational and system-level questions, including grantee impact on child welfare practice in the community and project plans for sustainability beyond the 3-year federal funding period.

The following questions assessed parent, child, and family-level outcomes:

- *To what degree do projects achieve short-term and intermediate outcomes?*

Parent Outcomes

- *Successful completion of residential, outpatient, and day treatment (safety, well-being)*
- *Confirmed living arrangements (permanency)*
- *Abstained from substance use (safety, well-being)*
- *Improved parenting skills (well-being)*
- *Improved education/vocational skills and employment (permanency, well-being)*
- *Maintained and/or regained physical custody of child (permanency)*
- *Decreased child maltreatment (safety)*
- *Decreased trauma symptoms (well-being)*

Child Outcomes

- *Improved birth outcomes (safety)*
- *Improved parent relationships (permanency, well-being)*
- *Decreased emotional-behavioral and trauma symptoms (well-being)*

Family Outcomes

- *Increased engagement with family members (permanency)*

Project Partner Outcomes

- *Increased referrals, education, training, and case management*
- *Improved collaboration and coordination*

- *To what degree do projects achieve long-term outcomes?*

Parent, Child, and Family Outcomes

- *Maintained children safely in their homes (safety)*
- *Provided permanency and stability for children in their living situations (permanency)*
- *Preserved continuity of family relationships and connections (permanency)*
- *Enhanced capacity of families to provide for their children's needs (well-being)*

Project Partner Outcomes

- *Improved grantee policies and procedures*
- *Disseminated project information to local, state, and federal audiences*
- *Integrated project elements into community partner operations.*

The following questions addressed organizational and system-level outcomes:

- *What new policies and procedures were developed as a result of the projects?*
- *To what extent have public child welfare agencies integrated elements of the service models?*
- *How have the projects impacted child welfare practice in the community?*
- *In what ways are projects sustainable beyond the federal funding period?*
- *To what extent have cost studies impacted sustainability efforts?*

Data Collection

Primary and secondary data consisted of information collected through grantee summaries and profiles; Web-based, electronic survey data; and evaluation reports. Qualitative data consisted of descriptions of service models, service implementation processes, service challenges and facilitators, and changes in the service model (and why they occurred). Qualitative data also consisted of descriptions of project staffing; continuous quality improvement; project leadership; collaboration between the grantee and partner agencies, including local and state child welfare agencies; and how collaboration affected service delivery. Quantitative data consisted of counts of parents, children, and family members served; descriptive statistics to characterize the target population (e.g., age, gender, race/ethnicity); different types of services; other outputs; and, to the degree available, short-term, intermediate, and long-term outcomes. Quantitative data also include the counts and descriptive statistics of the Web-based, electronic survey data.

Primary and secondary data reflected a mixture of quantitative and qualitative methodology. Secondary data addressing process and outcome evaluation questions were collected and synthesized. They were also supplemented with primary data collection to confirm information and to elicit additional information not readily available from these sources.

Secondary Data

Secondary data sources consisted of grantee- and JBA-generated documents. Grantee-generated documents included grant applications, logic models, evaluation plans, semi-annual project and evaluation reports, and other documents describing project and evaluation activities. Grantees were required to provide applications, logic models, evaluation plans, and semi-annual project and evaluation reports to CB. As made available, these documents were reviewed and incorporated.

Grantee Summaries. JBA-generated documents included grantee summaries originally created for the Kickoff Webinar in December 2012. Summaries chronicled in a narrative format each grantee's key project interventions and activities, evaluation design and data collection activities, and expected outcomes. An accompanying matrix incorporated detailed information on grantee services, outcomes, and evaluation design and measures. Summaries may be found in Appendix A: Grantee Summaries.

Grantee Profiles. Summaries and grantee-generated documents were used to create a detailed profile that organized information into the following categories: (1) needs and available resources, (2) goals and desired outcomes, (3) best practices and evidence-based models, (4) organizational capabilities and capacities, (5) project plans, (6) process and outcome evaluation plans, (7) continuous quality improvement strategies, and (8) sustainability strategies. Profiles were considered working documents and updated throughout the funding period per information from grantee semi-annual reports, other documents, and conversations with grantees. The profile template can be found in Appendix B: Grantee Profile Template. The profiles can be found in Appendix C: Grantee Profiles.

Evaluation Reports. An evaluation report template was designed to report the results of local process and outcome evaluations as part of semi-annual reports delivered to CB. The templates were designed to capture national cross-site evaluation information, yet provide the flexibility to report results consistent with local data collection procedures. Primary and secondary data sources were used to capture local elements of interest. Primary data sources included copyrighted, author-owned, or team-designed instruments; programmatic forms that captured administrative and intake data; assessments; and

interviews and focus groups with project staff members, project partners, and service recipients. Secondary data sources included administrative and project-specific electronic databases and paper-based records, as well as public child welfare data sets, such as the Statewide Automated Child Welfare Information System (SACWIS), Adoption and Foster Care Analysis and Reporting System (AFCARS), and National Data Archive on Child Abuse and Neglect (NCANDS).

A common reporting template was completed and had accompanying reporting instructions to provide guidance on how each section should be completed. Instructions further specified that evaluation reports should be consistent with information captured in profiles, semi-annual and annual reports to CB, and other local reports to project staff members and stakeholders. Grantees determined how to use text and/or tables to report information on progress and changes, process and outcome results, and conclusions. The report instructions and templates, in Appendix D: Evaluation Semi-annual Report Instructions and Templates, organized information into these categories: evaluation progress and modifications; process evaluation (including information on participant unit of analysis, participants served, demographics, type of service by participant, additional outputs, model fidelity, and cost studies); outcome evaluation (including information on data source changes, treatment and comparison group data, and data analysis timelines); and discussion.

Drawing upon JBA's previous experience conducting a cross-site evaluation of the 24 Family Connection grantees funded in 2009 and 7 grantees funded in 2011, a proactive approach was taken to ensure that semi-annual evaluation reports provided accurate and uniform data for the cross-site evaluation. In order to guide the review process and ensure consistency in evaluation reporting, a quality assurance checklist was used to assess evaluation semi-annual reports. The Evaluation TA Liaison used the checklist to identify areas that required additional information or clarification. This quality assurance review was conducted on a semi-annual basis as grantees submitted their reports, and the Evaluation TA Liaison provided feedback to grantees and the cluster Federal Project Officer. Reported information was cumulatively incorporated from semi-annual reports covering evaluation activities and outcomes from September 30, 2012, through September 30, 2015.

A final evaluation semi-annual report was completed by October 31, 2015, and a final progress report was produced on December 31, 2015. The Final Progress Report included suggestions and guidance to organize grantee reports into eight sections: Executive Summary; Overview of the Community, Population, and Needs; Overview of the Program (Service) Model; Collaboration; Sustainability; Evaluation; Conclusions; and Recommendations (see Appendix E: Grantee Final Progress Report Outline). The evaluation section asked grantees for details on evaluation methodology by process and outcome evaluation methods, results, and discussion.

Primary Data

The aforementioned secondary data sources were supplemented with primary data collection, consisting of a Web-based, electronic survey that was customized to confirm secondary data and solicit primary data on process constructs not readily available from existing grantee information. Surveys were administered to grantee leadership, project and evaluation staff members, service providers, and collaborating partners, including the child welfare agency director or managers. The survey was conducted in Year 3 of funding and addressed multiple aspects of implementation and impact.

Survey Development. Survey protocols were created for a cross-section of grantee participants: project leadership, service providers, child welfare agencies, community partners, and the evaluation team.

Surveys were developed from qualitative discussion protocols used for 2009- and 2011-funded Family Connection grantees, and their associated codebooks were used for qualitative analysis of discussion data. They were reviewed by Family Connection grantee representatives and the CB, and then revised accordingly. Protocols were organized by categories that corresponded to cross-site evaluation questions and implementation drivers/factors from the Implementation Science and EBP frameworks. Some similar questions were asked across various discussion participants to assess consistency in responses. The survey protocols for all five surveys are in Appendix F: Web-based Survey Protocols.

Key topics included the following:

- Participant background
- Project planning
- Project implementation and modifications
- Project referral process, service flow, and service provision
- Collaboration with project partners
- Collaboration with evaluation team
- Trends and benefits from service use
- Project achievements and challenges
- Project sustainability
- Evaluation process
- Assessing Comprehensive Residential Family Treatment Projects model fidelity
- Evaluation report highlights.

Institutional Review Board and Office of Management and Budget Approval. An exemption determination form was submitted to Western Institutional Review Board (WIRB) on January 27, 2015, to request that the process for collecting Web-based, electronic survey data from grantee project, evaluation staff members, and project partners be exempt from an IRB review. A regulatory opinion approving the exemption from WIRB was received on February 3, 2015.

JBA worked with CB to submit a general 60-day package in October 2014 and to submit a detailed 30-day package in January 2015 to the Office of Management and Budget (OMB). The package included Supporting Statement A: Justification, Supporting Statement B: Collections of Information Employing Statistical Methods, and related attachments. OMB approval was obtained on June 23, 2015.

Survey Administration. JBA and the CB disseminated a standard email communication to each grantee's project director and local evaluation team members that described the purpose and process of the survey in February 2015. The Evaluation TA Liaison followed up with each to verify the key informant sample and generate the convenience sample of service providers. Additional communication to all survey respondents from JBA and the CB occurred in April 2015 prior to survey dissemination.

The surveys were administered through Qualtrics Web-based electronic survey software in July 2015. As identified by the Evaluation TA Liaison, survey respondents were sent an invitation to their work email addresses to participate via an individualized link to the survey embedded in the email. Respondents had the option to complete the survey in more than one sitting; their responses were saved until surveys were electronically submitted to JBA. The surveys took approximately 15 to 45 minutes to complete, depending on the survey type (Project Leader, Service Provider, Public Child Welfare Agency, Community Partner, or Evaluation Team Member).

The dissemination period lasted approximately 4 weeks. Weekly reminder emails were sent only to those respondents who had not submitted a survey. At the end of approximately 3 weeks, a general communication was sent to all project directors and evaluators to ensure respondent lists for all projects

had remained consistent and that the service provider, evaluation team member, or project partner turnover was not contributing to nonresponse.

Data Analysis

Multiple sources were used to extract data indicating the processes used to implement projects and determine the extent to which the intended outcomes were achieved. Priority was given to analysis of quantitative and qualitative data responsive to research questions, particularly those related to safety, permanency, and well-being. Data included in the analyses were obtained through primary and secondary sources: (1) grantee profiles outlining project structures, goals, and activities; (2) grantee semi-annual reports describing project progress, evaluation activities, and findings; and (3) a Web-based survey, partnering organizations, and local evaluation team members. The data provided by grantees in semi-annual evaluation reports were aggregated and analyzed, yielding cluster-level findings in addition to grantee-specific findings. To ensure accuracy of reporting, an opportunity was provided to review and give feedback on the synthesized evaluation findings. These methods are further detailed below.

Quantitative Synthesis of Evaluation Semi-annual Reports

Quantitative data were synthesized in semi-annual evaluation reports, and final reports were submitted to CB. The cluster logic models and cross-site outcome evaluation questions guided the quantitative synthesis of grantee outcomes. Data were organized in the report by categories of safety, permanency, and well-being and by child, family, and organizational-level outcomes. Due to the diversity in outcomes reported, data were synthesized when provided by a majority of grantees within the cluster. Table 3: Grantee Data Sources and Instruments provides an overview of common data sources and measures used across the cluster. A table of all grantee evaluation data sources is in Appendix H: Comprehensive Residential Family Treatment Projects Process and Outcome Evaluation Findings.

The most common adult measures were the Addiction Severity Index (ASI), used by Meta House, the Queen of Peace Center, and Renewal House; and the Adult-Adolescent Parenting Inventory (AAPI-2), used by Meta House and the Queen of Peace Center. The most common child measure was the Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment, used by Amethyst and Renewal House. The most common organizational measures included client satisfaction questionnaires, used by the Queen of Peace Center and Susan B. Anthony Center; focus groups and interviews with project representatives, used by Amethyst, Meta House, Renewal House, and the Susan B. Anthony Center; and surveys of clients and project representatives, used by the Queen of Peace Center and Susan B. Anthony Center. Three projects—Amethyst, Meta House, and the Queen of Peace Center—used administrative grantee or project-specific databases as sources of secondary data. The Queen of Peace Center and Renewal House used the AFCARS and NCANDS, while Meta House used its SACWIS as secondary data sources. The remaining grantees cited other public child welfare data sets as sources for secondary data.

Table 3: Grantee Data Sources and Instruments

Data Source/ <i>Instruments</i>	Grantees				
	Amethyst	Meta House	Queen of Peace Center	Renewal House	Susan B. Anthony Center
Adult Measures					
<i>Addiction Severity Index (ASI)</i>		●*	●	●	
<i>Adult-Adolescent Parenting Inventory (AAPI-2)</i>		●	●		
<i>Adult Needs and Strengths Assessment (ANSA)</i>				●	
<i>Edinburgh Postnatal Depression Scale (EPDS)</i>			●		
<i>Family Empowerment Scale (FES)</i>			●		
<i>Maternal Social Support Scale (MSSI)</i>			●		
<i>Parenting Sense of Competence Scale (PSCS)</i>			●		
<i>Parenting Stress Index (PSI)</i>				●	
<i>Primary Care Tool for Assessment of Depression during Pregnancy and Postpartum (PDCAT)</i>			●		
<i>Symptom Checklist 90-Revised (SCL-90-R)</i>					●
<i>Trauma Assessment for Adults</i>					●
<i>Trauma Symptom Checklist (TSC-40)</i>		●			
Urinalysis	●				
Child Measures					
<i>Ages and Stages Questionnaire-3 (ASQ-3)</i>			●		
<i>Ages and Stages Questionnaire-SE (ASQ-SE)</i>			●		
<i>Battelle Developmental Inventory (BDI-2)</i>					●
<i>Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment</i>	●			●	
<i>Pediatric Symptom Checklist (PSC)</i>					●
<i>Trauma Symptom Checklist for Young Children (TSCYC)</i>		●			
Family Measures					
<i>24/7 Dad Fathering Inventory</i>					●**

Data Source/ <i>Instruments</i>	Grantees				
	Amethyst	Meta House	Queen of Peace Center	Renewal House	Susan B. Anthony Center
<i>24/7 Dad Fathering Skills Survey</i>					●**
<i>Celebrating Families!</i> evaluations	●				
<i>Family Advocacy and Support Tool (FAST)</i>				●	
<i>North Carolina Assessment Scale for General Services (NCFAS-G)</i>			●		
<i>Protective Factors Survey (PFS)</i>		●			●
Organizational Measures					
<i>Client Satisfaction Questionnaire</i>			●		●
<i>Creating Cultures of Trauma-Informed Care Self-Assessment Scale (CCTIC-SAS)</i>				●	
Focus groups, interviews with clients		●***			●
Focus groups, interviews with project representatives (e.g., leaders, staff members, partners, etc.)	●	●		●	●
<i>Frey's Levels of Collaboration Scale</i>				●	
Observations		●			●
Other collaboration measures		●			
Surveys of clients, project representatives			●		●
<i>Wilder Collaboration Factors Inventory</i>	●				
Secondary Data Sources					
Administrative grantee/project-specific databases and records	●	●	●		
<i>Adoption and Foster Care Analysis and Reporting System (AFCARS)</i>			●	●	
<i>National Data Archive on Child Abuse and Neglect (NCANDS)</i>			●		
<i>Statewide Automated Child Welfare Information System (SACWIS)</i>		●			
Other public child welfare data sets	●			●	●

* Meta House used a modified version of the ASI.

** No data reported due to low participation rates in 24/7 Dad services.

*** Although not part of the original evaluation plan, Meta House conducted key informant interviews with clients on the value of residential family treatment.

Quantitative Analysis of Web-based Electronic Survey Data

Quantitative analysis was completed in the Qualtrics' Web-based survey software and Microsoft Excel. Data were screened with Excel and duplications were removed. Frequencies and descriptive statistics were completed in Qualtrics. Complete survey data results by question and respondent type are documented in Appendix G: Web-based Survey Results.

Qualitative Analysis of Web-based Electronic Survey Data

Qualitative analysis was guided by the process and outcome evaluation questions developed for the cross-site evaluation. The analytic approach was adapted from Pandit's five-phase grounded theory method⁵ and Eisenhardt's approach to theory development using case-level data.⁶ The analytic approach described below included three major stages: data organization, qualitative coding, and analyzing emergent patterns and themes. See Appendix I: Web-based Survey Codebook for documentation of qualitative data codes.

Data Organization. In preparation for qualitative analysis, survey data were exported from the Qualtrics Web-based survey software into ATLAS.ti, qualitative software designed to organize and facilitate systematic coding and categorizing of narrative data. Data were organized further into ATLAS.ti "family" structures that aligned to the constructs addressed in each survey section/content area (e.g., Description of Parents, Children and Families, Collaboration, Service Models). The cluster, grantee organization, and respondent type embedded in each survey response were retained in the ATLAS.ti dataset to facilitate exploring patterns and relationships in the final stage of analysis. Once the data were organized in the software, the next tasks included identifying, coding, and categorizing primary patterns in the data.

Qualitative Coding. The coding process was completed in two phases. In the first phase of coding (Level 1), a descriptive alphanumeric code was developed for each qualitative survey question. Coded qualitative items included all open-ended questions. Level 1 code names were determined based on the survey section in which the question was asked and the construct examined. For example, Collab1 was assigned to the first qualitative item in the Collaboration section of the Web survey protocol. Questions asked in more than one protocol type (e.g., Project Leader and Evaluation Team surveys) were assigned the same code to facilitate comparison of findings by type of respondent. The second phase of coding (Level 2) included an open coding process to examine the narrative responses to the open-ended items, to categorize the information or concept(s) conveyed in the responses, and to assign a code to each response category. For example, in response to the open-ended question (What was the greatest barrier to collaboration?), a respondent might indicate *Lack of time on the part of staff*. The Level 2 code for the response and all other responses regarding time would be assigned the code CollabBarrier1. Where applicable, codes were omitted, modified, or added during the coding process to most accurately categorize a survey response.

Qualitative Data Codebook. All codes developed by the JBA research team were documented in a qualitative data codebook for ongoing reference throughout the coding and analysis process. The format of the codebook paralleled the structure of the Web survey and was organized by (1) survey

⁵ Pandit, N. (1996). The creation of theory: A recent application of the grounded theory method. *The Qualitative Report*, 2(4). Retrieved from: <http://www.nova.edu/ssss/QR/QR2-4/pandit.html/pandit.html>.

⁶ Eisenhardt, K. M. (1989). Building theories from case study research. *Academy of Management Review*, 14, 532-550.

section/construct, (2) survey question, (3) response category, (4) category code, and (5) type(s) of respondent. In keeping with the use of the implementation science framework, the final column of the codebook tables indicates the NIRN driver addressed in the survey question. Table 4: Sample Codebook Question, Response Categories, and Codes provides an example of assigned codes from the 2012 Family Connection Grantees Web-survey Codebook. As indicated in the table, the two-phase coding process was used to organize survey responses to the open-ended questions regarding “Lessons Learned.” As shown in the Respondent column, project leaders (PL) and service providers (SP) answered these questions.

Table 4: Sample Codebook Question, Response Categories, and Codes

Level 1 Code	Survey Question	Response Categories	Level 2 Code	Respondent	NIRN Driver
LLFam	Lessons Learned from a Project Implementation Perspective	Use of a strengths-based approach	LLFam1	PL, SP	Lessons Learned
		Ensuring needs are appropriately addressed	LLFam2	PL, SP	
	What advice would you give someone implementing a similar project about how to achieve positive outcomes – your “lessons learned”? ...	Responsiveness to cultural and other differences in families	LLFam3	PL, SP	
		Addressing behavior changes in children and families	LLFam4	PL, SP	
		In regard to serving adults, children, and families?	Preparation/responsiveness to crises in families	LLFam5	

Output for Analysis. All codes were generated and assigned within ATLAS.ti, which facilitated running ad hoc exploratory queries and producing reports at multiple levels. Grantee-level output and cluster-level data reports provided the research analysts a coded summary of responses for all open-ended questions. In order to address key research questions, the ATLAS.ti database was queried for all of the related Level 1 and Level 2 codes, and it generated output data organized by research question and by the selected codes.

Consistent with the codebook format and survey protocols, grantee and cluster-level summaries were structured as follows:

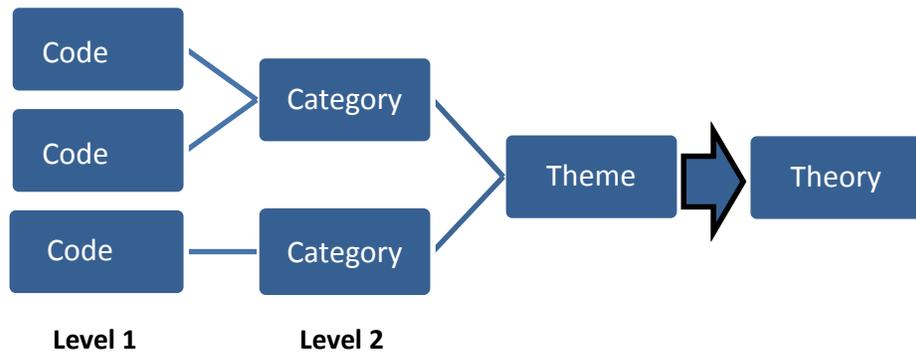
1. Evaluation question/header (e.g., Description of Parents, Children and Families)
2. Applicable evaluation sub-header (e.g., Target Population, Target Population Observations)
3. Survey protocol question
4. Summary of coded responses to the protocol question

Analyzing Emergent Patterns and Themes. Through the review of Level 1 and Level 2 codes, emerging themes were documented and relationships were examined. Throughout the coding process, analytic memos were used to highlight salient patterns and ideas that warranted further explanation and elaboration on themes that emerged from the data. Categories and themes were tested by reviewing data across grantees. In addition, patterns, categories, themes, and results that emerged from the qualitative analysis were discussed. In order to ensure reliable interpretation of the data, JBA cross-site evaluation team members met multiple times to review emerging codes and discuss category and theme variations across sites. Analyses were reviewed by the Lead Evaluation TA Liaison for each grantee cluster.

A modified approach to grounded theory was used, combining knowledge from past research with the development of additional constructs. This approach provided the analytic flexibility needed to more thoroughly understand the projects. Where possible, data supporting theoretical constructs were used to provide descriptive information regarding project implementation and/or corroborate quantitative findings. Figure 3: Web-based Survey Coding Structure illustrates the progression from Level 1 coding to theory.

Using the aggregated cluster-level data, the cross-site evaluation team was able to identify similarities and commonalities; identify relationships, patterns, and themes; identify clusters and categories; partition variables as needed; and analyze and incorporate differences and outliers (e.g., barriers and facilitators to implementation, advantages and challenges to collaboration, and sustainability strategies). More than one cross-site evaluation team member participated in summarizing the findings for the report to ensure adherence to categories and coding, reinforce decision rules, and promote consistency and accuracy.

Figure 3: Web-based Survey Coding Structure



Quality Assurance. Throughout the qualitative data coding and analysis process, the consistency and accuracy of interpretation and application of the response (Level 2) codes were ensured. A reliability check of the Level 2 coding was performed by pulling a sampling of codes from each research question and reviewing how these codes were applied across sites. Any differences in interpretation or code application were discussed. The coding was amended as needed and corrected in the database. Preliminary meetings conducted prior to the assignment of Level 2 codes also ensured that coding staff interpreted responses similarly, thus facilitating inter-rater reliability.

Report Review

This report was submitted to CB and Family Connection grantees for review as a strategy for testing and confirming findings, consistent with recommendations from Miles & Huberman in regard to qualitative analysis.⁷ Family Connection grantee members included project leaders, evaluators, and selected service

⁷ Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source book*. Thousand Oaks, CA: Sage Publications.

providers. All concerns and questions were discussed with CB and grantees, and findings and conclusions were revised as appropriate.

Limitations of the Evaluation

Cross-site evaluation of the RFT Projects provided a unique opportunity to assess whether concerted efforts were made to identify, coordinate, and directly provide appropriate, comprehensive services for adults, children, and families. Evaluation findings yielded evidence of improved child safety, increased permanency and housing stability, and increased capacity of adults to care for their children's needs. However, interpretation of findings should include consideration of significant limitations and constraints encountered in the evaluation.

In designing the evaluation, JBA reviewed the RFT grantees' site-specific local evaluation plans, determined commonalities, and revised the reporting process used by earlier cohorts of Family Connection grantees. These actions were intended to yield a common core of data for cross-site analysis while respecting the resources grantees had already allocated to local evaluations. Despite these efforts, considerable variation in the grantees' interventions and data reporting limit cross-site comparison. The following limitations should be considered when reading and interpreting process and outcome results for the cluster.

Outcome Variability

There was a high degree of heterogeneity in regard to outcome-level data collection. While similar or the same behaviors, attitudes, and knowledge were measured, there were differences in how those outcomes were operationalized. Matrices documenting key service activities, outcomes, and the evaluation design, along with the primary data sources, were shared in the first few months of funding so the grantees would be aware of instruments used by the cluster. Common instruments were not required to be used. Table 3: Grantee Data Sources and Instruments illustrates the diversity of primary data sources. These data were synthesized and described, but the ability to conduct quantitative analyses that would represent a common result across grantees was limited.

Variations in Numbers Served

There was variation in the number of adults, children, and families served by grantees. Comparisons among grantees in regard to service outputs may not be appropriate. Varying levels of adult clients who were available to provide data for outcome measures should be considered when evaluating the strength of the results.

Different Evaluation Designs

Grantees varied in evaluation designs. As a result, treatment and control or comparison groups sometimes were reported at baseline and followup, while other results were reported only for a treatment group at baseline and, depending on data availability, at followup. A table of grantee evaluation designs appears in Appendix H: Comprehensive Residential Family Treatment Projects Process and Outcome Evaluation Findings.

Section 3: Process Evaluation Findings

This section describes process evaluation findings of the Comprehensive Residential Family Treatment Projects. Process evaluation findings include a description of the target populations served; the number of children, adults, and families served; and the key demographic characteristics of RFT clients. Service models and key activities implemented by grantees are described, along with some of the most frequently provided services. Process outcomes related to service provision are highlighted. The report subsections address three cross-site evaluation research questions.

- *What are the characteristics of the children, parents, and families served?*
- *What are the service models, interventions, and activities implemented by the projects?*
- *What amount and mix of services are provided to parents, children, and families receiving services?*

Summary of Process Evaluation Findings

Chemically dependent women with co-occurring mental health challenges that either lost or were at risk of losing their children were served. Women often exhibited a variety of high-risk factors, such as involvement in multiple systems, limited education and work experience, unstable housing, and histories of health problems and trauma. Pregnant and postpartum women tended to be the focus. Children up to age 18 could live with their mothers in residence, although most grantees restricted the age of children to 13 years or younger. Other family members of women and children in residence, which included parents, grandparents, siblings, children not in residence, and women's partners (e.g., husband/wife, male or female partners, etc.), were also served. Throughout the funding period, 779 adults (mothers), 681 children in residence, and 720 other family members were served.

Most women were in their late twenties to early thirties and primarily Caucasian or African American. Pregnancy status varied, with higher percentages of pregnant clients served by grantees focusing on pregnant women. Most women were not married and typically had fewer than two children with them in residence. Drugs of choice included marijuana/cannabis, opiates, cocaine or crack, heroin, and alcohol. Depression, anxiety, and Posttraumatic Stress Disorder (PTSD) were the most common mental health diagnoses, with clients often exhibiting more than one diagnosis. Children served by the projects were mostly Caucasian or African American, although there were a higher percentage of multiracial children than of adult women. Children's gender tended to be split evenly between male and female, and ages ranged from 2 to 4 years.

RFT services were provided in a drug- and alcohol-free environment to promote safety, permanency, and well-being of children who were affected by parental substance abuse. Women spent a substantial amount of time in services, ranging from an average of 85 to 630 days. Guided by case management plans, gender-specific treatment incorporated several evidence-based, promising, and best practices for chemical dependence counseling; mental health services; skill building; and training in parenting, life skills, vocation, and employment. Child and family services were offered in individual and group settings. Key referral sources were public child welfare agencies, courts or other justice system organizations, alcohol and other drug abuse (AODA) treatment programs, and self-referral. Referred clients underwent screening and assessment to determine eligibility and appropriateness of treatment in a long-term residential setting. Accepted clients began with intensive treatment and supervision, and moved toward

more lenient services and housing per case management plans. Length of stay ranged from 6 to 18 months, although one grantee supported women for up to 24 months. Varying numbers of women were reported to have completed treatment stages, including moving from residential treatment to day or outpatient treatment.

Within the larger categories of chemical dependence counseling, mental health services, and skill building and training, specific service offerings were diverse with no more than two grantees offering any one service. The exceptions were *Dialectical Behavior Therapy (DBT)* for adults and *Celebrating Families!* for adults, children, and extended family members. Supporting data for process evaluation findings are in Appendix H: Comprehensive Residential Family Treatment Projects Process and Outcome Evaluation Findings.

Characteristics of Target Population

RFT grantees served adults, children, and other family members and collected data to describe target populations. Key characteristics of adults and their children are provided in Table 5: Key Characteristics of Grantee Target Populations.

Low-income women were served—a portion may have been living in unstable housing situations or were homeless at the time of entry into the residential facility. All women were mothers who had either lost custody or were at risk of losing custody of one or more children; some grantees required mothers to have custody of one or more children while in residence. Mothers had alcohol and other substance use disorders, often accompanied by co-occurring mental health disorders. Injection drug users were a priority population for grantees. Grantees also tended to focus on pregnant and postpartum women.

All grantees allowed at least one minor-age child to reside with his/her mother during treatment. Projects set different age limits for children in residence. Amethyst was the only grantee to allow children up to age 18 in residence; all others restricted child age to 4 years or younger (Queen of Peace Center), 12 years or younger (Meta House), 10 years or younger (Renewal House), or 13 years or younger (Susan B. Anthony Center). In addition to women and focus child(ren), all grantees served extended family members, including parents, grandparents, siblings, children not in residence, and partners (e.g., husband/wife, male or female partner, etc.). Meta House and the Susan B. Anthony Center implemented programs focused on engaging fathers or father surrogates of children in residence through special outreach activities, including father involvement specialists on their staffs and offering responsible fatherhood classes. Challenges in engaging this population were reported.

Table 5: Key Characteristics of Grantee Target Populations

Characteristic	Grantees				
	Amethyst	Meta House	Queen of Peace Center	Renewal House	Susan B. Anthony Center
Mothers with alcohol and other substance use disorders	•	•	•	•	•
Mothers with co-occurring mental health disorders	•	•	•		•
Mothers who lost custody or are at risk of losing current custody of their children	•	•	•		•

Characteristic	Grantees				
	Amethyst	Meta House	Queen of Peace Center	Renewal House	Susan B. Anthony Center
Pregnant and postpartum women	•	•	•	•	•
Children of minor age living in residence with their mother; age of the child may be limited for some grantees	•	•	•	•	•
Extended family members of women and children served	•	•	•	•	•
Partners of the women (e.g., husbands/wives, male or female partners)		•	•		
Fathers or father surrogates of children in residence		•			•

Women typically came to residential facilities with a variety of other high-risk factors:

- Involved in multiple systems, including child welfare, TANF, and criminal justice
- Limited education and work experience; living at or below the poverty level
- Acute and chronic health problems (e.g., HIV positive); potential cognitive impairment from drug use, accidents, or physical abuse
- Lack of prenatal care
- Experienced past and current trauma; history of physical, emotional, and sexual abuse
- Homeless or unstable housing; may have been incarcerated prior to project entry
- Gender-related issues, including low self-esteem, race, ethnicity and cultural issues, relationships with family and significant others, interpersonal violence, eating disorders, parenting, grief and loss, isolation related to a lack of support systems and other resources, life plan development, and childcare custody issues

Their children are also at a higher risk of physical and developmental conditions, often possessing behavioral disorders, physical health and medical complications, and developmental delays. Fathers and other family members, including siblings and grandparents, are typically low income, lack access to services to meet needs and support, and have similar social and emotional problems as the mothers. Fathers are frequently absentee, and kinship care is often provided by aging grandparents.

Adults, Children, and Families Served

The total number of adults, children, and families served by grantees from September 30, 2012, through September 30, 2015, is provided in Table 6: Number of Adults, Children, and Families Served. Throughout the funding period, 779 adults (mothers), 681 children in residence, and 492 other family members were served. Two grantees, Meta House and Renewal House, worked with a total of 13 project partners.

- **Adults.** The total number of adults served throughout the project period ranged from 93 mothers at Renewal House to 272 mothers at the Susan B. Anthony Center.

- **Children.** The total number of children in residence served throughout the project period ranged from 77 at Meta House to 254 at the Susan B. Anthony Center. Mothers may have had additional children in other guardianship arrangements; these children were counted as other family members, given their participation in such services as family therapy and the family-based substance abuse prevention services.
- **Family Members.** The total number of other family members served throughout the project period ranged from 54 at Amethyst to 272 at the Susan B. Anthony Center. In addition to other family members, the Susan B. Anthony Center served a total of 20 fathers. Meta House served other family members (including fathers); however, only the number of children served who were not residing with their mother was reported (n = 248 children).

Table 6: Number of Adults, Children, and Families Served

Grantee	Adults (Mothers)	Children in Residence	Other Family Members	Project Partners
Amethyst	126	125	54	N/A
Meta House	158	77	248***	9
Queen of Peace Center	130*	141	69	N/A
Renewal House	93	84	77	4
Susan B. Anthony Center	272**	254	272	N/A
Total	779	681	720	13

* Of 130 adult mothers served, 77 were included in the local evaluation. Evaluation was not completed on the remaining adult mothers due to pending IRB approval.

** Includes 257 unduplicated admissions and 15 second admissions.

*** The 248 other family members only include children served who were living off site.

Adult, Child, and Family Demographics

All five grantees provided demographic data on the adults and children served, including average age, gender, and race/ethnicity. Several grantees provided additional data on the adult clients served through the projects.

Age of Adults and Children Served. Adult mothers in their late twenties to early thirties were served as shown in Table 7: Average Age of Adults and Children. The average age of mothers ranged from 28 years at Queen of Peace Center to 35 years at Amethyst. The average age of mothers in comparison groups was similar to those in treatment groups, with the Queen of Peace Center’s comparison mothers averaging 28 years and Susan B. Anthony Center’s comparison mothers averaging 30 years. Most grantees served younger children living with their mothers in residential facilities, with ages ranging from 2 years at the Queen of Peace Center and Renewal House to over 4 years at Susan B. Anthony Center. Amethyst tended to serve children in residence who averaged 8 and half years. Average ages are consistent with the age range limits set by grantees; Amethyst was the only grantee to serve children up to 18 years of age who lived with their mothers in residential facilities.

Table 7: Average Age of Adults and Children

Grantee	Adults (Mothers) (years) (n)	Children in Residence (years) (n)
Amethyst	34.6 (126)	8.6 (125)
Meta House	29.2 (158)	2.4 (77)
Queen of Peace Center	QOPC: 27.7 (77) Comparison: 28.4 (13)	QOPC: 2.1 (43) Comparison: 1.1 (13)
Renewal House	28.8 (72)	2.2 (85)
Susan B. Anthony Center	SBAC: 30.6 (257) Comparison: 30.0 (132)	4.6 (254)

Gender of Adults and Children Served. A mother in residence was the primary adult served by all five grantees; thus females comprised 100 percent of adult clients, as shown in Table 8: Adult and Child Gender. This was consistent for the comparison groups that were part of the Queen of Peace Center and Susan B. Anthony Center’s local evaluations. Child gender tended to be split evenly across four grantees, ranging from 49 percent to 54 percent female at Meta House and the Queen of Peace Center, respectively, and ranging from 47 percent to 51 percent male at Queen of Peace Center and Meta House, respectively. Renewal House had more distinct gender proportions among children in residence, with 40 percent female and 60 percent male.

Table 8: Adult and Child Gender

Grantee	Adults (Mothers)		Children in Residence	
	Female (percent) (n)	Male (percent) (n)	Female (percent) (n)	Male (percent) (n)
Amethyst	100 (126)	0.0 (0)	50.4 (63)	49.6 (62)
Meta House	100 (158)	0.0 (0)	49.4 (38)	50.6 (39)
Queen of Peace Center (QOPC)	QOPC: 100 (77) Comparison: 100 (13)	QOPC: 0.0 (0) Comparison: 0.0 (0)	QOPC: 53.5 (23) Comparison: 44.4 (4)	QOPC: 46.5 (18) Comparison: 55.6 (5)
Renewal House	100 (72)	0.0 (0)	40.0 (34)	60.0 (51)
Susan B. Anthony Center (SBAC)	SBAC: 100 (257) Comparison: 100 (132)	SBAC: 0.0 (0) Comparison: 0.0 (0)	50.4 (128)	49.6 (126)

Race and Ethnicity of Adults and Children Served. Adults and children served were reported within six main race/ethnicity categories: Caucasian, African American, Hispanic, American Indian/Alaska Native, Hawaiian, Asian, and multiracial. A particular racial or ethnic group was not focused on as part of the target service populations. As noted in Table 9: Adult Race and Ethnicity, Caucasian mothers comprised the largest percentage of service recipients for four grantees. The Queen of Peace Center was the exception, with African American mothers comprising 58 percent of adults served. This was not reflected in the grantee’s comparison group, which included 69 percent Caucasian mothers and 15 percent African American mothers. Proportions of Caucasian and African American mothers were also somewhat dissimilar for the Susan B. Anthony Center’s comparison group, with a similar percentage of Caucasian (42

percent) and African American (46 percent) mothers contrasting with 54 percent Caucasian and 23 percent African American mothers in the treatment group. The Susan B. Anthony Center served the largest percentage of Hispanic mothers at 15 percent, while Meta House reported the largest percentage of multiracial mothers at 6 percent. Few American Indian/Alaska Native, Hawaiian, or Asian mothers were served.

This demographic for children living with their mothers in residence is shown in Table 10: Child Race and Ethnicity. Proportions of Caucasian, African American, Hispanic, American Indian/Alaska Native, and multiracial children mirrored those of adults for Meta House. While proportions of African American children were similar to those of adults, Amethyst reported lower proportions of Caucasian children (48 percent) compared to Caucasian adults (63 percent), and higher proportions of multiracial children (15 percent) compared to multiracial adults (2 percent). There were also more African American and multiracial children at the Queen of Peace Center and Renewal House compared to adults of the same ethnicities. Renewal House and the Susan B. Anthony Center reported substantially more multiracial children than multiracial adults. The Susan B. Anthony Center continued to serve the highest proportion of Hispanic children (9 percent). Few American Indian/Alaska Native and Hawaiian children were served.

Table 9: Adult Race and Ethnicity

Grantee		Race					Ethnicity		
		Caucasian (percent) (n)	African American (percent) (n)	Hispanic (percent) (n)	American Indian/ Alaska Native or Hawaiian (percent) (n)	Asian (percent) (n)	Multiracial (percent) (n)	Hispanic (percent) (n)	Non-Hispanic (percent) (n)
Amethyst		62.7 (79)	29.4 (37)		0.8 (1)		1.6 (2)	4.8 (6)	84.9 (107)
Meta House		57.6 (91)	24.1 (38)	8.2 (13)	4.4 (7)	0.0 (0)	5.7 (9)		
Queen of Peace Center	Treatment	37.7 (29)	58.4 (45)				3.9 (3)	1.3 (1)	98.7 (76)
	Comparison	69.2 (9)	15.4 (2)				15.4 (2)	7.7 (1)	92.3 (12)
Renewal House		69.0 (50)	25.0 (18)	1.0 (1)		1.0 (1)	3.0 (2)		
Susan B. Anthony Center	Treatment	54.1 (139)	23.0 (59)	14.7 (38)	44.7 (12)*	0.4 (1)	2.3 (6)		
	Comparison	41.7 (55)	45.5 (60)	6.8 (9)	33.0 (44)*	0.8 (1)	2.3 (3)		

* Includes 3.1 percent (n = 8) Haitian for Treatment group, and 1.5 percent (n = 2) for Comparison group.

Table 10: Child Race and Ethnicity

Grantee	Race						Ethnicity		
	Caucasian (percent) (n)	African American (percent) (n)	Hispanic (percent) (n)	American Indian/ Alaska Native or Hawaiian (percent) (n)	Multiracial (percent) (n)	Other or Unknown (percent) (n)	Hispanic (percent) (n)	Non-Hispanic (percent) (n)	
Amethyst	48.0 (60)	35.2 (44)		1.6 (2)	15.2 (19)	0.0 (0)	6.4 (8)	93.6 (117)	
Meta House	53.2 (41)	29.9 (23)	6.5 (5)	1.3 (1)	7.8 (6)	1.3 (1)			
Queen of Peace Center	Treatment	14.0 (6)	67.4 (29)			18.6 (6)		2.3 (1)	97.7 (42)
	Comparison	88.9 (8)	11.1 (1)			0.0 (0)		0.0 (0)	100.0 (4)
Renewal House	39.0 (33)	33.0 (28)		1.0 (1)	27.0 (23)				
Susan B. Anthony Center	40.2 (102)	26.8 (68)	9.1 (23)	2.8 (7)	20.1 (51)				

Additional Adult Demographics. All five grantees provided data on additional pertinent demographics for adult-level treatment, and as available, comparison adult populations.

- **Pregnancy Status.** Four grantees focused on pregnant and postpartum women. The pregnancy status of women ranged from 20 percent at the Susan B. Anthony Center to 92 percent at Queen of Peace Center, reflecting this priority. Amethyst, which did not note a focus on pregnant and postpartum women, reported that less than 1 percent of the adult clients were pregnant.
- **Number of Dependents.** Most mothers had few dependents living with them in residential facilities. Three grantees reported the average number of dependents ranged from one at Amethyst and Renewal House, to two at the Susan B. Anthony Center (which restricts the number of children living with their mother to four).
- **Marital Status.** Most women were not married, percentages ranging from 86 percent at Queen of Peace Center to 91 percent at Amethyst. “Not married” status included single, never married, divorced, widowed, and committed/long-term relationship. The Susan B. Anthony Center reported 36 percent as not married; however, this grantee also reported missing data for 40 percent of its treatment population on this variable.
- **Education Level.** Clients tended to have limited education. On scales ranging from “less than high school” to “completed college/higher degree,” the largest percentages of women in four projects fell into completing high school or a GED, ranging from 37 percent at the Susan B. Anthony Center to 52 percent at Renewal House. Amethyst reported the largest number of women with less than a high school diploma or GED at 57 percent, and the Queen of Peace Center reported the largest number of women who received some college or vocational training at 18 percent.
- **Employment Status.** Few clients were employed, which reflected the need to focus on treatment, particularly during initial care at residential facilities. The exception was Amethyst, which reported that 28 percent of women were employed compared to 5 percent or fewer women being employed full time or part time in other projects.
- **Chemical Dependence.** Consistent with target population criteria, high percentages of women reported substance use 30 days prior to admission (90 percent at Meta House), a history of substance use and drug charges (98 percent and 57 percent, respectively, at the Susan B. Anthony Center), and meeting the DSM-IV-TR criteria for chemical dependence (100 percent at Renewal House). As part of intake procedures to obtain client histories of chemical dependence, including primary drug of choice, recorded substances frequently used were marijuana/cannabis, opiates, cocaine and/or crack, followed by heroin and alcohol. Below are the most frequently used substances among the women in four of the five projects, noting that women could indicate the use of one or more substances.
 - Amethyst: Opiates (53 percent), Alcohol (27 percent), Cocaine (24 percent), and Cannabis/Marijuana (14 percent)
 - Meta House: Prescription medication (62 percent), Marijuana/Cannabis (41 percent), Cocaine/Crack (38 percent), and Heroin (28 percent)
 - Queen of Peace Center: Heroin (51 percent), Marijuana/Cannabis (16 percent), and Cocaine (9 percent)

- Susan B. Anthony Center: Amphetamines (89 percent), Opiates (53 percent), Marijuana/Cannabis (41 percent), and Alcohol (24 percent).

Amethyst was the one grantee that included nicotine among substances; 45 percent of women reported nicotine use. In addition to primary drug of choice, the Queen of Peace Center also reported that 36 percent of mothers were on methadone and 5 percent had babies born with a positive drug test.

- **Mental Health Diagnosis.** Four of five projects reported information on women’s mental health diagnosis. Meta House noted that 81 percent of women had a co-occurring disorder or mental health symptoms, and the Susan B. Anthony Center reported that 60 percent of women had a mental health diagnosis. Depression, anxiety, and PTSD were commonly found among clients. Below are the most frequent diagnoses among three of the five projects, noting that more than one diagnosis could apply to each client.
 - Amethyst: Depressive disorder (40 percent), Anxiety (30 percent), PTSD (27 percent), and Bipolar (21 percent)
 - Queen of Peace Center: Pregnant/Postpartum Depression (62 percent), Anxiety (EPDS) (52 percent), Suicidal Ideation (36 percent), Depression (26 percent), and PTSD (23 percent)
 - Susan B. Anthony Center: Anxiety (32 percent), Major depression (20 percent), PTSD (18 percent), Bipolar (6 percent), and Borderline (6 percent).

Table 11: Additional Adult Demographics includes information on pregnancy status, number of dependents, marital status, education level, employment status, chemical dependence, and mental health diagnosis.

Table 11: Additional Adult Demographics

Demographic Variable	Amethyst (percent) (n)	Meta House (percent) (n)	Queen of Peace Center (percent) (n)	Renewal House (percent) (n)	Susan B. Anthony Center (percent) (n)
Pregnant (Yes)	0.8 (1)	34.2 (54) (at admission)	<u>Treatment</u> 92.2 (71) <u>Comparison</u> 76.9 (10) (includes postpartum)	32.0 (25)	<u>Treatment</u> 20.2 (52) <u>Comparison</u> 6.1 (8)
Number of Dependents	Living with Mother Average = 1.0 0 = 32.5 (41) 1 = 38.1 (48) 2 = 21.4 (27) 3 = 7.9 (10) 4 = 0.0 (0) 5+ = 0.0 (0) Overall Average = 2.3 1 = 32.5 (41) 2 = 31.0 (39) 3 = 23.8 (30) 4 = 3.2 (4) 5+ = 7.9 (10)	Number of Minor Children 0 (pregnant at intake) = 8.9 (14) 1 = 37.3 (59) 2 = 17.1 (27) 3 = 19.0 (30) 4 = 8.2 (13) 5+ = 9.5 (15)	<u>Treatment</u> 0 = 55.8 (43) 1 = 16.9 (13) 2 = 13.0 (10) 3 = 5.2 (4) 4 = 1.3 (1) 5 = 1.3 (1) 6+ = 6.5 (5) <u>Comparison</u> 0 = 46.2 (6) 1 = 23.1 (3) 2 = 7.7 (1) 3 = 15.3 (2) 4 = 0.0 (0) 5 = 0.0 (0) 6+ = 7.7 (1)	Average = 1.0 (72) Minimum = 0 Maximum = 2	<u>Treatment</u> Average = 1.7 Range = 0-5 <u>Comparison</u> Average = 2.7 dependents Range = 1-10
Marital Status	Single/Never Married = 63.5 (80) Married/Living Together as Married = 0.0 (0) Separated = 8.7 (11) Divorced = 25.4 (32) Widowed = 2.4 (3)	Single = 60.1 (95) Long Term Relationship = 25.3 (40) Married = 8.2 (13) Separated = 2.5 (4) Divorced = 3.2 (5) Widowed = 0.6 (1)	<u>Treatment</u> Single = 81.8 (63) Married = 3.9 (3) Separated = 9.1 (7) Divorced = 2.6 (2) Widowed = 1.3 (1) <u>Comparison</u> Single = 76.9 (10) Married = 7.7 (1) Separated = 7.7 (1) Divorced = 7.7 (1) Widowed = 0.0 (0)	Not married = 87.0 (62) Married = 13.0 (10)	<u>Treatment</u> Single = 23.7 (61) Committed relationship = 10.1 (26) Married = 4.3 (11) Divorced = 1.9 (5) Missing = 40.1 (103) <u>Comparison</u> Not married = 86.4 (114) Married = 13.6 (18)

Demographic Variable	Amethyst (percent) (n)	Meta House (percent) (n)	Queen of Peace Center (percent) (n)	Renewal House (percent) (n)	Susan B. Anthony Center (percent) (n)
Education Level	Less than high school/GED = 57.1 (72) High school diploma/GED = 6.3 (8) Some college/trade school = 4.8 (6) In college = 3.2 (4) College graduate = 0.0 (0) Unknown = 28.6 (36)	8 th grade or less = 2.5 (4) 9 th to 11 th grade = 21.5 (34) High school diploma or GED = 41.8 (66) Some college = 31.0 (49) College degree = 3.2 (5)	<u>Treatment</u> Less than high school graduate = 45.5 (35) High school graduate/GED = 32.5 (25) Some college/vocational training = 18.2 (14) College graduate/higher degree = 3.9 (3) <u>Comparison</u> Less than high school graduate = 53.8 (7) High school graduate/GED = 15.4 (2) Some college/vocational training = 30.8 (4) Completed college/ higher degree = 0.0 (0)	Through 8 th grade = 6.0 (4) Some high school = 28.0 (20) High school diploma = 35.0 (25) GED = 17.0 (12) Some college = 14.0 (10)	<u>Treatment</u> Less than high school = 8.9 (23) Some high school = 36.6 (94) High school diploma/GED = 36.6 (94) Some college = 12.1 (31) Associate's degree = 3.5 (9) Bachelor's degree = 1.6 (4) <u>Comparison</u> Less than high school = 8.3 (11) Some high school = 35.6 (47) High school diploma/GED = 27.3 (36) Some college = 6.9 (9)
Employment Status	Not employed = 65.9 (83) Employed = 27.8 (35)	Unemployed = 89.2 (141) Unemployed and disabled = 9.5 (15) Employed full or part-time = 1.3 (2)	<u>Treatment</u> Unemployed = 94.0 (63) Part or full-time = 4.5 (3) Disabled = 1.5 (1) <u>Comparison</u> Unemployed = 90.9 (10) Disabled = 9.1 (1) Part or full-time = 0.0 (0)	Unemployed = 97.0 (70) Part-time = 1.0 (1) Full-time = 1.0 (1)	<u>Treatment</u> Unemployed = 75.1 (193) Employed = 3.5 (9) <u>Comparison</u> Unemployed = 72.7 (96) Employed = 25.8 (34)

Demographic Variable	Amethyst (percent) (n)	Meta House (percent) (n)	Queen of Peace Center (percent) (n)	Renewal House (percent) (n)	Susan B. Anthony Center (percent) (n)
Chemical Dependence	History of Chemical Dependence Opioid = 52.8 (67) Nicotine = 45.2 (57) Poly-substance = 26.2 (33) Alcohol = 26.8 (33) Cocaine = 23.8 (30) Cannabis = 14.2 (18) Sedative/Hypnotic/Anxiolytic = 2.4 (3) Amphetamine = 0.8 (1) Hallucinogen = 0.8 (1)	30 Days Prior to Admission Any substance use = 90.1 (73) Illegal drugs = 77.8 (63) Use of more than one substance in same day = 51.9 (42) No substance use in prior 30 days but have substance use history = 9.9 (8) Substance Use at Intake* Prescription medication = 61.7 (50) Marijuana = 40.7 (33) Cocaine = 37.5 (30) Alcohol = 34.6 (28) Heroin = 28.4 (23)	Primary Drug of Choice <u>Treatment</u> Heroin = 50.6 (39) Cannabis = 15.6 (12) Cocaine = 9.1 (7) Other opiates = 3.9 (3) Amphetamines = 2.6 (2) Alcohol = 2.6 (2) More than one substance = 15.6 (12) <u>Comparison</u> Heroin = 22.2 (2) Cannabis = 11.1 (1) Cocaine = 11.1 (1) Amphetamines = 11.1 (1) Alcohol = 11.1 (1) Other opiates = 11.1 (1) More than one substance = 22.2 (2) Mother on Methadone <u>Treatment</u> : Yes = 36.4 (28) <u>Comparison</u> : Yes = 54.4 (6) Baby Born with Positive Drug Test <u>Treatment</u> : Yes = 4.5 (2) <u>Comparison</u> : Yes = 0.0 (0)	DSM-IV-TR Criteria for Chemical Dependence Yes = 100 (72)	History of Substance Use <u>Treatment</u> : Yes = 88.3 (227) <u>Comparison</u> : Yes = 100 (132) History of Drug Charges <u>Treatment</u> : Yes = 48.2 (124) <u>Comparison</u> : Yes = 8.3 (11) Substance Use History <u>Treatment</u> Average number of substances = 2.73 Amphetamines = 88.7 (228) Opiates = 52.9 (136) Cannabis = 40.5 (104) Alcohol = 24.1 (62) Prescription Meds = 21.0 (54) Cocaine/Crack = 14.0 (36) <u>Comparison</u> Average number of substances = 1.98 Cannabis = 69.7 (92) Cocaine/Crack = 37.9 (50) Prescription Meds = 33.3 (44) Opiates = 28.0 (37) Alcohol = 22.7 (30) Amphetamine = 6.1 (8)

Demographic Variable	Amethyst (percent) (n)	Meta House (percent) (n)	Queen of Peace Center (percent) (n)	Renewal House (percent) (n)	Susan B. Anthony Center (percent) (n)
Mental Health Diagnosis	Depressive disorder = 39.7 (50) Anxiety = 30.2 (38) PTSD = 27.0 (34) Bipolar = 21.4 (27) Attention Deficit = 7.9 (10) Mood Disorder = 6.3 (8) Impulse Control Disorder = 2.4 (3) Panic Disorder without Agoraphobia = 2.4 (3) Obsessive-Compulsive Disorder = 1.6 (2) Bulimia = 0.8 (1) Intermittent Explosive Disorder = 0.8 (1) Schizophrenia = 0.7 (1) Schizoaffective Disorder = 0.7 (1)	Co-occurring disorder /mental health symptoms = 81.0 (128)	<u>Treatment</u> Pregnant/Postpartum Depression = 62.3 (48) Anxiety (EPDS) = 51.9 (40) Suicidal Ideation = 36.4 (28) Depression = 26.0 (20) PTSD = 23.4 (18) Bipolar = 15.9 (12) General Anxiety (DSM) = 11.7 (9) Schizoaffective Disorder = 3.5 (2) Psychotic Disorder = 1.8 (1) <u>Comparison</u> Pregnant/Postpartum Depression = 69.2 (9) Anxiety (EPDS) = 61.5 (8) General Anxiety = 45.5 (5) Suicidal Ideation = 38.5 (5) Depression = 18.0 (2) Bipolar = 9.1 (1) PTSD = 9.1 (1) Psychotic Disorder = 0.0 (0) Schizoaffective Disorder = 0.0 (0)	DSM-IV-TR criteria for a substance-related disorder = 100 (72)	<u>Treatment</u> Mental health diagnosis = 59.5 (153) Anxiety = 31.9 (82) Major depression = 19.5 (50) PTSD = 17.5 (45) Bipolar disorder = 6.2 (16) Borderline = 6.2 (16) Schizophrenia = 3.5 (9) Obsessive-Compulsive Disorder (OCD) = 1.9 (5) Other = 7.4 (19) <u>Comparison</u> Mental health diagnosis = 77.3 (102) Major depression = 56.1 (74) Anxiety = 19.5 (39) Bipolar disorder = 23.5 (31) PTSD = 15.2 (20) Other = 11.5 (15) Schizophrenia = 4.5 (6) Borderline = 0.8 (1) Obsessive-Compulsive Disorder (OCD) = No data

* N = 120, based on data as of January 1, 2015.

Service Models

RFT services were provided to increase the well-being of, improve permanency outcomes for, and enhance the safety of children who have been affected by parental substance abuse. Table 12: Service Model Descriptions lists a variety of service models. Comprehensive, gender-specific, trauma-informed treatment included alcohol and drug counseling in individual and group settings, mental health assessment, and treatment customized to each woman’s needs. Attendance in classes and other instruction methods to improve parenting skills were priorities; sometimes women attended with their children. Services were also offered to bolster women’s health and nutrition, home management and life skills, and education and employment. Support services—such as childcare, transportation, and prenatal and health care—facilitated women’s participation. Multiple assessments, therapies, and group classes were offered for children based on age. All adult clients and children received comprehensive case management throughout their participation.

Residential facilities were drug- and alcohol-free, and in the cases of Amethyst and Meta House, also tobacco-free. They included one or a combination of housing types, such as group home environments; private apartments adjacent to treatment facilities, sometimes in a campus-like setting; and private apartments requiring a commute to treatment facilities.

The flow of services typically progressed from more intensive to less intensive with corresponding changes in housing. Clients concluded residential and/or intensive outpatient treatment by moving into nonproject facilities where participation in outpatient services may continue based on the client’s treatment plan. For mothers who were ready for permanent housing, assistance was provided. The intended length of treatment within residential facilities or as outpatient/day treatment ranged from 6 to 18 months for four grantees. Amethyst described a service model to support women and their families for up to 24 months. Residential projects determined length of treatment based on the goal of long-term change for the client, which might have been difficult to meet with a 30- to 90-day treatment program. Also considered was the need to incorporate intensive treatment and each client’s ability to progress and stabilize.

Table 12: Service Model Descriptions

Grantee	Service Model Description
Amethyst	<p>Modeled after Center for Substance Abuse Treatment (CSAT) (2009) recommendations are for comprehensive, gender-specific treatment, services include (1) intensive case management to connect clients to resources, (2) Cognitive Behavioral Therapy (CBT) in individual and group counseling sessions, (3) Assertive Community Treatment (ACT), and (4) non-western and alternative healing practices.</p> <p>Services are organized into three milestones moving from treatment focused on the mother (6-12 months); to treatment for the family as a unit (9-20 months); and to long-term, ongoing individual and group treatment and in addition to support services for the reunified families.</p> <p>Amethyst discontinued its Therapeutic Community model as of December 1, 2014.</p>
Meta House	<p>Integrated and coordinated trauma-informed services address The Protective Factors Framework from ACF’s Preventing Child Maltreatment and Promoting Well-being: A Network for Action 2012 Resource Guide. Framework builds six protective factors: parental resilience, social connections, concrete supports, knowledge of parenting and child development, nurturing and attachment, and children’s social and emotional competence.</p>

Grantee	Service Model Description
	<p>Grantee promotes four child well-being domains from ACF-adapted framework: cognitive functioning, physical health and development, behavioral/emotional functioning, and social functioning.</p> <p>Length of stay, averaging 6 months for full continuum of care, is determined by need based on treatment plans, state-level placement criteria, case management plan, and Single Coordinated Care Plan (SCCP). Mothers and children move from residential family treatment to grantee-owned, drug-free housing or other community housing and receive day treatment services as needed.</p>
<p>Queen of Peace Center</p>	<p>Service model is guided by (1) <i>The Collaborative Practice Model for Child Safety, Permanency, and Recovery</i>, which advocates collaboration among child welfare, family treatment, dependency courts, agencies, and providers and (2) the <i>Strengthening Families Protective Factors Framework</i>, which provides a common language to describe what all families need. Substance abuse treatment is provided per Missouri's Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs for women with children using <i>TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders</i>.</p> <p>Queen of Peace operates a three-level continuum of care with a client entering treatment at any level based on need and prior treatment history. Levels include community-based primary treatment that takes place in residence; community-based rehabilitation via individually tailored programs to address substance abuse issues; and supportive services to sustain therapeutic gains from treatment and rehabilitation. Core services are provided at the grantee organization and Our Lady of Perpetual Help, Queen of Peace's residential facility.</p>
<p>Renewal House</p>	<p>The Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocol (TIP) 51, Appendix B (CSAT's Comprehensive Substance Abuse Treatment Model for Women and Their Children), grounded in women's experiences, built on women's strengths, and based on best- promising or research-based practices, directs the grantee's approach to working with families affected by addiction and co-occurring mental health disorders. Safe, drug-free living is combined with wraparound services focusing on five key areas: addiction and co-occurring mental health recovery, parenting, life skills, vocational skills, and child intervention and prevention services. The project uses a spiritually based, 12 Step philosophy and takes into account the unique culture, traditions, and rituals of individuals and families. Mothers and children live in furnished, independent apartments on grantee premises for 6 to 18 months to complete the transitional housing component of the program.</p>
<p>Susan B. Anthony Center</p>	<p>SBAC replicates a comprehensive ecological best practices model developed by Bronfenbrenner (1989) and endorsed by SAMHSA (TIP 51, 2009). SBAC also uses the Covington approach, focusing on addressing women-sensitive needs, including physical, psychosocial, support, parenting, vocational, and life skills. SBAC services, based on an individualized treatment plan, are gender-specific, trauma-informed, culturally based, and family-centered. Services also adhere to the National Standards on Culturally and Linguistically Appropriate Services (CLAS) to ensure its practices are culturally and linguistically accessible and sensitive to all individuals served.</p> <p>Families reside in the family treatment center for 6 to 18 months, averaging a 9-month stay. Two families share two-bedroom apartment homes that are designed to encourage developing family rituals and improving relationships (one family resides alone if there are more than two children). Women and their children may participate in aftercare services for up to 1 year after leaving residential treatment with peer mentoring, recovery support groups, and job coaching.</p>

Referral Sources and Client Eligibility

Clients were typically referred through multiple sources: public child welfare, courts/justice system, health and human service organizations, and self-referral. For referred clients, various eligibility requirements were employed with associated screening processes to determine the appropriateness of RFT for the women and their child(ren), including their willingness and desire to participate in services.

Referrals. Table 13: Referral Sources lists the sources clients used to enter projects. The most common referral sources included public child welfare agencies, courts or other justice system organizations, and alcohol and other drug treatment programs. A substantial number of clients are self-referred. Less frequent referral sources, reported by at least two grantees each, included community programs, family members and friends, medical facilities, and mental health providers.

Table 13: Referral Sources

Referral Source	Grantees				
	Amethyst (percent) (n)	Meta House (percent) (n)	Queen of Peace Center (percent) (n)	Renewal House (percent) (n)	Susan B. Anthony Center (percent) (n)
211					5.1 (13)
AODA Treatment and Care Programs	12.7 (16)		9.1 (7)		11.6 (30)
Community Programs (e.g., family services, job services, shelter)	4.8 (6)				5.9 (15)
Court/Justice System	12.7 (16)		16.9 (13)		28.8 (74)
Family/Friend/Former Client	0.8 (1)		14.3 (11)		5.8 (15)
Hospital/Medical Facility			10.4 (8)		0.4 (1)
Mental Health Provider	2.4 (3)				2.7 (7)
Public Child Welfare Agency/ Child Protective Services/ Children's Services	2.4 (3)	57.0 (90)	2.6 (2)	100**	23.7 (61)
Prior Service Recipient			19.5 (15)		
Self	15.1 (19)		14.3 (11)		15.2 (39)
Other		43.0 (68)*			0.8 (2)
Missing/Unknown	46.0 (58)		13.0 (10)		

* Meta House's "Other" category included any other referral source besides public child welfare.

** Renewal House did not collect this variable, although grantee profiles document that referrals are primarily received from the public child welfare, courts, and other health and human service organizations. Grantee also maintains a network of over 35 referral source contacts.

Eligibility. Clients fulfilled several eligibility requirements in order to participate in services. Requirements varied slightly across grantees; the most common requirements are listed below.

- Female
- 18 years or older
- Already involved or at high risk of involvement in the child welfare system
- Pregnant and/or has physical custody of a minor child; typically restrict the age of a child or youth (Amethyst allows children/youth up to age 18 to reside with the mother.)
- Suspected or confirmed substance use
- Homeless or at risk of being homeless
- No convictions or history of sexual offenses or violent crime
- No immediate need for detoxification services

A variety of screening processes were incorporated to determine if RFT was the most appropriate type of service for a client and her children. Renewal House processes were client driven; by keeping scheduled interview appointments, clients demonstrated commitment and motivation to be admitted. Processes may be required by the state or another entity; existing processes may be adopted or adapted by the grantee; the grantee may develop its own processes; or there is a combination of these options. For example, one process used by Meta House is to screen for a mother's eligibility based on the level of care required to meet the need using the American Society of Addiction Medicine's Patient Placement Criteria (ASAM PPC-2R). Assessment information is compared against ASAM criteria from the context of a family perspective to be gender and family responsive. This is a best practice and requirement of the State of Wisconsin for people entering treatment programs.

Key Services

Table 14: Evidence-based Practices, Promising Practices, and Best Practices notes multiple treatments used to address the needs of grantee target populations. Practices acknowledged the culture of addiction and recovery and addressed the issues of women with co-occurring trauma and drug use, high-risk children and families, families living in poverty, children facing diverse stressors, and varying literacy levels. Most practices were gender-specific. Evidence-based practices are denoted with an asterisk (*).

A total of 14 evidence-based, promising, or best practices in adult, child, and family programming were implemented. Practices at each service level are listed below.

- **Adult Services (nine services):** Acceptance and Commitment Therapy, Art Therapy, *Dialectical Behavior Therapy (DBT)*, Eye Movement Desensitization and Reprocessing, Motivational Interviewing, Peer-based Recovery Support Services, Seeking Safety, Stages of Change, and substance abuse education based on the Center for Substance Abuse Treatment's (CSAT) recommendations for women
- **Child Services (four services):** Al's Pals: Kids Making Healthy Choices, Art Therapy, Child-Centered Play Therapy, and Filial Therapy
- **Family Services (one service):** Celebrating Families! and Family Team Meetings / Single Coordinated Care Plan (SCCP) meetings

RFT consists of a comprehensive program of services designed for adults, children and families. This report is limited to those services that were grant-funded. Appendix H: Comprehensive Residential Family

Treatment Projects Process and Outcome Evaluation Findings contains a full list of evidence-based, promising, and best practices offered by grantees. Additional services, not funded by the grant, may also be specified in individual grantee profiles located in Appendix C: Grantee Profiles.

Table 14: Evidence-based Practices, Promising Practices, and Best Practices

Service	Grantees				
	Amethyst	Meta House	Queen of Peace Center	Renewal House	Susan B. Anthony Center
Adult-level Services					
<i>A Woman’s Way through the 12 Steps*</i>		•			
<i>Acceptance and Commitment Therapy (ACT)</i>			•	•	
<i>Adult Children of Dysfunctional Families (ACODF)</i>	•				
<i>AODA Education Groups*</i>		•			
<i>Art Therapy*</i>		•	•		
<i>Budgeting for Life</i>	•				
<i>Case management per CSAT’s Comprehensive Case Management for Substance Abuse Treatment (CSAT TIP #27) wraparound model *</i>		•			
<i>Cognitive Behavioral Therapy (CBT)*</i>			•		•
<i>Cooking Matters</i>	•				
<i>Dialectical Behavior Therapy (DBT)*</i>	•	•**	•	•	
<i>Eye Movement Desensitization and Reprocessing (EMDR)*</i>		•	•		
<i>Filial Therapy*</i>		•			
<i>Helping Women Recover*</i>		•			
<i>Mindful about Money</i>					•
<i>Motivational Enhancement Therapy (MET)*</i>					•
<i>Motivational Interviewing*</i>		•			•
<i>Nurturing Networks*</i>			•		
<i>Nurturing Parent Program (NPP)*</i>			•		
<i>Nurturing Program for Families in Substance Abuse Treatment and Recovery (NPFSTR), including Mom and Me nurturing lab*</i>		•			

Service	Grantees				
	Amethyst	Meta House	Queen of Peace Center	Renewal House	Susan B. Anthony Center
<i>Parent-child Interaction Therapy (PCIT)*</i>				•	
<i>Peer-based Recovery Support Services*</i>			•	•	
<i>Rational Emotive Behavior Therapy (REBT)*</i>					•
<i>Seeking Safety Therapy for PTSD and Substance Abuse*</i>		•	•		
<i>Stages of Change*</i>		•	•		
<i>Strengthening Families*</i>	•				
<i>Substance abuse education and treatment based on CSAT's recommendations for women*</i>	•				•
<i>Supported Employment</i>	•				
<i>The Incredible Years*</i>	•				
<i>Therapeutic Daycare</i>			•		
<i>Thinking for a Change (T4C)*</i>					•
<i>Trauma Incident Reduction Therapy (TIR)*</i>					•
<i>Trauma Recovery and Empowerment Model (TREM) Group*</i>			•		
<i>Wellness Recovery Action Plan (WRAP)*</i>				•	
Child-level Services					
<i>Al's Pals: Kids Making Healthy Choices*</i>			•	•	
<i>Art Therapy*</i>		•	•		
<i>Child-centered Play Therapy*</i>		•	•		
<i>Cognitive Behavioral Play Therapy (CBPT)*</i>					•
<i>Eye Movement Desensitization and Reprocessing (EMDR)*</i>		•***			
<i>Filial Therapy*</i>		•	•		
<i>Food Matters</i>	•				
<i>IMPACT Safety Courses</i>	•				
<i>Keepin' It REAL*</i>	•				

Service	Grantees				
	Amethyst	Meta House	Queen of Peace Center	Renewal House	Susan B. Anthony Center
<i>Parent Child Action Plan*</i>				•	
<i>Parent-child Interaction Therapy (PCIT)*</i>				•	
<i>Promoting Alternative Thinking Strategies (PATHS)*</i>	•				
<i>The Incredible Years Child Training Series*</i>	•****				
<i>Trauma-Focused Cognitive-Behavioral Therapy (TFCBT)*</i>			•		
<i>Y.E.S. (You're Extra Special)</i>	•				
Family-level Services					
<i>24/7 Dad A.M. Curriculum (fathers)*</i>					•
<i>Celebrating Families!*</i>	•	•	•		
<i>Cognitive Behavioral Therapy (CBT)*</i>					•
<i>Family Systems Therapy*</i>			•		
<i>Family Team Meetings/Single Coordinated Care Plan (SCCP) meetings*</i>		•			•
<i>Motivational Enhancement Therapy (MET)*</i>					•
<i>Motivational Interviewing*</i>					•
<i>Nurturing Program Lab</i>		•			

* Evidence-based practice.

**Although not an original service, Meta House began implementing DBT during the grant.

*** Meta House planned service, but no child became eligible for service.

**** Amethyst planned, but did not offer service.

The most frequently used RFT services by adults, children in residence, and family members are documented in Table 15: Frequently Used Services by Adults, Children, and Family Members. The top three to five services by number of clients served are listed. Documented services not listed in Table 14 include specific evidence-based practices, promising practices, and practice-based evidence that often fall under the general service categories of substance use treatment, mental health counseling, and parenting and life skills classes. Case management, a standard service across all grantees that occurs for all adults and children in residence, is not included in Table 15.

Adult services provided by Renewal House and Amethyst included *Dialectical Behavior Therapy (DBT)* as part of a larger stress reduction service for women. More frequently provided child services included assessments and screenings. Intervention and prevention services and educational and recreational services were also provided; grantees identified these services as general categories and by specific

names. In regard to family services, family therapy and *Celebrating Families!* were each provided by two grantees.

Table 15: Frequently Used Services by Adults, Children, and Family Members

Grantee	Adult Services	Child Services	Family Services
Amethyst	<ul style="list-style-type: none"> • Mood disorders, including Clusters • Stress Reduction, including Meditation and/or Mind Body Connection and <i>Dialectical Behavior Therapy (DBT)*</i> • Substance abuse education based on <i>CSAT's recommendations for women*</i> 	<ul style="list-style-type: none"> • Assessment via Child and Adolescent Needs and Strengths (CANS) • <i>Food Matters</i> • Summerquest (grantee's summer camp for children in residence) <ul style="list-style-type: none"> - Keepin' It REAL* - Y.E.S. (You're Extra Special) 	<ul style="list-style-type: none"> • <i>Celebrating Families!*</i> • Family counseling and therapy • Grantee orientation and social activities (e.g., Family Nights, Welcome Workshops) • Recovery Residences
Meta House	<ul style="list-style-type: none"> • <i>AODA education groups*</i> • <i>Motivational Interviewing*</i> • Transportation, other wraparound services • <i>Nurturing Program for Families in Substance Abuse Treatment and Recovery (NPFSTR)*</i> • <i>Stages of Change*</i> 	<ul style="list-style-type: none"> • Educational and recreational services • Pediatric health care • Screenings, developmental and trauma assessments, infant and mental health assessments 	<ul style="list-style-type: none"> • Family Team Meetings/ Single Coordinated Care Plan (SCCP) meetings* • <i>Nurturing Program Lab*</i> • Recreational activities
Queen of Peace Center	<ul style="list-style-type: none"> • Anger management, stress management, etc. groups • Childbirth education group • <i>Eye Movement Desensitization and Reprocessing (EMDR)*</i> (within individual counseling) • <i>Stages of Change*</i> (part of Recovery Support) 	<ul style="list-style-type: none"> • Early intervention and prevention services • Educational and recreational activities • Pediatric health care and other health services 	<ul style="list-style-type: none"> • <i>Celebrating Families!*</i> • <i>Family Systems Therapy*</i> • Supportive and permanent housing
Renewal House	<ul style="list-style-type: none"> • Public child welfare consultation services • <i>Dialectical Behavior Therapy (DBT)*</i> • <i>Wellness Recovery Action Plan (WRAP)*</i> 	<ul style="list-style-type: none"> • <i>Al's Pals: Kids Making Healthy Choices*</i> • <i>Parent Child Action Plan*</i> • <i>Parent-Child Interaction Therapy (PCIT)*</i> 	<ul style="list-style-type: none"> • Case management support • Monthly family orientation <p><i>Note: Grantee only offered two grant-funded family-level services.</i></p>

Grantee	Adult Services	Child Services	Family Services
Susan B. Anthony Center	<i>Note: Grantee documented 14 services offered to counts of 531 women. See Appendix H for additional details.</i>	<ul style="list-style-type: none"> • Developmental, psychosocial, and trauma assessment • Medical and health assessment • Referrals to supplemental services, therapies, education, childcare, and recreational services 	<ul style="list-style-type: none"> • <i>Cognitive Behavioral Therapy*</i> • <i>Motivational Enhancement Therapy (MET)*</i> • <i>Motivational Interviewing*</i> <p><i>Note: Practices offered as part of family therapy.</i></p>

* Evidence-based practice.

Time in Service and Client Progress

The average number of days in residential treatment ranged from 85 to 630 days. Fewer days in residential treatment were reported by the Queen of Peace Center (85 days) and Meta House (95 days). Higher days in residential treatment were reported by Renewal House (198 days) and the Susan B. Anthony Center (221 days) for successful discharges. Amethyst reported 630 average days in treatment, which is consistent with its milestone-based treatment model and includes long-term, ongoing individual treatment and support services to reunified families from month 12 to 24.

Three grantees reported on client progression in treatment. Almost two-thirds (64 percent, n = 99) of discharged women served at Meta House were considered to have successfully completed treatment. Of those who were successful, 70 percent (n = 69) continued to day treatment. The Queen of Peace Center also reported that 19 percent of women transitioned to day or outpatient treatment. Amethyst reported that over half of families (56 percent) moved from Milestone I to Milestone II. Milestone I, treatment for individuals, lasts from 6 to 12 months. Women move into Amethyst’s residential treatment program and engage in treatment services and parenting education; services are also provided for children and nonresidential family members. Milestone II, treatment for the family as a unit, lasts 9 to 20 months. Services continue for individuals, but the focus shifts to family interventions. No clients reached Milestone III (long-term, ongoing individual and group treatment and support services to reunified families in Recovery Residences); reaching this goal may have been challenging for clients, given the length of time women and children are in Milestones I and II and considering the duration of Family Connection funding.

Section 4: Implementation Components

This report was designed to include a description of the organizational characteristics, activities, and processes that facilitated the successful implementation of Comprehensive Residential Family Treatment Projects as a promising practice within grantee organizations. Subsections were developed using the NIRN implementation science framework⁸ and JBA's EBP framework⁹ as a reporting structure to help address the cross-site evaluation research questions.

- *How do grantees select, develop, and sustain staff member's ability to effectively implement project services?*
- *What is the quality of service implementation in regard to timeliness, fidelity, and administration?*
- *How do the grantees pursue continuous quality improvement as a way to improve services?*
- *How do project leaders promote, guide, and sustain effective project implementation?*
- *To what extent do grantees collaborate with key partners, particularly child welfare agencies, to serve children and families?*

Data for this section were collected through JBA's Web-based electronic survey, described in Section 2: Evaluation Approach. A comprehensive quantitative and qualitative analysis of survey data is provided below, while the complete survey data results for the cluster by question and respondent type are documented in Appendix G: Web-based Survey Results.

Summary of Implementation Components

- **Staff Selection and Development.** Characteristics required for successful RFT staff were ability to engage clients, effective communication, and ability to work in a team environment. From the project leaders' perspectives, the initial staffing strategy that relied on existing staff members did not hinder the projects' implementation. However, evaluators, service providers, and community partners found initial staffing strategies to be problematic, and this delayed implementation. Turnover was an issue across grantees and the impact varied considerably. Loss of knowledge, overloaded staff members, decrease in data, and delays or inconsistent services were noted as problems due to turnover. Training was provided to all levels of staff as mostly project model or direct service presentations. Project leaders, evaluators, and service providers indicated that supervision or coaching was used at least quarterly.
- **Service Implementation Quality.** The service population generally matched the population originally intended, and neither eligibility criteria nor the referral process changed for most of the grantees during the grant period. Service delivery was challenging; the challenges mentioned were substance abuse, resistance to services, and lack of support systems. The best strategies for client engagement were developing relationships with the client and families and addressing basic needs. Services were adjusted during the course of funding to meet the needs of each service population. Examples included expanded hours and adoption of specialized practices for unique

⁸ The National Implementation Research Network (NIRN) (2011). Available at: <http://www.fpg.unc.edu/~nirn/>

⁹ James Bell Associates (2013). *Lessons learned through the application of implementation science concepts to Children's Bureau discretionary grant programs*. Arlington, VA: Author.

population characteristics. Fidelity of services and the service model were assessed regularly and shared with project leaders. Ongoing training, supervision, and coaching were the main strategies used to promote fidelity with staff. Most project leaders indicated the project met or exceeded service expectations, whereas most evaluators indicated the project had only partially met expectations due to fewer numbers of children and families served than projected.

- **Continuous Quality Improvement.** Quality assurance was best achieved through individual guidance, training, and sharing evaluation results. Evaluators indicated project leaders were highly involved in the local evaluation, and project leadership involvement was cited as a contributing factor to a successful evaluation. Relationships with service providers, community partners, and the child welfare agency were also important for a successful evaluation. Most of the grantees shared the evaluation results on a quarterly basis and project leaders used the information to guide decision making. Examples included broadening the understanding of the service population, tracking service delivery, assessing staff skills, and understanding program effectiveness in achieving outcomes. The grantees also noted that data management systems would be sustained following the conclusion of funding, and new policies and procedures were developed as a result of the project.
- **Leadership.** Most grantees indicated the leaders were supportive of the projects and regular communication occurred among projects leaders, service providers, community partners, and evaluators. Leaders engaged other staff members by sharing information regarding project implementation and outcomes or assisting directly with the work. The identified facilitators of project implementation were having sufficient amounts of staff members, strong leadership, and communication. The challenges of project implementation were start-up delays, insufficient incentives for client engagement, and staff member retention. Strengthening communication with partners, co-locating staff, improving training, and increasing the availability of resource materials were strategies used to overcome implementation challenges. A majority planned to sustain most RFT services. The top services identified by leadership as priorities to sustain included substance abuse treatment and education, parenting education, and counseling/mental health services.
- **Collaboration.** Existing relationships and established systems of communication among grantees, child welfare agencies, and other community partners readied the child welfare systems for RFT. A majority of grantees' indicated relationships with partners were collaborative and worked as planned over the grant period. The relationships with the child welfare agencies were identified as less collaborative, but were strengthened as a result of the project. Positive factors contributing to the relationships were open communication, relationship building among staff which increased understanding in one another's services, and mutual goals and interest in serving children and families. Turnover was observed as a major challenge for collaboration within the system. Other challenges included the time and effort to learn new service approaches, changes in leadership, and different communication styles. Strategies to address these challenges were more consistent communication and regular, detailed reporting. The grantees' indicated RFT positively impacted the child welfare system by filling a service gap, reducing the time children spent in foster care, and improving family outcomes.

Survey Participants

Eighty-two surveys were sent out to grantee leadership, project and evaluation staff members, service providers, and collaborating partners, including the child welfare agency director or managers. The total number of survey participants based on survey type can be seen in Table 16: Total Number of Survey Respondents by Survey Type. The overall response rate was 58.5 percent.

Table 16: Total Number of Survey Respondents by Survey Type

Respondent Group	Included in Category	Total Respondents (n)	Surveys Sent (n)	Percentage Responded
Project Leaders	Project Director, Executive Leadership (e.g., President, CEO), and other Project Leadership (e.g., Program or Project Manager, Service Provider Supervisor)	10	17	58.8
Service Providers	Advocates, case managers, case workers, counselors, educators, facilitators, mentors, nurses, therapists, etc.	20	38	52.6
Evaluation Team	Lead evaluator and evaluation team members	9	10	90.0
Public Child Welfare Agency Partners	County and/or state-level public child welfare partner representative(s) (required for private/non-profit grantee organizations and non-child welfare public agencies)	5	9	55.6
Community Partners	Local community partner representative(s)	4	8	50.0
Total N		48	82	58.5

Table 17: Length of Time in Role shows the length of time participants have been in their roles on the RFT projects. The largest proportions of project leaders (60.0 percent), community partners (75.0 percent), and evaluation team members (66.7 percent) have been in their roles between 2 to 3 years. Service providers and public child welfare agency respondents tended to have been in their roles a shorter period of time.

Table 17: Length of Time in Role

Time in Years	Project Leaders (percent)(n)	Service Providers (percent)(n)	Community Partners (percent)(n)	Public Child Welfare Agency Partners (percent)(n)	Evaluation Team (percent)(n)
Less than 1	10.0 (1)	20.0 (4)	25.0 (1)	25.0 (1)	22.2 (2)
1+ to 2	30.0 (3)	25.0 (5)	0.0 (0)	50.0 (2)	11.1 (1)
2+ to 3	60.0 (6)	55.0 (1)	75.0 (3)	25.0 (3)	66.7 (6)
Total N	10	20	4	4	9

Table 18: Length of Time in Organization shows the length of time participants have been in their current organizations. Corresponding with Table 17, service providers and public child welfare agency partners tended to have been with their organizations for shorter periods of time.

Table 18: Length of Time in Organization

Time in Years	Project Leaders (percent)(n)	Service Providers (percent)(n)	Community Partners (percent)(n)	Public Child Welfare Agency Partners (percent)(n)	Evaluation Team (percent)(n)
Less than 1	30.0 (3)	35.0 (7)	25.0 (1)	40.0 (2)	30.0 (3)
1+ to 2	20.0 (2)	20.0 (4)	50.0 (2)	0.0 (0)	20.0 (2)
3+ to 5	20.0 (2)	20.0 (4)	0.0 (0)	20.0 (1)	20.0 (2)
5+ to 10 years	20.0 (2)	15.0 (3)	0.0 (0)	20.0 (1)	20.0 (2)
Over 10	10.0 (1)	10.0 (2)	25.0 (1)	20.0 (1)	10.0 (1)
Total N	10	20	4	5	10

Staff Selection and Development

Staff Selection

Initial Staffing. According to project leaders, the initial staffing strategy for program services drew from existing staff members or hiring new staff to manage and/or deliver RFT services. Most project leaders did not find staffing to be a challenge; those leaders who did note staffing challenges blamed them for delayed project implementation. A majority of evaluators and nearly half of the service providers found staffing to be a challenge. Service providers indicated the staffing challenge delayed service implementation, whereas evaluators indicated it only somewhat delayed project implementation.

Turnover. All of the project leaders and 65 percent of service providers indicated turnover in staff members during the grant period; both groups considered turnover minimal to moderate. The majority of evaluators also indicated turnover was minimal to moderate. Most common types of turnover indicated by both project leaders and service providers were due to employment elsewhere or termination. Project leaders, service providers, and evaluators differed in opinions as to the extent turnover impacted the project as seen in Figure 4 and Table 19: Impact of Staff Turnover on Project Implementation.

According to project leaders, the top three ways turnover impacted implementation were additional time to train staff members, overloaded staff members, and a decrease in the quality and timeliness of evaluation data collection. Service providers also indicated implementation was negatively impacted by overloaded staff members, additional training time, and a decrease in data collection timeliness and/or quality. The loss of knowledge from departing staff and the decrease or inconsistent quality of services were also seen as problems due to turnover.

Figure 4: Impact of Staff Turnover on Project Implementation

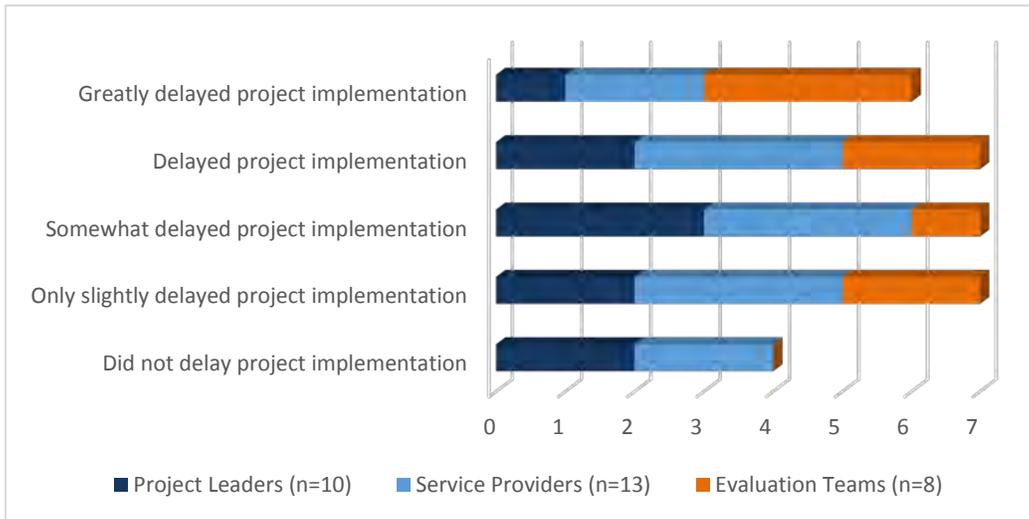


Table 19: Impact of Staff Turnover on Project Implementation

Survey Response	Project Leaders (n=10)	Service Providers (n=13)	Evaluation Team (n=8)	Total (n=31)
Greatly delayed project implementation	1	2	3	6
Delayed project implementation	2	3	2	7
Somewhat delayed project implementation	3	3	1	7
Only slightly delayed project implementation	2	3	2	7
Did not delay project implementation	2	2	0	4

The impact of staff turnover on the evaluation was similar to that on project implementation, with evaluation team members reporting several negative effects. The three most frequently cited that disrupted the evaluation included communication problems and knowledge gaps between program staff members and evaluators, changes in evaluation policies and/or processes due to the turnover, and delays in the evaluation. For example, staff changes affected participant recruitment, delayed data collection, and in some instances, led to preferences for different instruments or evidence-based practices to be used than originally planned.

Staff Development

Training. Project leaders and evaluators indicated the following received training on the overall service model or training on specific components and services of the service model: project directors, service providers, other project leaders, public child welfare and community partners, lead evaluators and the evaluation team members, and a prior Family Connection grantee. Most project leaders said that training included a general project orientation, supplemental topics related to direct services, and/or direct training on the project service model. Service providers indicated training was mostly general orientation and/or supplemental topics related to direct care. The main modality of training was presentations or trainings either by in-house staff or by external trainers and experts.

Supervision. Fifty percent of the project leaders indicated coaching or supervision occurred at least quarterly, whereas service providers' responses varied widely, from no coaching or supervision (35 percent) to quarterly (20 percent), monthly (30 percent), or weekly (15 percent). Several evaluators confirmed that coaching or supervision was completed either monthly or quarterly, but a majority said they were unaware of the frequency.

Staff Characteristics

Figure 5 and Table 20: Experience, Skills, and Personal Characteristics Required for Treatment Staff depict what is necessary for being a successful RFT staff member. The ability to engage individual clients and/or families in services was the top skill mentioned by project leaders, whereas service providers indicated effective communication skills.

Figure 5: Experience, Skills, and Personal Characteristics Required for Treatment Staff



Table 20: Experience, Skills, and Personal Characteristics Required for Treatment Staff

Survey Response	Project Leaders (n=9)	Service Providers (n=20)	Total (n=29)
Ability to engage individual clients and/or families in services	7	11	18
Effective communication skills	2	13	15
Passion for serving families	2	7	9
Ability to work in a team environment	6	3	9
Positive role model (for staff members, families)	1	7	8
Interpersonal skills	1	6	7
Knowledge of resources	3	4	7
Ability to collaborate	1	4	5
Experience working with families	3	2	5
Persistence	1	2	3
Leadership skills	0	1	1

Service Implementation Quality

Client Engagement

Service Population. Sixty percent of project leaders said the project met or exceeded service expectations. The majority of evaluators indicated the project had partially met service expectations (i.e., behind projections for number of children and families served). All stated the population receiving services matched the original intention of the project and was the same as described in the federal funding application. Four of the five grantees did not modify the service population after receiving funding, but one grantee modified as a result to changes in state law. The law criminalized mothers of children who tested positive at birth for maternal drug use, which increased the number of pregnant women in the service population.

Service Delivery. Sixty percent of project leaders and 35 percent of service providers indicated engaging clients was challenging. The top three reasons were drug dependency/substance abuse of the client and/or family member, client resistance to receiving services, and/or lack of support system. The main three engagement strategies used are listed in Figure 6: Top Service Engagement Strategies for Adults, Children, and Families. The most common responses were to develop a relationship with the family and to establish rapport and trust. Seventy percent of project leaders and 47 percent of service providers indicated RFT services changed during the project to meet the needs of the service population. According to project leaders, expanded hours and specialized practices to address unique population characteristics were the most common ways that services were modified. Service providers also endorsed specialized practices for unique populations.

Figure 6: Top Service Engagement Strategies for Adults, Children, and Families



Eligibility and Referral

Eligibility. Only 10 percent of project leaders and service providers revealed that the eligibility criteria had changed during the grant period; reasons included serving different populations or expanding access due to fewer eligibility requirements.

Referral. Twenty percent of project leaders said that the referral process had changed mostly in a positive way by streamlining the process through communication activities with caseworkers. Results for service providers were similar, indicating the process was improved and expanded. Eighty percent of child welfare agencies referred families to projects, whereas 75 percent of community partners did not refer families. Child welfare agencies indicated minor changes to the referral process. These changes included expanding geographic referral areas or increasing communication/collaboration among referring organizations in order to streamline the process for clients. Fifty percent of child welfare agencies thought there were challenges with the referral process. Common challenges included adult clients or families who were eligible, but not ready or willing to engage in services; disruption of referral practices due to turnover of project team staff in the grantee organization; and disruption due to turnover among public child welfare and community partner staff.

Program Model Fidelity

Fidelity assessments of project services or the service model in general were included and shared primarily with the project director and other leaders in written reports or oral briefings during meetings. Fidelity results were most often given annually either in reports, briefings, or presentations, while some evaluators shared them semi-annually or quarterly. Most evaluators reported they did not know if fidelity results had been used by the project; however, for those who indicated they had, results were used to improve program and/or evidence-based practice implementation. Evaluators thought training, coaching, and/or service provider supervision had promoted fidelity. As reported by one evaluator, “The program has been building in ‘fidelity checks’ on most of its evidence-based practices, including supervisors observing sessions and team members reviewing audio and/or video recordings of sessions.” Training and ongoing communication through coaching, supervision, and/or meetings with the evaluation team reportedly increased service providers’ understanding of fidelity and increased the priority these staff placed on fidelity in working with project clients. Several evaluators noted improved service delivery and “keeping on track” despite any changes that may have occurred in practices.

Continuous Quality Improvement

Quality Assurance

Project leaders cited training of staff members and project partners and providing individual guidance as the best strategies for continuous quality improvement in their RFT projects. Service providers also reported that training of staff and partners and providing TA resources were important strategies. A majority of project leaders and service providers thought these strategies were effective.

Administration

Most project leaders and service providers reported new policies or procedures had not been developed in the grantee organization, or they had no knowledge of their development. For those who indicated they had been developed, modifying existing service delivery policies/procedures and existing staff member performance criteria were the most common changes. When asked to provide a brief description of the policy/procedural changes that were made, respondents noted the following:

- One project leader stated, “Prompt and accurate data collection is part of performance evaluations for new and existing staff members. Data collection is included in staff job

descriptions as a core job function. Staff are encouraged to use collaborative documentation practices.”

- One service provider said, “The Family Team was added as part of the treatment team. New materials and trainings were provided. New productivity criteria were created. A system and practice have been implemented for future engagement of the clients receiving services.”

Local Evaluation

Roles and Training. The majority of project leaders and service providers participated in the local evaluation. The project leaders’ most common role was evaluation report review and feedback, while the service providers’ was data collection from clients and/or families. The evaluation team, project director and other leaders, and service providers received training regarding the evaluation. Fifty percent of the child welfare agencies had a role in the evaluation, while only 25 percent of the community partners played a role. Public child welfare agencies and community partner representatives that had a role collected primary data or provided access to SACWIS data (child welfare agencies), submitted secondary/administrative data (community partners), and reviewed and provided feedback on evaluation reports.

Support. Evaluators indicated project leaders were highly involved in facilitating the evaluation, but involvement from child welfare agencies and community partners varied widely. Child welfare agencies’ roles in facilitating the evaluation ranged from greatly facilitating the evaluation (33.3 percent) to not facilitating the evaluation (33.3 percent). Community partners’ facilitation of the evaluation varied from greatly (16.7 percent) or adequately (33.3 percent) to none (33.3 percent). Evaluators reported numerous ways that collaborating with project leaders, public child welfare partners, and other community agency partners facilitated the evaluation. Project leader involvement was most frequently cited as contributing to the service providers having a better understanding of evaluation goals and design (e.g., encouraging clinical staff to provide data that funneled into the evaluation); and creating methods for ongoing feedback and exchanging evaluation information and findings. The relationships with child welfare and other community agencies also helped increase the priority that partners placed on evaluation activities, particularly the importance of following the evaluation design (e.g., providing services consistent with client assignment to treatment and control conditions). Partners also contributed to the evaluation through improved data collection (e.g., ensuring instruments were completed by or for program participants) and identifying areas of importance that might be added to the evaluation plan. Feedback between the grantees’ partners and the evaluation team was mutually beneficial: “Relationships and collaborative structures developed during a past RFT project have helped the evaluation team present findings to the managers in the child welfare agency and have facilitated getting data from the child welfare agency.”

A minority of evaluators thought the project leaders had been a challenge, clarifying that this was due to confusion related to data needs for the evaluation or turnover on the evaluation team. They indicated that the child welfare agency only slightly challenged the evaluation or did not challenge it at all. For those who indicated issues, the reasons stated were lack of engagement on the part of the child welfare agency liaison, which changed when the individual was replaced, or turnover in child welfare staff, which made it more difficult to collect data. They also reported that the community partners did not challenge the evaluation. Only one evaluator noted issues with community partners, stating that they pushed for larger budget cuts for the evaluation.

Data Management. Evaluators indicated that most often an existing system was modified for the project, or a combination of new and updating an existing system was used. The person most often responsible for data management was an evaluation team member; however, external vendors or the grantee organization MIS/data administrator were also mentioned. Initial and ongoing training for the system was provided, and quality checks in the system were completed weekly, monthly, or quarterly. Evaluators responded that the entire data management system would be sustained following the conclusion of funding and would be maintained by the grantee's IT support, MIS/data administrator, and/or an evaluator. Asked to identify the top three ways that having a data management system impacted the project, evaluators cited the following impacts (in order of frequency): (1) increased efficiency in data collection, entry, analysis, and reporting; (2) provided an ongoing and timely source of feedback for the project; and (3) allowed easy, centralized access to program and evaluation staff for data entry, running queries, and generating reports.

Dissemination. Two-thirds of project leaders and evaluators shared process and/or outcome evaluation information with other partners or providers involved in the RFT project. The remaining third indicated the analysis had not yet been completed or they did not know if it had been shared. When evaluation information was shared, it was typically done through written reports and in-person presentations on a quarterly basis. Project leaders frequently used evaluation results to guide decisions, while service providers used them occasionally for decision making. Ultimately, evaluators thought the projects had used the evaluation results to improve the project. According to evaluators, evaluation results were shared with 50 percent of child welfare agencies; however, the majority of community partners indicated they were unaware of the results or they had not been shared. Main methods of sharing the evaluation information were through written reports, in-person presentations, or monthly conference calls. Neither the child welfare agencies nor the community partners reported using evaluation information.

Project leaders and service providers with whom evaluation data were shared applied the information to four key aspects of their projects. Process and outcome results were used to (1) broaden understanding of the service population, (2) track and assess service delivery, (3) identify areas of strength and weakness in staff skills, and (4) determine program effectiveness in achieving outcomes. Other applications of evaluation results included communicating findings to partner organizations and the public for multiple purposes (e.g., publication, funding, and sustainability). Project leaders were the largest group of evaluation data consumers and used results in decision making throughout the projects' implementation. The most frequent applications were identifying the needs of the client population and modifying service delivery to most effectively meet client's unique needs. For example, evaluation findings led one project leader to expand services in response to the changing demographics of women served. The project expanded the length of stay for women beyond 3 months postpartum and targeted more interventions toward women after delivery of a baby. Similarly, evaluators reported that analyses of data obtained through adult and child assessments were used to monitor program impacts and identify areas in which service adjustments might contribute to improved outcomes. The value of such data sharing between evaluators, project leaders, and service providers is reflected in the comments of one evaluator ("The data have been showing only minimal improvement in women's parenting attitudes. As a result, the program is in the process of reviewing its array of parenting services and considering additional or different parenting curricula.").

Evaluation Facilitators, Barriers, and Lessons Learned

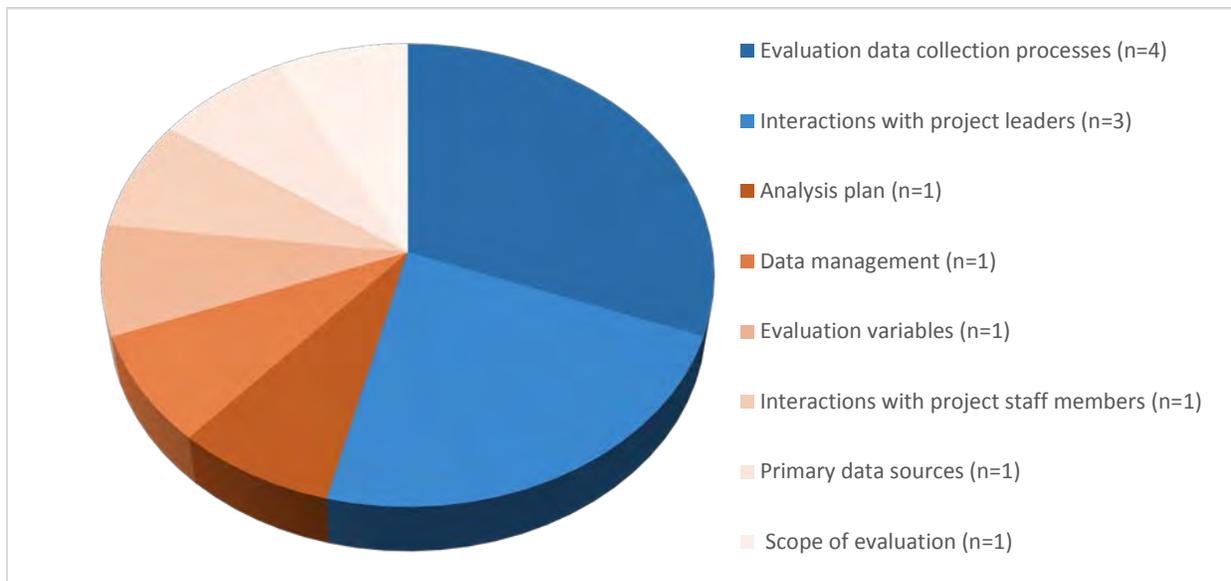
Project leaders and evaluators reported a variety of facilitators, barriers, and lessons learned regarding evaluation of the projects. The top three reported in order of frequency were strong, open lines of

communication between the evaluator and project team that included access to all staff to ask questions about the projects; ability to review data with project leaders and staff (i.e., data collection quality, practices, and results); and a strong collaborative relationship with the project team and other stakeholders in which there is mutual respect. The top three challenges in order of frequency were staff turnover within the project team and in partnering organizations; meeting all of the requirements of the evaluation, such as conducting the cost study component; and change in the evaluation team itself due to staff changes or the evaluator coming into the project after its start.

Project leaders were less specific in their feedback regarding the evaluation. Asked what advice they would give to others implementing a similar project, they cited the benefit of having shared, electronic data systems to facilitate data collection and reporting. Electronic health records were recommended as a means to eliminate multiple databases. The nature and length of an RFT program was noted as possibly limiting the number of families served. Small sample sizes were a challenge in some project evaluations because they made it difficult to draw conclusions or evaluate trends at required statistical confidence levels. Individuals whose evaluation plans included use of comparison or control groups were advised to ensure easy access to families in those groups.

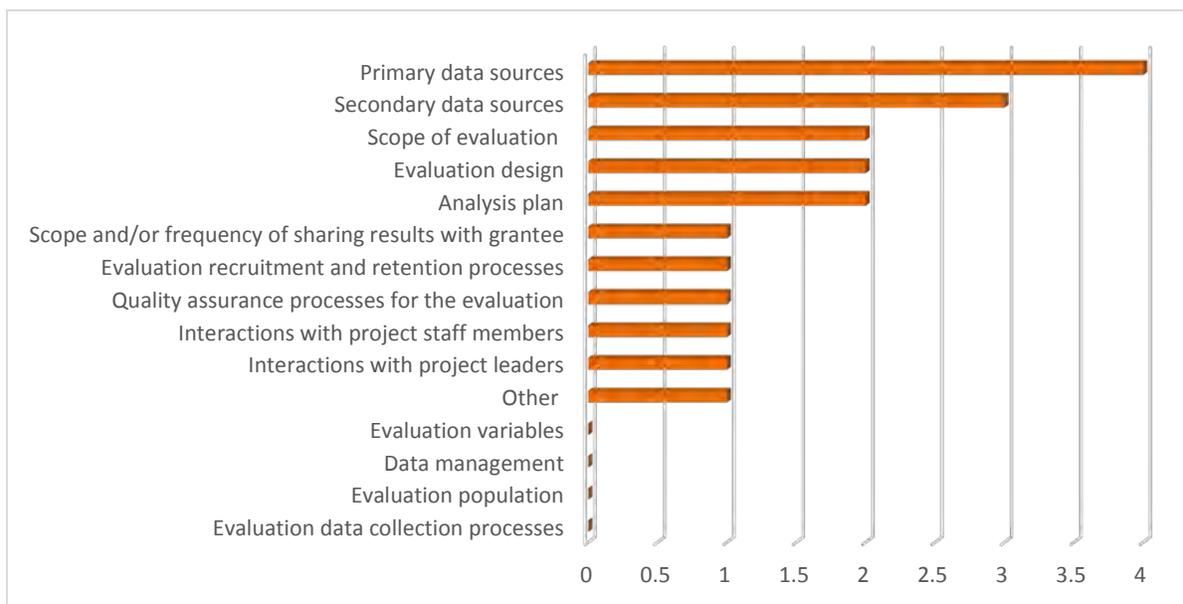
Changes made to the evaluation included evaluation data collection processes (e.g., incorporated qualitative interviews); interactions with project leaders; analysis plan; data management; evaluation variables; interactions with project staff members; primary data sources (e.g., evaluation instruments); and scope of evaluation (number and/or breadth of activities) as depicted in Figure 7: Areas Evaluators Changed in the Local Evaluation. Changes made to the scope of the evaluation included scaling back the involvement of the evaluator in some projects and expanding evaluator interaction with project leaders and staff members in others. Evaluation data collection and analysis practices were changed by introducing more qualitative data collection methods (e.g., client and other key stakeholder interviews and focus groups), placing greater emphasis on fidelity assessment, and adding more sophisticated analyses to the evaluation design.

Figure 7: Areas Evaluators Changed in the Local Evaluation



In hindsight, if the evaluation team could have changed the local evaluation, it would have changed primary data sources (e.g., evaluation instruments), secondary data sources (e.g., SACWIS, local administrative databases), analysis plan, evaluation design, and scope of evaluation (number and/or breadth of activities), all of which is documented in Figure 8: Areas Evaluators Would Have Changed in the Local Evaluation. Three evaluators reported dissatisfaction with the quality of data obtained from the Protective Factors Survey and the difficulty in obtaining a sufficient number of the Trauma Symptom Checklist for Young Children questionnaires. Evaluators also experienced challenges accessing child welfare data through state SACWIS systems, despite agreements for data sharing. The third aspect the evaluation team would like to have changed was to have decreased the scope of the evaluation, particularly being “less ambitious” about its ability to complete a cost analysis within the project period.

Figure 8: Areas Evaluators Would Have Changed in the Local Evaluation



Leadership

Engagement

Eighty percent of project leaders and 63 percent of service providers thought their leadership supported the projects. The main three activities conducted by leaders and service providers to achieve and maintain engagement are listed in Figure 9 and Table 21: Top Three Leadership Engagement Activities. Project leaders stated there was regular communication among leaders, service providers, and evaluators. They were most likely to participate in regularly scheduled project leadership meetings and project staff meetings and to have read written updates from their local evaluators. Service providers were most apt to read written updates from the local evaluators to project leaders and service providers and to participate in regular project staff meetings.

Figure 9: Top Three Leadership Engagement Activities

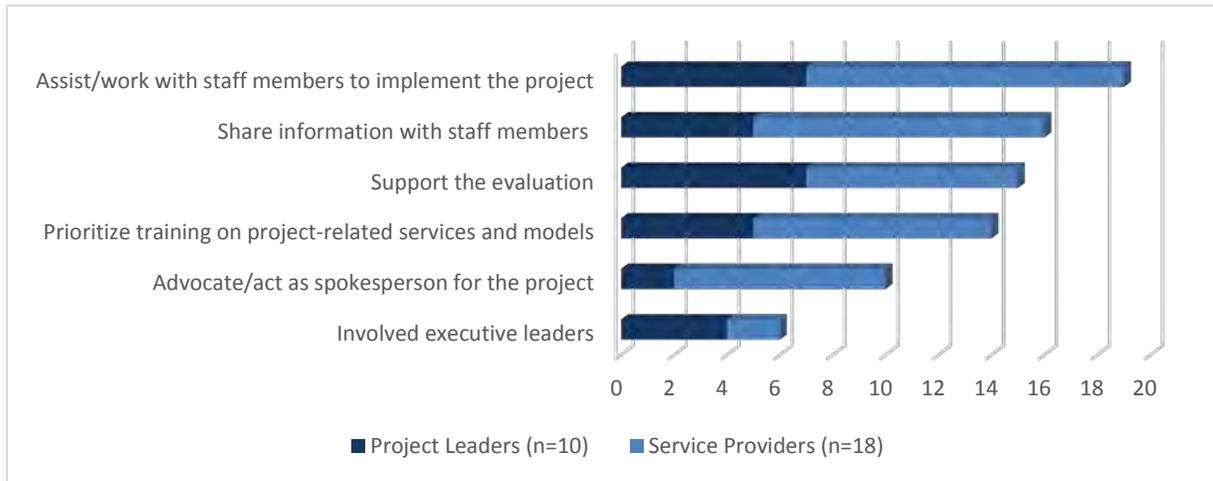


Table 21: Top Three Leadership Engagement Activities

Survey Response	Project Leaders (n=10)	Service Providers (n=18)	Total (n=28)
Assist/work with staff members to implement the project	7	12	19
Share information with staff members	5	11	16
Support the evaluation	7	8	15
Prioritize training on project-related services and models	5	9	14
Advocate/act as spokesperson for the project	2	8	10
Involved executive leaders	4	2	6

Implementation Facilitators, Barriers, and Lessons Learned

The main three facilitators of implementation according to project leaders and service providers are displayed in Figure 10 and Table 22: Top Facilitators of Project Implementation. The primary facilitator for project leaders was staff member capacity (sufficient staff members) to implement project and project leadership support; for service providers, it was communication. The top challenge to project implementation according to project leaders involved start-up delays, and the main challenge according to service providers was lack of or insufficient incentives for clients to engage in services (e.g., monetary, transportation).

Figure 10: Top Facilitators of Project Implementation

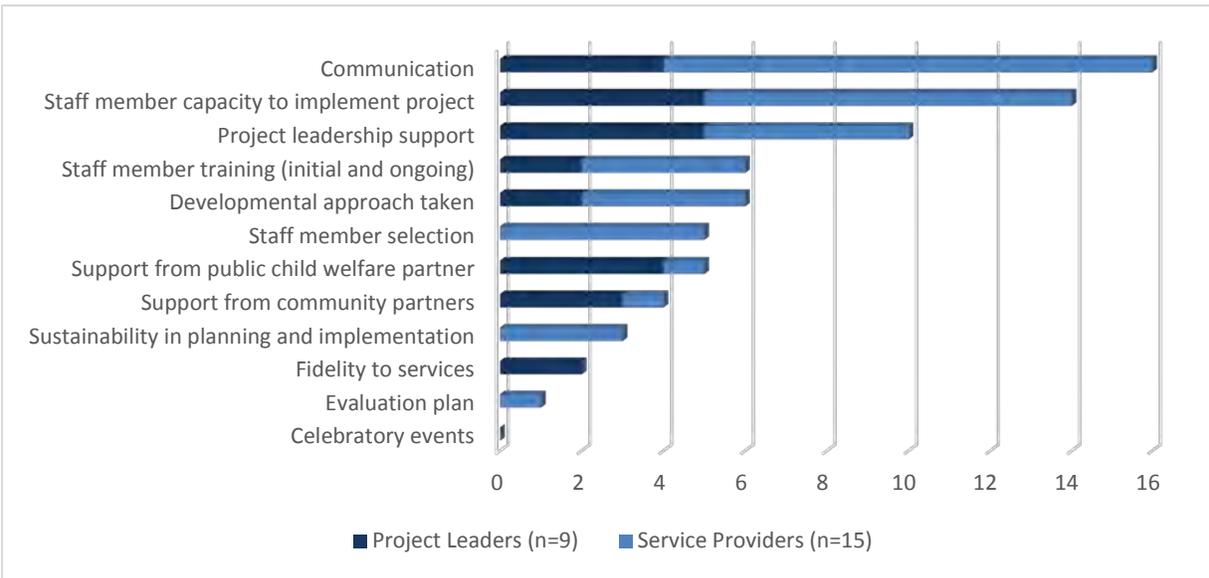


Table 22: Top Facilitators of Project Implementation

Survey Response	Project Leaders (n=9)	Service Providers (n=15)	Total (n=24)
Communication	4	12	16
Staff member capacity to implement project	5	9	14
Project leadership support	5	5	10
Staff member training (initial and ongoing)	2	4	6
Developmental approach taken	2	4	6
Staff member selection	0	5	5
Support from public child welfare partner	4	1	5
Support from community partners	3	1	4
Sustainability in planning and implementation	0	3	3
Fidelity to services	2	0	2
Evaluation plan	0	1	1
Celebratory events	0	0	0

Key challenges to project implementation are presented in Figure 11 and Table 23: Top Challenges of Project Implementation. Project leaders and service providers identified the same strategies used to overcome implementation challenges: strengthen communication with partners, co-locate staff, and improve the referral system. Service providers also mentioned improving the initial training (e.g., content, type, frequency) and increasing availability of resource materials.

Figure 11: Top Challenges of Project Implementation

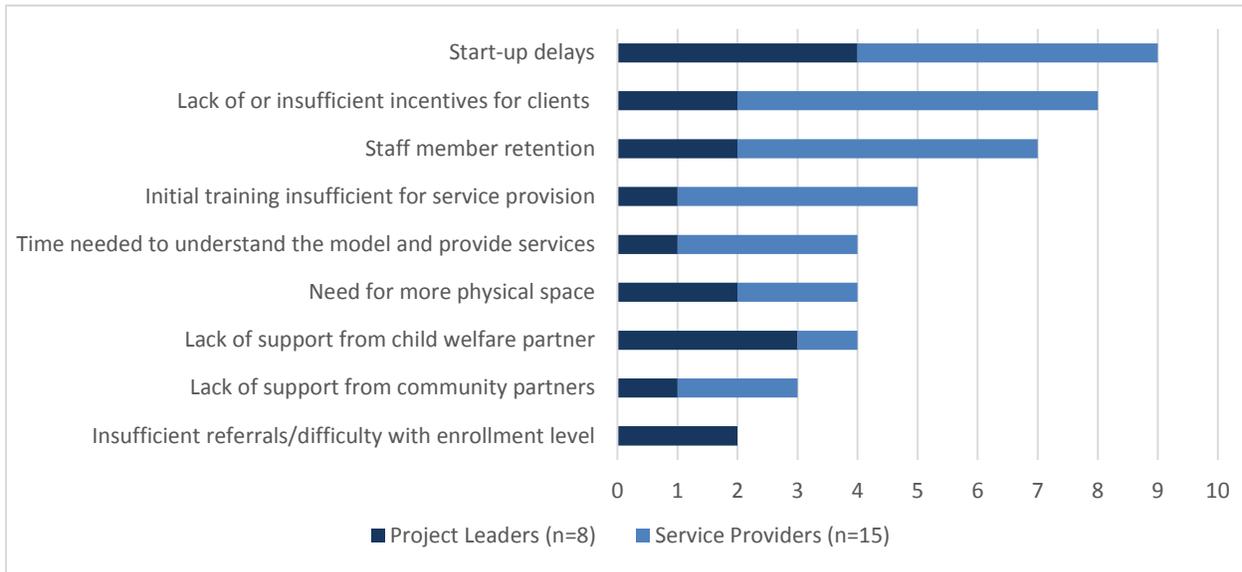


Table 23: Top Challenges of Project Implementation

Survey Response	Project Leaders (n=8)	Service Providers (n=15)	Total (n=23)
Start-up delays	4	5	9
Lack of or insufficient incentives for clients	2	6	8
Staff member retention	2	5	7
Initial training insufficient for service provision	1	4	5
Time needed to understand the model and provide services	1	3	4
Need for more physical space	2	2	4
Lack of support from child welfare partner	3	1	4
Lack of support from community partners	1	2	3
Insufficient referrals/difficulty with enrollment level	2	0	2

Project leaders and service providers reported similar lessons learned regarding achieving positive outcomes from serving adults, children, and families. Asked what advice would be given to others implementing a similar project, they emphasized the most important contributors to achieving positive outcomes were strong, well-trained staff who have the skills to provide a family-centered level of care and good communication at all levels. Project leaders also recommended project planners use a minimal number of tools to assess child and family outcomes. Service providers further stressed the importance of staff members, recommending that they have sufficient training and the number working with families is adequate to “support the mission.” Service provider recommendations also focused on the manner in which families were served, emphasizing providers should be respectful, supportive, and responsive to family needs: “Be genuine and respectful. Families recover in time, and they will improve if they feel supported.” In addition, services should be put in place to meet the needs of the adults and children. For example, services should be provided that reduce barriers to families obtaining assistance (e.g., providing transportation).

Sustainability

Seventy-eight percent of project leaders planned to sustain most RFT grant-funded services. The top three services identified as priorities included substance abuse treatment and education, parenting education, and counseling/mental health services. Adult and child-level services most frequently mentioned in these service areas included Celebrating Families![™], an evidence-based program for families in which one or more parents has a serious alcohol or drug abuse problem; and AI's Pals, a research-based curriculum for at-risk preschool and elementary-school children. Project leaders responded that sustaining services would most likely occur through integrating project practices into current work or through funding from another organization. The cost study was minimally or somewhat helpful in sustainability planning. Those who thought it was useful stated that it assisted in continued funding and client service use.

Collaboration

System Readiness

Project leaders were split as to what degree the broader child welfare system was ready for the comprehensive RFT project. Fifty percent thought the system was mostly ready, while the other 50 percent thought it was only slightly ready. The top three factors that contributed to the child welfare system's readiness were existing relationships between the project team and child welfare agencies (e.g., prior work together on a similar project or serving mutual clients); having systems in place for communication (e.g., memorandums of understanding); and having prior knowledge of the RFT service model and potential outcomes. Project leaders reported the main three factors that prevented the child welfare system from being ready were high turnover in child welfare staff; organizational upheavals (e.g., agency reorganizations and frequent changes in upper and senior management); and leadership challenges within child welfare agencies due to management being overwhelmed by significant changes and the overburdened system.

Roles

Thirty-three percent of project leaders and 15 percent of service providers indicated that there had been changes in project partners. According to project leaders, changes occurred due to revisions in organization structure, turnover at the child welfare agency, or reduced responsibilities/tasks of the partner in the project. Service providers indicated either an addition or reduction of partners and/or addition or reduction of partner responsibilities, as well as changes in service regions.

Fifty percent of child welfare agencies and 50 percent of community partners participated in planning the project. Child welfare agencies indicated they assisted in planning the project through meetings, emails, one-on-one phone calls, and informal channels with project planners. Community partners mostly assisted through emails and one-on-one phone calls. Seventy-five percent of child welfare agencies had an opportunity to provide ongoing feedback to the project, but only 25 percent of community partners felt that they had the same opportunity.

Evaluators rated their level of collaboration with the project leaders or service providers as collaborative or very collaborative. They also indicated that project leaders and service providers were involved or very involved in planning the evaluation. Project leaders were involved or very involved in implementing the evaluation; however, the evaluators rated service providers as involved, but less so than the project leaders.

Relationships

Sixty percent of child welfare agencies and 75 percent of community partners had worked with the grantee organization prior to the project. A majority of project leaders thought relationships with partners had worked as planned. For those who thought otherwise, key reasons were lack of partner support for project services and activities, not fulfilling roles and responsibilities, poor communication, and changes in service provision. Community partners thought the relationship prior to the project was collaborative and felt no evident change in their relationship with the grantee due to the project. The child welfare agencies thought the prior relationship was only somewhat collaborative, but most perceived the relationship was much more positive as a result of the project. The main three ways the project has impacted the grantee organization’s role with project partners may be seen in Figure 12 and Table 24: Top Three Ways the Project Impacted the Grantees’ Relationship with Project Partners.

Figure 12: Top Three Ways the Project Impacted the Grantees’ Relationship with Project Partners



Table 24: Top Three Ways the Project Impacted the Grantees’ Relationship with Project Partners

Survey Response	Project Leaders (n=9)	Service Providers (n=16)	Total (n=25)
Increased contacts between grantee organization and project partners	9	5	14
Increased awareness of project services among project partners	3	9	12
Expanded awareness of the grantee organization’s own strengths and weaknesses per project partner feedback	3	6	9
Increased/improved case coordination	5	4	9
Increased understanding of child welfare system by project partners	1	6	7
Improved reputation of grantee organization among project partners	2	3	5
Other	0	4	4

Child welfare agency and community partners reported the same main factors contributed to the positive aspects of the relationship: (1) open and positive communication, including between project leaders and

partners' front-line staff; (2) building relationships with contacts in each other's organizations resulted in "knowing exactly who to call" to access services for clients; and (3) mutual respect and trust in one another's knowledge and shared commitment to serving families. These positive aspects of the partnerships were achieved in diverse ways, including frequent contact with one another, having a liaison between organizations, or co-locating staff.

Project partners also experienced challenges in working with the grantee organizations; most related to staff turnover. For example, high staff turnover and transitions had one community partner feeling "left by the wayside" while trying to meet the minimum number of participants. Similar gaps in the relationship with the grantee were reported by a child welfare agency partner. High staff turnover in the project team and change in the lead evaluator within the first half of the grant period resulted in "low follow through and service delivery" and loss of contact between the new evaluation team and the partner agency. An additional challenge was concern about the ability to sustain services when the grant-funding period ended. At least one community partner indicated that delays in creating joint-training opportunities were a challenge. The project partners who were able to address these challenges did so by meeting with new leaders in the grantee organization to discuss their concerns or by adding another partner to provide the necessary assistance. For example, a university-based child welfare training team was brought into the collaboration to increase training opportunities. The challenges experienced by some child welfare agencies and community partners had not been addressed.

Communication

Child welfare agencies and community partners had a process for regular communication; emails, regular project meetings, and informal channels were the most common methods. Seventy-five percent of child welfare agencies and community partners indicated there was sufficient communication. For those reporting that communication could be improved, suggestions included more consistent feedback and monthly reports. Most project leaders communicated with partners at least quarterly, and partners communicated with them at least monthly. The top three communication mechanisms for project leaders were (1) emails, (2) informal channels, and (3) reports or project meetings (equally weighted). Service providers' top three communication mechanisms were (1) emails, (2) reports, and (3) informal channels or project meetings/community meetings (equally weighted).

From the perspective of project leaders, partner feedback led to changes in services, processes, and evaluation activities. Partners documented feedback regarding communication between the project team and partner organizations; staff training needs; data collection problems; and discrepancies between client eligibility, referral, and services received. For example, evaluation partners informed the project leaders that they were experiencing problems receiving timely and clean data from service providers. Other partners identified individual staff member performance issues and areas in which staff members could benefit from additional training (e.g., client eligibility, referral, and intake processes), and suggested increased communication through regularly scheduled meetings. In response to this feedback, project leaders worked with individual staff members to improve performance; provided additional training to staff members on data collection processes, tools, and schedules; added eligibility requirements to the baseline data collected from clients; streamlined referral processes; and improved overall management of the project (e.g., holding meetings with partner agency supervisors to discuss programs and including partners in professional development and training).

Collaboration Facilitators, Barriers, and Lessons Learned

The main benefit that the projects experienced through their work with partners was strengthened collaboration for project leaders and service providers. The remaining benefits can be seen in Figure 13 and Table 25: Top Benefits the Project Has Experienced Through Work with Partners. All of the child welfare agencies and community partners indicated that developing partnerships was beneficial, illustrated by the following survey response: “By working together we learn each other's systems and provide better service to our mutual clients.”

Asked to identify up to three benefits from developing partnerships, child welfare agencies and community partners reported that improved communication and understanding of one another’s services were the most valuable. Additional benefits included service providers’ improved ability to access and “mobilize” services for families without duplicating efforts and families feeling more supported by coordinated services. At least one community partner identified improved adult and child outcomes as a benefit of the project partnerships.

Figure 13: Top Benefits the Project Has Experienced Through Work with Partners

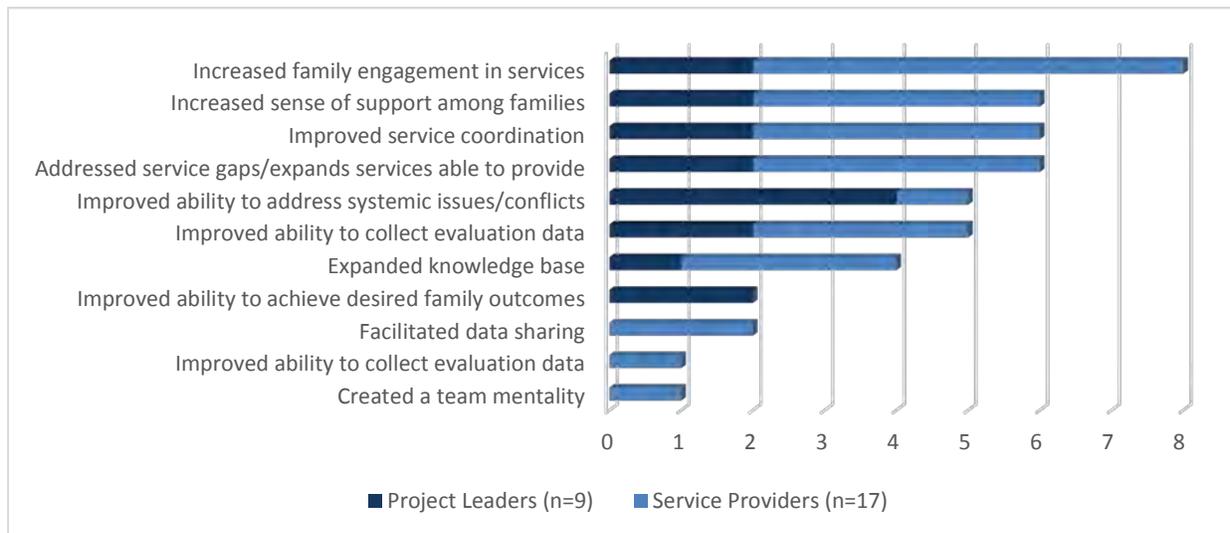


Table 25: Top Benefits the Project Has Experienced Through Work with Partners

Survey Response	Project Leaders (n=9)	Service Providers (n=17)	Total (n=26)
Increased family engagement in services	2	6	8
Increased sense of support among families	2	4	6
Improved service coordination	2	4	6
Addressed service gaps/expands services able to provide	2	4	6
Improved ability to address systemic issues/conflicts	4	1	5
Improved ability to collect evaluation data	2	3	5
Expanded knowledge base	1	3	4
Improved ability to achieve desired family outcomes	2	0	2
Facilitated data sharing	0	2	2
Improved ability to collect evaluation data	0	1	1
Created a team mentality	0	1	1

The predominant challenges experienced by project leaders while working with partners were changes required in service approaches/processes/procedure, (changes in partner leadership, differing communication styles, and staff turnover. Service providers’ main challenges were differing communication styles, substantial staff training and orientation requirements, quality of the partnering service provider, and choice of services were not best practices. When asked how collaboration between public child welfare agencies and private/not-for-profit agencies might be strengthened, different recommendations were offered. Child welfare representatives emphasized communication, recommending “consistent two-way communication,” “understanding the language that each agency speaks,” and regular detailed reporting. Community partners recommended more focus on relationships, indicating that relationships between partners would be improved by less frequent turnover in child welfare agencies. In order to ensure that the most appropriate plans were implemented, community partners recommended that not-for-profit organizations be given more authority and input into child welfare decisions, based on staff members having greater knowledge about the child than the child welfare agency. The main strategies for successful partnerships are identified in Figure 14 and Table 26: Top Strategies for Developing and Sustaining a Successful Partnership. Project leaders and service providers named the same top two strategies: engage in ongoing, open communication, and identify common goals. Similarly, the advice that project leaders and service providers would give to others implementing a similar project regarding collaboration emphasized the importance of communication, ensuring buy-in at all levels, and strong commitment to shared goals for families. Specific advice provided by project leaders regarding each of these areas included the following:

- ✓ “Communication is key. Include all members in decision making. Be prompt in notifying partners about challenges or problems. Don’t forget to communicate about the successes along the way.”
- ✓ “Clear guidelines on intended services to be provided and clear 'buy-in' from executive level partners creates opportunities to demonstrate usefulness with front line staff.”
- ✓ “Work well with others by communicating effectively and pursuing common goals.”

Figure 14: Top Strategies for Developing and Sustaining a Successful Partnership



Table 26: Top Strategies for Developing and Sustaining a Successful Partnership

Survey Response	Project Leaders (n=9)	Service Providers (n=17)	Total (n=26)
Engage in ongoing, open communication	9	15	24
Identify common goals	6	10	16
Ensure that partners understand roles and responsibilities	2	9	11
Share information about project	3	7	10
Share information about organizations	2	5	7
Co-locate staff members	3	2	5
Enter formal agreement	2	2	4
Other	0	1	1

Perceptions of Overall Impact

According to project leaders, the RFT projects affected child welfare practice in the community by improving service planning for families and increasing support and advocacy for RFT. Most child welfare agencies and community partners thought the projects had a positive influence, primarily by filling a service gap. Community partners believed the project reduced the time children spent in foster care and increased awareness of RFT services among child welfare providers. Child welfare agencies thought they had somewhat integrated elements of the project model into their own service delivery systems. Community partners were more varied in their responses, with some indicating a great deal of integration, while others stated not at all.

According to child welfare partners, the most important accomplishments were improving staff knowledge about the alcohol and drug issues of clients served, and related treatment options; providing treatment to clients in residential settings; improving communication between RFT projects and child welfare staff members; and expediting alcohol and drug assessments of “difficult to reach” parents, which enabled them to receive services faster. Community partners noted accomplishments at more of a client than a system level. In addition to the success of providing a residential treatment setting, community partners included improved family outcomes among the most important accomplishments. These outcomes included improving women’s recovery and quicker reunification of children with parents. One community partner said, “This project allowed women to spend more time in residence before moving to outpatient; thus helping improve recovery.”

Final thoughts from project leaders and service providers included recognizing the project’s role in creating opportunities for additional collaborative efforts on behalf of families, and expressing the need for longer funding periods to demonstrate the “usefulness and effectiveness of services.”

Section 5: Outcome Evaluation Findings

This section describes grantees' interim outcome evaluation findings, which are organized by adult, child, family, and organizational and systems-level outcomes. Adult, child, and family-level outcomes are documented within the key areas of safety, permanency, and well-being, and address the cross-site evaluation question, *To what degree do the Comprehensive Residential Family Treatment Projects achieve short, intermediate, and long-term outcomes?* Examples of organization and systems-level changes regarding policies and procedures, service model integration by the public child welfare agencies and other key agencies, and impacts on the child welfare practice in the community that occurred due to the RFT projects were provided in semi-annual reports. These data and cost study findings are synthesized in this section.

A summary of key outcome findings is provided below. Supporting data for this section are in Appendix H: Comprehensive Residential Family Treatment Projects Process and Outcome Evaluation Findings.

Summary of Outcome Evaluation Findings

The following outcomes in the areas of permanency and well-being were addressed:

- (1) Permanency outcomes showed the extent that participation of families in the projects supported increased safety and stability for children in their living situations by reducing the time they were involved with the child welfare system and meeting their immediate and long-term needs for safety, permanency, and well-being within their family system.
- (2) Well-being outcomes indicated improvement after project participation: domains of child well-being, including cognitive functioning, behavioral/emotional functioning, physical health and development, social functioning, and mental health; and indicators of caregiver well-being, including concrete family needs, social support, parental stress, and physical and mental health.

In addition, systems-level outcomes were addressed to show to what degree the collaborative approach contributed to improved outcomes for children and families in the target population.¹⁰

- **Safety.** Four grantees reported findings with positive results for parent sobriety, risk and protective factors for child abuse and neglect, and family functioning. Inconclusive results were found for one grantee's assessment of home safety.
- **Permanency.** One grantee reported increased involvement of mothers with their children, demonstrated by retaining placement of children, reunifying with one or more children, or being granted increased visitation. Efforts to assess increased involvement of fathers for another grantee were hampered by low enrollment in services designed for fathers and unavailable evaluation data. One grantee reported high percentages of mothers employed or in school and having stable housing for their children. Two grantees reported one positive and one negative rates of reunification, and also higher than expected rates of children re-entered into foster care.

¹⁰ HHS, Administration for Children and Families (2012). *Family connection discretionary grants*. Funding Opportunity Number: HHS-2012-ACF-ACYF-CF-0511 RFT.

Public child welfare data were not available to two grantees that planned to assess length of stay in foster care, reunification, and other permanency arrangements using these information systems as key data sources. One grantee was able to provide positive results on child welfare case closure at discharge.

- **Well-being.** An extensive collection of measures was used to assess adult and child-level well-being. Positive outcomes for women were found in substance use and sobriety and trauma-related symptoms. Mixed results were found on maternal mental health measures, and negative or inconclusive results were found for increased social connections and supports. Positive results were reported for sense of family empowerment and parental resilience, and for parental competence and the capacity to provide for child(ren)'s needs.

Child-level outcome goals were measured by all five grantees. Positive outcomes were found related to birth weight, attachment, family well-being, and ability to assess, identify, and connect child(ren) to appropriate support services. Mixed or inconclusive results were found for general well-being; physical, cognitive, and social-emotional development; and trauma-related symptoms.

- **Organizational and Systems Impact.** Grantees addressed outcomes designed to demonstrate successful implementation of the projects. Results for 17 out of 24 outcome goals were provided in the areas of service provision, policies and procedures, and impact on child welfare practice. Grantees were successful in integrating new evidence-based practices into their existing services and training staff members at the grantee organization and project partner agencies. Collaborative practices were implemented, including procedural guides, joint referral processes, consultations, and assessments as a way to develop and solidify relationships with public child welfare and other community partners.
- **Project Costs.** All grantees reported cost study findings. Different approaches (i.e., cost allocation, cost effectiveness, and cost benefit) were used, with four grantees implementing more than one approach. At a minimum, all five projects conducted cost allocation analyses. Cost data were collected within different timeframes (ranging from 1 month to 18 months) to determine project expenditures and estimate annual projects. Data sources also varied, including staff time tracking spreadsheets, program budgets, and audit reports produced by internal fiscal staff and external contractors. Study approaches yielded total project/operating costs, direct and indirect services costs, and costs per family and individuals. Cost benefit analyses findings showed cost savings associated with providing RFT services as a strategy to prevent children from entering or re-entering the child welfare system, and preventing parents from entering the criminal justice system.

Local Evaluation Approach

The funding announcement for the 2012-funded projects cluster required grantees to design local evaluations to “show whether the Comprehensive Residential Family Treatment Projects’ program will stabilize, strengthen, preserve, and reunite families through a range of effective, individualized services designed to increase well-being of family members, and improve well-being, strengthen permanency, and

enhance safety for children in the target population.”¹¹ Organizational level outcomes were addressed, such as development of policies and procedures, promoting client satisfaction, and facilitating project partner collaboration as contributors to increased safety, permanency, and well-being among women, children, and family members.

All grantees employed quasi-experimental designs with plans to employ comparison groups consisting of women and children with similar characteristics to those in RFT. Meta House planned for a retrospective design, comparing current treatment group outcomes to those of women who participated in their 2009 RFT project. Renewal House and the Susan B. Anthony Center compared treatment participants to women and children receiving “services as usual” from public child welfare agencies. Renewal House added a second comparison group, women receiving “services as usual” from child welfare agencies and services from the grantee’s Addictions Consultant. The Queen of Peace Center designed an evaluation to collect data from women receiving grantee services and services from a comparable health agency at baseline and two followup points. Additional details on local evaluation designs are in Appendix H: Comprehensive Residential Family Treatment Projects Process and Outcome Evaluation Findings.

Two grantees, Amethyst and the Queen of Peace Center, experienced difficulties in obtaining comparison participants. The Queen of Peace Center partnered with a local community organization for this purpose; it later replaced the partner organization with two new agencies in hopes of acquiring additional comparison group participants. Amethyst experienced challenges in reaching women and children served by public child welfare agencies, but who declined to participate in RFT, as comparison group participants. Amethyst did not develop another option to create a comparison group.

Outcome Evaluation Reporting Criteria

The following criteria were used to classify implications from available outcome data as positive, negative, or inconclusive. Classifying an implication as positive may indicate that percentages or scores increased, such as heightened parenting knowledge and demonstrated skills or improved family functioning. A positive implication may also signify a decrease, such as an incidence of substance use. Group Ns, scores, and significance data are documented in this report to the degree the information was provided by grantees. An implication may be characterized as positive or negative despite a lack of significance data. Inconclusive classifications were most often due to lack of followup data; no changes from baseline to followup in treatment groups; or if there were changes from baseline to followup, they were of the same amount and direction for both treatment and comparison/control groups.

Positive

- Treatment group demonstrated a positive difference between baseline and followup, preferably noted as statistically significant.
- Treatment group demonstrated a positive difference between baseline and followup relative to the control or comparison group, preferably noted as statistically significant.
- Treatment group achieved a grantee-specified goal at a designated point in time.

Negative

- Treatment group demonstrated a negative difference between baseline and followup, preferably noted as statistically significant.

¹¹ HHS, Administration for Children and Families. (2012). *Family Connection Discretionary Grants*. Funding Opportunity Number: HHS-2012-ACF-ACYF-CF-0511 RFT.

- Treatment group demonstrated a negative difference between baseline and followup relative to the control or comparison group, preferably noted as statistically significant.
- Treatment group failed to achieve a grantee-specified goal at a designated point in time.

Inconclusive

- Data were provided for the treatment group at one point in time, but no outcome goal was specified to indicate if the treatment group demonstrated sufficient achievement.
- Baseline data were provided for the treatment group, but no followup data were provided to indicate differences over time relative to outcome.
- The treatment group demonstrated no difference, statistically significant or otherwise, between baseline and followup.
- Differences between baseline and followup were of equivalent size and direction for treatment and control or comparison groups.
- Baseline data were provided for treatment and control or comparison groups, but with no difference in baseline between treatment and control groups.

Adult, Child, and Family-level Outcomes

All grantees assessed safety, permanency, and well-being as part of the local evaluation. Several primary and secondary data sources were used to assess these outcomes for women, children, and other family members (see Table 3: Grantee Data Sources and Instruments). Outcomes presented were documented in the semi-annual reports and reflect data available through September 30, 2015. Most evaluation outcome data were provided through primary data sources. The Susan B. Anthony Center provided outcome data through primary and secondary data sources. Brief descriptions of primary data sources are in Table 27: Primary Data Source Descriptions.

Table 27: Primary Data Source Descriptions

Instrument	Outcome	Description
24/7 Dad Fathering Inventory and Fathering Skills Survey*	Well-being	<u>Adult</u> : Fathering Inventory assesses fathering and parenting attitudes and determines whether a positive or negative shift in attitude occurs as a result of program participation. Fathering Skills Survey collects demographic information and measures fathering and parenting knowledge and skills.
Addiction Severity Index (ASI)	Well-being	<u>Adult</u> : This 200-item self-administered survey or interview detects and measures the severity of potential treatment problems in seven areas commonly affected by alcohol and drug dependence: Alcohol, Drugs, Employment, Family/Social, Legal, Medical, and Psychiatric. Meta House uses a modified version of the ASI.
Adult-Adolescent Parenting Inventory (AAPI-2)	Safety	<u>Adult</u> : This 40-item measure assesses parenting attitudes and provides an index of possible risks for child abuse and neglect via a Total Score and five subscale scores for Inappropriate Expectations, Lack of Empathy, Physical Punishment, Role Reversal, and Power and Independence.
Adult Needs and Strengths Assessment (ANSA)	Well-being	<u>Adult</u> : This adult version of the Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool used by behavioral health services to support decision making, including level of care and service planning, facilitate quality improvement initiatives, and allow monitoring of service outcomes. The ANSA assesses Acculturation, Life Domain Functioning, Mental Health Needs, Risk Behaviors, Strengths, and Caregiver Strengths and Needs.

Instrument	Outcome	Description
Ages and Stages Questionnaire (ASQ-3) Ages and Stages Questionnaire – Social/Emotional (ASQ-SE)	Well-being	<u>Child</u> : The ASQ-3 screens infants and young children for delays in five developmental areas: Communication, Fine Motor, Gross Motor, Personal-Social, and Problem Solving. ASQ-SE is a culturally sensitive screening tool of social-emotional development that assesses Affect, Adaptive Functioning, Autonomy, Communication, Compliance, Interaction with People, and Self-Regulation. Both instruments are completed by a parent or primary caregiver.
Battelle Development Inventory (BDI)	Well-being	<u>Child</u> : The 450 items screen and evaluate early childhood developmental milestones in five domains: Adaptive, Cognitive, Communication, Motor, and Personal-Social. It can be administered as observations of the child in a natural setting having interactions with the child using toys, games and tasks and parent/caregiver interviews.
Child and Adolescent Needs and Strengths (CANS) multi-system assessment and supplemental interview	Safety Permanency	<u>Child</u> : As a 41-item self-administered survey or interview, the CANS can be used as an assessment tool for decision support during service planning or a retrospective assessment tool based on review of existing information for use in designing high quality systems of services. Dimensions include Child Safety, Functioning, Problem Presentation, Risk Behaviors, Strengths, and Family and Caregiver Needs and Strengths.
Edinburgh Postnatal Depression Scale (EPDS)	Well-being	<u>Adult</u> : This 10-item self-report measure screens women for symptoms of emotional distress during pregnancy and the postnatal period. Scale items correspond to various clinical depression symptoms such as guilt feeling, sleep disturbance, low energy, anhedonia, and suicidal ideation.
Family Empowerment Scale (FES)	Well-being	<u>Adult</u> : This 34-item survey measures parent levels of empowerment in statements about personal attitudes, knowledge, and behaviors about family, children’s services, and involvement in the community.
Maternal Social Support Index (MSSI)	Well-being	<u>Adult</u> : This 21-item self-administered survey assesses a mother’s amount of support and satisfaction with the quality of support in seven areas: Contacts with Extended Family, Help with Crisis and Emergency Childcare, Help with Daily Tasks, Involvement in Community Activities, and Quality of Communication with Partner and One Other Support Person.
North Carolina Assessment Scale for General Services (NCFAS-G)	Safety Permanency	<u>Adult and Child</u> : This 59-item interview identifies family needs, areas of concern, strengths/protective factors, and resources by assessing eight domains of family functioning: Child Well-being, Environment, Family Health, Family Interactions, Family Safety, Parental Capabilities, Social/Community Life, and Self-Sufficiency.
Parenting Sense of Competence Scale (PSCS)	Well-being	<u>Adult</u> : This 16-item measure identifies parenting satisfaction and primary caregiver efficacy. Parents indicate agreement with statements about degree of satisfaction with parenting roles and degree of confidence in carrying out parenting roles in three scales: Parent Self-efficacy, Parent Satisfaction, and Parent Competence.
Parenting Stress Index (PSI)	Well-being	<u>Adult</u> : This index identifies at an early stage parenting and family characteristics that fail to promote normal development and functioning in children, children with behavioral and emotional problems, and parents at risk for dysfunctional parenting. It predicts the potential for parental behavior problems and child adjustment difficulties within the family system. Child characteristics are measured via six subscales: Acceptability, Adaptability, Demanding-ness, Distractibility-Hyperactivity, Mood, and Reinforces Parent. A parent personality and situational variables component consists of seven subscales: Attachment, Competence, Depression, Health, Isolation, Role Restriction, and Spouse. There is an optional 19-item Life Stress scale, and a Total Score.

Instrument	Outcome	Description
Pediatric Symptom Checklist (PSC)	Well-being	<u>Child</u> : The 37 items describe potential problems with a child’s behavior, emotions, and learning and facilitate recognition of emotional and behavioral problems to initiate appropriate interventions as early as possible. Three subscales identify attentional, internalizing, and externalizing problems.
Primary Care Tool for Assessment of Depression during Pregnancy & Postpartum (PDCAT)	Well-being	<u>Adult</u> : This tool is administered by health care professionals in primary care settings. The PDCAT evaluates women who score above the cut-off point on peripartum screening tools and/or are suspected to be clinically depressed. Sections include diagnosing major depression, ruling out bipolar disorder, assessing risk of suicide, assessing risk of harm to babies, and evaluating psychosocial factors that might contribute to depression.
Protective Factors Survey (PFS)	Safety	<u>Adult</u> : The self-administered survey provides feedback to agencies for continuous improvement and evaluation purposes. The PFS measures protective factors in five areas: Concrete Support, Family Functioning/Resiliency, Knowledge of Parenting/Child Development, Nurturing and Attachment, and Social Support. A program staff member completes one section, and a parent or caregiver completes the second section consisting of demographics and 20 core items.
Symptom Checklist 90-Revised (SCL-90-R)	Well-being	<u>Adult and Child (13+ years)</u> : The 90 items evaluate a broad range of psychological problems and symptoms of psychopathology. Respondents rate the severity of experiences with the following symptoms: Anxiety, Depression, Hostility, Interpersonal Sensitivity, Obsessive-compulsive, Phobic Anxiety, Paranoid Ideation, Phobic Anxiety, Psychoticism, and Somatization.
Trauma Assessment for Adults (TAA)	Well-being	<u>Adult</u> : The 17 items assess 14 potentially stressful life events such as combat exposure during military service, physical or sexual assault, surviving a serious car accident, and other events.
Trauma Symptom Checklist (TSC-40)	Well-being	<u>Adult</u> : The TSC-40 evaluates symptomatology in adults associated with childhood or adult traumatic experiences. Forty items yield a total score and six sub-scale scores in the areas of Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index, Sexual Problems, and Sleep Disturbances.
Trauma Symptom Checklist for Young Children (TSCYC)	Well-being	<u>Child</u> : The 90 items are completed by the child’s parent or primary caregiver. They evaluate posttraumatic stress symptoms and provide a tentative PTSD diagnosis via eight clinical scales: Anger-Aggression, Anxiety, Depression, Dissociation, Posttraumatic Stress–Arousal, Posttraumatic Stress–Avoidance, Posttraumatic Stress–Intrusion, and Sexual Concerns, along with a summary PTSD scale.

* No data reported due to low participation rates in 24/7 Dad services.

Safety

All grantees planned to assess safety outcomes for adults, children, and families. Adult-level outcome goals were measured by four grantees. Outcome goals addressed parent sobriety, increased knowledge about parenting and child development, ability to demonstrate competent parenting, decreased risk factors and increased protective factors regarding child abuse and neglect, and incidence of removal of a child due to safety concerns. Text in the “outcome” column for the three outcomes tables is taken from grantee funding applications and other evaluation documentation.

- **Sobriety.** Amethyst reported positive results in regard to parental sobriety via urinalysis; 90 percent of treatment clients had not tested positive for substances.
- **Risk and Protective Factors for Child Abuse and Neglect.** Meta House administered the AAPI-2 (Adult-Adolescent Parenting Inventory) to treatment parents at intake and 6-month followup. Fifty-seven percent had no areas of parenting attitudes that indicated a possible risk for child abuse or neglect at followup. While most pre-post AAPI-2 results were not significant, significant increases in the Lack of Empathy subscale from intake to 6-month followup suggested women became more attentive to children's needs over time. The Queen of Peace Center also administered the AAPI-2 to treatment participants; results yielded a significant trend toward maternal endorsement of alternative forms of punishment (i.e., no corporal punishment) and increased empathy from intake to 6-month followup.

Meta House also administered the Protective Factors Survey (PFS) to treatment participants at intake and 6-month followup. PFS results yielded significant pre-post improvement in family protective factors against child abuse and neglect, specifically women's perceptions of the extent to which they have social support and concrete supports.

As part of the CANS (Child and Adolescent Needs and Strengths) Comprehensive Multisystem Assessment and supplemental interview, Renewal House administered the Family Advocacy and Support Tool (FAST) and found over half the women had improved in financial resources and residential stability from baseline to followup. Renewal House also saw a decrease in the women's safety risk during the same timeframe as measured by the Caregiver Needs and Strengths.

- **Child Removal.** Meta House reported 81.8 percent of mothers (n = 72) avoided having a child removed from their care in the 12 months following admission to residential treatment.

Two grantees planned to assess child-level safety outcomes using methods that take into consideration protective factors within the family in addition to risk indicators.

- **Risk and Protective Factors for Child Abuse and Neglect.** The Queen of Peace Center planned to use AFCARS (Adoption and Foster Care Analysis and Reporting System) and NCANDS (National Data Archive on Child Abuse and Neglect) data from Missouri Child Welfare to address (1) percentage of children identified as at risk of removal from the home who remained in the custody of a parent or caregiver through case closure, (2) percentage of children with an initial occurrence and/or recurrence of substantiated/indicated child maltreatment after enrolling in the program, and (3) reduced incidence of child maltreatment from ages 0 to 4. During the service window, the Queen of Peace Center reported 61.5 percent of children had no abuse or neglect incidents, and 38.5 percent had one or more; roughly 85 percent of the children remained with their mother and were not placed in alternative care during the service window. No age ranges were reported for the children.

Renewal House assessed rates of protective factors and risk factors in improving resiliency via the CANS Comprehensive Multisystem Assessment and supplemental interview. Children aged 0 to 4 had minor to no improvement, and children aged 5 to 17 had a 64 percent mean improvement across all protective factors and therapeutic assessment subscales.

Family-level outcome goals related to safety were measured by two grantees. Outcome goals addressed family functioning and home safety.

- **Family Functioning.** The Susan B. Anthony Center administered a retrospective version of the PFS at baseline and 90-day followup to treatment for comparison participants. Treatment participants also provided data at 6-months followup. Significant increases were found for 89 percent of treatment women from baseline to 90-day followup, and 92 percent of women from baseline to 6-month followup indicated that parenting/family functioning improved. Both results surpassed the Susan B. Anthony Center's outcome goal of 75 percent of families improving at 90-day followup, and 80 percent of families improving at 6-month followup.
- **Home Safety.** The Queen of Peace Center administered the North Carolina Family Assessment Scale for General Services (NCFAS-G) Family Safety Domain at baseline and 6-month followup to treatment participants. No significant pre-post differences were found for Family Safety.

Permanency

All grantees planned to assess permanency outcomes for adults and children as part of the evaluation. Four grantees reported results. Adult-level outcome goals related to permanency were measured by two grantees. Outcome goals addressed increased involvement with children, employment, and stable housing.

- **Increased Involvement with Children.** Meta House reported positive findings for women who met the following criteria: (1) retained placement of any children or newborn infants, (2) reunified with one or more children, or (3) were granted increased visitation with any children in out-of-home care (e.g., moved from supervised to unsupervised visits). Eighty-eight percent of women with children both in and out of their care increased involvement with their children from intake to 6-month followup. In addition, 90.5 percent of women who had children in out-of-home care at intake increased involvement with their children from intake to 6-month followup. This latter finding was 15.5 percent above the outcome goal for mothers whose children were not in their care at intake. One of the Susan B. Anthony Center's permanency outcome goals was for 50 percent of fathers to maintain involvement in their children's lives 6 months after graduating from the 24/7 Dad program. Six fathers graduated from the program, but followup data have not been available from the project partner.
- **Employment and Stable Housing.** The Susan B. Anthony Center reported that 77 percent of mothers were employed or in school, and 76 percent of mothers had stable housing at completion of treatment. These percentages were above the outcome goal of 75 percent of mothers being employed or in school and having stable housing for their children.

Four grantees planned to assess child-level permanency outcomes; two grantees provided results in regard to foster care re-entry and one provided results based on child welfare-case closure.

- **Child Reunification and Permanency.** Amethyst reported that for families with children in placement, 21 percent reunified; however, the rate of reunification was 50 percent below the outcome goal of 70 percent. It also reported no reunified children re-entered foster care. The Susan B. Anthony Center reported 80 percent of children in residence with their mother did not enter, re-enter, or remain in the child welfare system within 12 months of admission, exceeding its outcome goal of 50 percent. Unfortunately, 19 percent, 4 percent more than estimated, entered, re-entered, or remained in the child welfare system 6 months after graduation from RFT.

Renewal House reported 72 percent of children had closed Department of Children Services (DCS) cases at discharge. Thirty-six percent of the cases closed while families were involved with services and 22 percent still had reduced the level of DCS involvement and regained physical custody. Renewal House had also expected to report on the increased ability to remain safe in parent custody by preventing new or additional open public child welfare cases throughout family stays in transitional housing and up to 6 months following exit from program housing; however, the data from DCS were not available by the end of the reporting period.

The Queen of Peace Center expected to provide results regarding average length of stay in foster care; average length of stay in days for children discharged from foster care, from date of most recent entry into foster care until date of discharge; percentage of children returned home from foster care that re-entered foster care in less than 6 or 12 months; percentage of children reunified in less than 12 months from the date of the most recent entry into foster care; and the percentage of children placed in foster care who, in less than 12 months from date of the most recent foster care placement, achieved the outcome of finalized adoption or legal guardianship. These data were not reported.

Well-being

All grantees planned to assess well-being outcomes for adults, children, and families as part of their local evaluations.

Adult-level outcome goals related to well-being were measured by four grantees. Outcome goals addressed substance use and sobriety; trauma-related symptoms; increased social connections and supports; maternal mental health; sense of family empowerment; parental resilience; parents' capacity to provide for children's needs; protective and risk factors; and improvement in knowledge, skills, and attitudes in child development and parenting.

- **Substance Use and Sobriety.** Using the ASI (Addiction Severity Index) at Meta House, women in residential treatment demonstrated a significant decrease from intake to 6-month followup in the extent to which they were using illegal drugs and drinking alcohol. There was also a significant increase in the number of days they were completely free of alcohol or drugs, including potentially addictive prescription medications. In addition, there was a self-reported decrease in use of any substance and days of illegal drug use from intake to 6-month followup.

The Queen of Peace Center also assessed maternal substance use through the ASI, reporting a significant improvement in drug use, family/social interaction, and psychological functioning from baseline to 6-month followup for treatment participants, but a significant decrease in legal domain during that same time period. The legal domain does not always indicate new criminal activity, but historical activity incurred by clients that has remained unaddressed.

Through administrative grantee/project-specific databases and records, the Susan B. Anthony Center reported 100 percent of treatment mothers were drug-free at completion of services, 15 percent above the outcome goal of 85 percent. After 6 months, 90 percent of mothers were reported to be identified as sober and employed or in school, 25 percent above the outcome goal of 65 percent.

- **Trauma-related Symptoms.** Through the Trauma Symptom Checklist-40 (TSC-40) at Meta House, women demonstrated a significant decrease in overall and specific trauma symptoms from intake

to 6-month followup. The Susan B. Anthony Center reported 77 percent to 82 percent of treatment women significantly improved in the three indices of the Symptom Checklist 90-Revised (SCL-90-R), slightly above the outcome goal of 75 percent.

- **Increased Social Connections and Supports.** Results from the Maternal Social Support Scale (MSSI) used by the Queen of Peace Center found treatment participants' social support did not improve from baseline to 6-month followup.
- **Maternal Mental Health.** The Queen of Peace Center used the Edinburgh Postnatal Depression Scale (EPDS) and the Primary Care Tool for Assessment of Depression during Pregnancy and Postpartum (PDCAT) to assess depression in treatment clients. The EPDS yielded positive results, with women demonstrating significant improvement in EPDS depression and anxiety scores from baseline to 6-month followup; however, via the PDCAT, women did not improve levels of psychological functioning during this same time period.
- **Sense of Family Empowerment.** Using the Family Empowerment Scale (FES), the Queen of Peace Center reported significant improvement for treatment women on the Family subscales from baseline to 6-month followup, indicating an improved understanding of family.
- **Parental Resilience.** The Queen of Peace Center reported the treatment women had a significantly higher sense of self-confidence as measured by the self-confidence subscales of the Parenting Sense of Competence Scale (PCSC) from baseline to 6-month followup.
- **Parent Capacity to Provide for Child Needs.** Renewal House reported increases in nonclinical supportive services, including employment and cash income using the Adult Needs and Strengths Assessment (ANSA) from intake to discharge. In addition, child housing stability increased by 93 percent during the same timeframe.
- **Protective and Risk Factors.** At Renewal House, the ASI administered at baseline and followup indicated improvements across all domains, including substance use, employment, family, and legal involvement. Renewal House also reported improvement across all domains on the Parenting Stress Index (PSI), including a 91 percent increase in parenting competence.
- **Child Development and Parenting.** The Susan B. Anthony Center planned to assess father improvements in knowledge, skills, and attitudes based on participation in the 24/7 Dad program; however, this outcome was unable to be evaluated due to low participation.

Child-level outcome goals related to well-being were measured by all grantees. Outcome goals addressed birth weight; general well-being; trauma-related symptoms; physical, cognitive, and social-emotional development; support service needs; and attachment.

- **Birth Weight.** At Meta House, three-fourths of births were within the normal weight range for their gestational age, and three-fourths were carried to term. In addition to standard birth outcomes, more than 90 percent of the babies tested negative for alcohol or illegal substances at birth.
- **General Well-being.** Amethyst reported positive results from the CANS Multisystem Assessment and supplemental interview. Eighty-eight percent of children ages 5 and older showed

improvement in at least one domain at 6-month followup, and 100 percent of children under the age of 5 improved in at least one domain.

Using the Battelle Development Inventory (BDI-2) and Pediatric Symptom Checklist (PSC), the Susan B. Anthony Center found that 61 percent of children improved BDI-2 scores from baseline to 90-day followup, and 67 percent of children improved PSC scores from baseline to 90-day followup. These improvements were below the outcome goal of 85 percent of children improving from pre- to postmeasurement.

- **Trauma-related Symptoms.** Meta House planned to assess prepost changes in trauma-related symptoms using the Trauma Symptom Checklist for Young Children (TSCYC). As the program serves primarily infants and toddlers, a lower than expected number of children fell within the age range for TSCYC administration (3–12 years old). There were insufficient data available for pre- to postcomparisons. Upon case review, most children experienced at least one clinically significant or potentially significant symptom at the time admission, and some demonstrated symptom improvement over time.
- **Physical, Cognitive, and Social/Emotional Development.** The Queen of Peace Center found that the need for service referrals for children in residence was consistently less at 6-month followup than at baseline in all domains of the Ages and Stages Questionnaire (ASQ-3). The need for mental health referral was lower at followup than at baseline for children in residence for the Ages and Stages Questionnaire—Social/Emotional (ASQ-SE).
- **Support Service Needs.** Renewal House used the CANS to identify supportive service needs. Eight-one percent of children were connected to appropriate supports and services. The remaining children were not in the program long enough or were too young for the assessment.
- **Attachment.** Renewal House reported 71 percent of mothers reported no attachment problems at discharge in mother-child relationships with children in residence.

One grantee, the Queen of Peace Center, assessed family-level well-being.

- **Family Functioning.** Using the NCFAS-G, the Queen of Peace Center reported significant improvement in family interactions and parenting abilities from baseline to 6-month followup.

Table 28: Safety Outcomes, Table 29: Permanency Outcomes, and Table 30: Well-being Outcomes provide specific outcome results.

Table 28: Safety Outcomes

Grantee	Client	Outcome	Data Source	Results	Implications
Amethyst	Adult	Parents demonstrate competent parenting.	Mother treatment plans. Documented instances of parenting issues of treatment participants.	46.8 percent of parents completed grantee-parenting program. No results reported on documented instances of parenting issues.	Inconclusive Unclear if 46.8 percent completion rate is positive or negative for grantee.
Amethyst	Adult	Parents achieve and maintain sobriety.	Urinalysis of treatment participants.	89.7 percent of clients have <u>not</u> had a positive urinalysis. 10.3 percent have tested positive. Results unknown for 24.6 percent.	Positive 89.8 percent of clients have not tested positive for substances.
Meta House	Adult	Women will demonstrate a significant pre-post decrease in parenting attitudes associated with risk for child abuse/neglect.	Adult-Adolescent Parenting Inventory (AAPI-2) administered at intake and 6-month followup to treatment participants (n = 62).	<ul style="list-style-type: none"> • Significant increase in Lack of Empathy (intake M = 38.52, followup M = 42.16, $t = 6.59, p < .001$). • Significant decrease Power and Independence (intake M = 21.08, followup M = 19.84, $t = 3.55 (p < .001)$). • Non-significant improvement in Total Score or Inappropriate Expectations, Physical Punishment, or Role Reversal subscales. <p>Less than 25 percent of scores were associated with risk for child abuse or neglect at followup.</p> <ul style="list-style-type: none"> • Lack of Empathy = 24.2 percent (n = 15) • Inappropriate Expectations = 19.4 percent (n = 12) • Power and Independence = 12.9 percent (n = 8) • Role Reversal = 12.9 percent (n = 8) • Physical Punishment = 3.2 percent (n = 2) 	<p>Inconclusive Most results were non-significant. Significant decreases in Power and Independence, indicating less positive attitudes.</p> <p>Significant <u>increase</u> in Lack of Empathy, suggesting women were more attentive to their children’s needs by the time of the followup interview.</p> <p>Fewer than 25 percent of women’s post scores were associated with risk for child abuse or neglect.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
				<p>Combining AAPI-2 scores with child custody status, 30.6 percent of women with children living in the home and 25.8 percent of women with no children in the home demonstrated no areas of high-risk parenting attitudes. 43.6 percent of women with children living or not living in the home demonstrated one or more areas of high risk parenting attitudes.</p> <ul style="list-style-type: none"> • Level 1: No areas of high-risk parenting attitudes and children living in the home = 30.6 percent (n = 19) • Level 2: No areas of high-risk parenting attitudes, without children living in the home = 25.8 percent (n = 16) • Level 3: One area of high-risk parenting attitudes, without children living in the home = 9.7 percent (n = 6) • Level 4: One area of high-risk parenting attitudes and children living in the home = 14.5 percent (n = 9) • Level 5: More than one area of high-risk parenting attitudes, without children living in the home = 12.9 percent (n = 8) • Level 6: More than one area of high-risk parenting attitudes and children living in home = 6.5 percent (n = 4) 	<p>Over 40 percent of women with children living or not living in the home demonstrated one or more areas of high risk parenting attitudes; over half (56.4 percent) demonstrated no such attitudes.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Meta House	Adult	Women demonstrate significant pre-post increase in family protective factors against child abuse and neglect (i.e., family functioning/resiliency, social emotional support, concrete support, and nurturing and attachment).	Protective Factors Survey (PFS) administered at intake and 6-month followup to treatment participants (n = 74).	<p>Paired t-tests indicated statistically significant pre-post improvements.</p> <ul style="list-style-type: none"> • Social Support subscale (t [73] = 4.31, p<.001) scores increased from a mean of 16 at intake to a mean of 18 at followup (intake M = 15.74, SD = 4.63; followup M = 17.81, SD = 3.55). • Concrete Support subscale (t [73] = 2.16, p = .034) scores increased from a mean of 16 at intake to a mean of 17 at followup (intake M = 16.22, SD = 4.65; followup M = 17.50, SD = 3.85). • No significant pre-post changes indicated in the extent to which women experienced support in their families. <p>Little improvement from intake to followup on the Family Functioning and Resiliency subscale (intake M = 19.97, followup M = 20.73).</p>	Positive Significant improvement in family protective factors against child abuse and neglect indicated from intake to 6-month followup, specifically women's perceptions of the extent to which they have social support and concrete supports.

Grantee	Client	Outcome	Data Source	Results	Implications
Meta House	Adult	90 percent of women who remain in treatment for 30+ days avoid having a child or children removed from their care for safety concerns in the 12 months following admission to treatment.	Wisconsin Statewide Automated Child Welfare Information System (eWiSACWIS) data on treatment participants (n = 88) remaining in residential treatment for more than 30 days with 12 months elapsing between their treatment admission dates and the close of the grant.	<p>81.8 percent (n = 72) avoided having a child or children removed from their care in the 12 months following admission to residential treatment. 18.2 percent (n = 16) had one or more children removed from their care for safety concerns. 13 women had one child removed; 3 women had multiple children removed. Result was better than 28.2 percent (n = 11 of 39) of Families Come First (pilot study in 2009-2012 funding cycle) of women who had one or more children removed in the 12 months following their referral to child welfare.</p> <p>Among 16 women who had one or more children removed, 19 children were placed in out-of-home care. 28 days to 10.8 months (M = 5.2 months) elapsed between mothers' admissions to treatment and removal of 19 children.</p> <ul style="list-style-type: none"> • 26.3 percent (n = 5) of children removed within 2 months of mothers' admissions to residential treatment. • 36.8 percent (n = 7) of children removed while their mothers were still in treatment. • 63.2 percent (n = 12) removed after their mothers had been discharged from the residential treatment program. 	<p>Negative</p> <p>81.8 percent (n = 72) avoided having a child or children removed from their care in the 12 months following their admission to residential treatment. This was 8.2 percent short of the project goal, but a significant accomplishment given the extensive history of child welfare involvement of the population.</p> <p>Of removed children, 31.6 percent reunified within a year of their placement into out-of-home care.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
				<p>The 19 children removed from their mothers' custody were placed in a variety of out-of-home care settings.</p> <ul style="list-style-type: none"> • 47.4 percent (n = 9) placed in foster homes with non-relatives. • 26.3 percent (n = 5) placed with relatives (unlicensed n = 4, licensed n = 1). • 15.8 percent (n = 3) placed in hospitals. • 10.5 percent (n = 2) placed in treatment foster homes. <p>Children experienced 1 to 4 (M = 2.0) placements, spending an average of 115.0 days (3.8 months) in out-of-home care.</p> <p>31.6 percent (n = 6 of 19) of children were reunified with their mothers within 12 months of removal and placement in out-of-home care (2 children were reunified with the same mother).</p>	
Queen of Peace Center	Adult	Increased knowledge of parenting and child development. Increased nurturing and attachment.	Adult-Adolescent Parenting Inventory (AAPI-2) administered at baseline and 6-month followup to treatment participants (n = 29).	<p>Paired t-tests indicated significant increases in Empathy and Discipline subscales.</p> <ul style="list-style-type: none"> • Empathy: Baseline M = 5.21 (SD = 2.23), 6-month M = 6.24 (SD = 2.13), $t(28) = -2.27$ ($p < .05$) • Discipline: Baseline M = 5.24 (SD = 1.98), 6-month M = 6.10 (SD = 1.93), $t(28) = -2.34$ ($p < .05$) 	Positive Significant trend toward maternal endorsement of alternative forms of discipline (i.e., no corporal punishment) and increased empathy in treatment group.

Grantee	Client	Outcome	Data Source	Results	Implications
Queen of Peace Center	Child	<p>Percent of children identified as at risk of removal from the home that remained in the custody of a parent of caregiver through case closure.</p> <p>Percent of children with an initial occurrence and/or recurrence of substantiated/indicated child maltreatment after enrolling in program.</p> <p>Reduced incidence of child maltreatment from ages 0-4 (long-term).</p>	<p>Adoption and Foster Care Analysis and Reporting System (AFCARS) from Missouri Child Welfare.</p> <p>National Data Archive on Child Abuse and Neglect (NCANDS) from Missouri Child Welfare.</p> <p>Treatment participants (n = 65).</p>	<p>Number of abuse/neglect incidents during service window.</p> <ul style="list-style-type: none"> • Zero = 61.5 percent (n = 40) • One = 21.5 percent (n = 14) • Two = 6.2 percent (n = 4) • Three = 9.2 percent (n = 6) • Four = 1.5 percent (n = 1) <p>Placed in alternative care during service window.</p> <ul style="list-style-type: none"> • Yes = 15.4 percent (n = 10) • No = 84.6 percent (n = 55) <p>Total placements in alternative care during service window.</p> <ul style="list-style-type: none"> • Zero = 84.6 percent (n = 55) • One = 3.1 percent (n = 2) • Two = 4.6 percent (n = 3) • Three = 3.1 percent (n = 2) • Four = 1.5 percent (n = 1) • Five = 1.5 percent (n = 1) • Six = 1.5 percent (n = 1) <p>Placement reason.</p> <ul style="list-style-type: none"> • Reason to suspect child abuse/neglect = 15.4 percent (n = 10) • Not applicable = 84.6 percent (n = 55) <p>Foster family structure (n = 10, Missing = 55).</p> <ul style="list-style-type: none"> • Single female = 50.0 percent (n = 5) • Married couple = 30.0 percent (n = 3) • Not applicable = 20.0 percent (n = 2) 	<p>Inconclusive</p> <p>61.5 percent had no abuse or neglect incidents, 38.5 percent had one or more incidents.</p> <p>84.6 percent were not placed in alternative care, 15.4 percent were placed in alternative care due to suspected child abuse or neglect.</p> <p>Of those placed in alternative care, the largest number of placements was two. Data provided at one point, no followup data to indicate difference over time relative to outcome.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Queen of Peace Center	Family	Improved home safety.	North Carolina Family Assessment Scale for General Services (NCFAS-G) Family Safety Domain administered at baseline and 6-month followup to treatment participants (n = 66).	Paired tests yielded no significant difference for treatment participants from baseline to 6-month followup.	Negative Treatment families did not improve Family Safety from baseline to 6-month followup.
Renewal House	Adult	Improve resiliency by increasing protective factors in at least 75 percent of children.	Family Advocacy and Support Tool (FAST)/Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment administered at baseline and followup to treatment participants (n = 14).	<p>Pre- and Posttest Scores.</p> <ul style="list-style-type: none"> • Education: Pretest = .69 (SD = .63, n = 14); Posttest = .5 (SD = .76, n = 14) • Financial Resources: Pretest = 2.0 (SD = .91, n = 13); Posttest = 1.38 (SD = .51, n = 13) • Residential Stability: Baseline=2.23 (SD = 1.1, n = 13); Discharge=1.23 (n = 13; SD = 1.09) <p>Percent of Improvement.</p> <ul style="list-style-type: none"> • Financial Resources: 57 percent (n = 8 of 14) improved; 28.6 percent (n = 4) remained the same; 14.3 percent (n = 2) worsened. • Residential Stability: 53.8 percent (n = 7 of 13) of families improved, 30.8 percent (n = 4) remained the same, 15.4 percent (n = 2) decreased. • Little variance regarding the degree to which the participants' school was involved in helping the child; any results skewed positive. 	Inconclusive Over half of women improved in financial resources and residential stability, but unclear if improvement was statistically significant.

Grantee	Client	Outcome	Data Source	Results	Implications
Renewal House	Adult	Improve resiliency by addressing risk factors for at least 75 percent of children.	Caregiver Needs and Strengths/Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment at baseline and followup for treatment participants (n = 14). Supplemental interview.	<p>Pre- and Posttest Means.</p> <ul style="list-style-type: none"> • Mental Health: Pretest = 1.1, SD = .27; Posttest = 1.0, SD = .39 • Organization: Pretest = .64, SD = .84; Posttest = .71, SD = .73 • Safety: Pretest = .50, SD = .53; Posttest = .21, SD = .43 • Substance Use: Pretest = 1.1, SD = .36; Posttest = 1.0, SD = .00 <p>Percentage of Families with Decreased Family Level Risk Factor Scores.</p> <ul style="list-style-type: none"> • Mental Health: 14.3 percent • Organization: 11.1 percent • Safety: 57.1 percent • Substance Use: 14.3 percent 	<p>Negative</p> <p>Over half of families demonstrated improvement in decreasing their level of risk in safety. Unclear if improvement was statistically significant. Results did not meet outcome goal.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Renewal House	Child	Improve resiliency by increasing protective factors in at least 75 percent of children.	<p>Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment Protective Factors at baseline and followup for treatment participants (n = 37) aged 0 to 4.</p> <p>Supplemental interview.</p>	<p>Child-level Protective Factors.</p> <ul style="list-style-type: none"> • Curiosity: Pretest = .32, SD = .70; Posttest = .39, SD = .83 • Persistence: Pretest = .47, SD = .72; Posttest = .41, SD = .74 • Relationship Permanence: Pretest = .97, SD = .67; Posttest = 1.14, SD = .71 • Social Functioning: Pretest = .42, SD = .71; Posttest = .33, SD = .80 <p>Family-level Protective Factors.</p> <ul style="list-style-type: none"> • Empathy for the Child: Pretest = .42, SD = .55; Posttest = .38, SD = .56 • Involvement: Pretest = .31, SD = .53; Posttest = .56, SD = .48 • Knowledge: Pretest = .56, SD = .61; Posttest = .68, SD = .75 • Organization: Pretest = .81, SD = .74; Posttest = .76, SD = .86 • Social Resources: Pretest = .95, SD = .79; Posttest = .95, SD = .74 • Supervision: Pretest = .56, SD = .65; Posttest = .60, SD = .72 	<p>Negative</p> <p>Minor improvement in Persistence and Social Functioning, no improvement in Curiosity and Relationship Permanence.</p> <p>Minor improvement in Organization, no improvement in Empathy, Involvement, Knowledge, Social Resources, and Supervision.</p> <p>Improvement did not affect 75 percent of children; unclear if improvement was statistically significant.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Renewal House	Child	Improve resiliency by increasing protective factors in at least 75 percent of children.	<p>Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment Protective Factors at baseline and followup for treatment participants (n = 14) aged 5 to 17.</p> <p>Supplemental interviews.</p>	<p>Pre- and Posttest Means.</p> <ul style="list-style-type: none"> • Interpersonal Adult: Pretest = .71, SD = .83; Posttest = .50, SD = .76 • Interpersonal Peer: Pretest = 1.0, SD = .96; Posttest = .79, SD = .80 • Optimism: Pretest = .79, SD = .80; Posttest = .29, SD = .61 • Resiliency Crisis: Pretest = 1.29, SD = .99; Posttest = .93, SD = 1.0 • Resilience Long-term: Pretest = 1.29, SD = .73; Posttest = .79, SD = .89 <p>Percentage of Improved Child-level Protective Factor Scores.</p> <ul style="list-style-type: none"> • Interpersonal Adult: 57.1 percent (n = 4 of 7) • Interpersonal Peer: 45.5 percent (n = 5 of 11) • Optimism: 87.5 percent (n = 7 of 8) • Resiliency Crisis: 41.7 percent (n = 5 of 12) • Resilience Long-Term: 61.5 percent (n = 8 of 13) <p>Percentage of Improved Family-level Protective Factor Scores.</p> <ul style="list-style-type: none"> • Caregiver Collaboration: 45.5 percent (n = 5 of 11) • Extended Family: 45.5 percent (n = 5 of 11) • Extended Family Relations: 38.5 percent (n = 5 of 13) • Family Communication: 53.8 percent (n = 7 of 13) • Involvement: 62.5 percent (n = 5 of 8) • Natural Supports: 91.7 percent (n = 11 of 12) • Nuclear Family: 54.5 percent (n = 6 of 11) • Parental Permanence: 21.4 percent (n = 3 of 14) • Sibling Relations: 71.4 percent (n = 5 of 7) • Supervision: 40.0 percent (n = 4 of 10) 	<p>Negative</p> <p>Over half improved in Interpersonal Adult, Optimism, and Resilience Long-Term with 63.5 percent mean total improvement.</p> <p>Over half improved in 5 of 10 family-level scores: Nuclear Family, Involvement, Family Communication, Sibling Relations, and Natural Supports. One-third or more improved in 9 of 10 family-level scores.</p> <p>Unclear if improvement was statistically significant. Results approached, but did not meet outcome goal.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Renewal House	Child	Improve resiliency by addressing risk factors for at least 75 percent of children.	<p>Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment Therapeutic Assessment at baseline and followup for treatment participants (n = 14) aged 5 to 17.</p> <p>Supplemental interview.</p>	<p>No results were reported for children aged 0 to 4 (n = 41) as no pre- and posttest means differed by more than .20 for therapy assessment section variables.</p> <p>Pre- and Posttest Means for Ages 5-17.</p> <ul style="list-style-type: none"> • Anger Control: Pretest = 1.07, SD = 1.21; Posttest = .64, SD = .93 • Conduct: Pretest = .29, SD = .61; Posttest = .14, SD = .36 • Danger to Others: Pretest = .29, SD = .61; Posttest = .14, SD = .14 • Emotional Control: Pretest = 1.21, SD = .96; Posttest = .86, SD = .86 • Oppositional Behavior: Pretest = .64, SD = .93; Posttest = .43, SD = .76 • Other Self-Harm: Pretest = .36, SD = .63; Posttest = .07, SD = .27 • Sanction-seeking Behaviors: Pretest = .43, SD = .76; Posttest = .21, SD = .21 • Self-Mutilation: Pretest = .21, SD = .58; Posttest = .07, SD = .27 • Suicide Risk: Pretest = .07, SD = .27; Posttest = .00, SD = .00 <p>Percentage of Children Ages 5-17 with Decreased Child-level Risk Factor Scores</p> <ul style="list-style-type: none"> • Anger Control: 46.2 percent • Conduct: 66.7 percent • Danger to Others: 33.3 percent • Emotional Control: 46.2 percent • Oppositional Behavior: 62.5 percent • Other Self-Harm: 75.0 percent • Sanction-Seeking Behaviors: 75.0 percent • Self-Mutilation: 66.6 percent • Suicide Risk: 100 percent 	<p>Negative</p> <p>No improvement for children aged 0 to 4. Mean percentage of improvement for all risk factor variables was 63.1 percent.</p> <p>Unclear if improvement was statistically significant. Results approached, but did not meet outcome goal for children aged 5 to 17.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Susan B. Anthony Center	Family	75 percent of families served at least 90 days will improve family functioning.	Protective Factors Survey (PFS).	<p>Significant increase in average scores for treatment group from baseline to 90-day followup $t = 9.03$ ($p = .000$) ($n = 103$). Scores for treatment group increased 88.8 percent.</p> <p>Non-significant increase in average scores for comparison group from baseline to 90-day followup, $t = 4.55$ ($p = .092$) ($n = 30$). Comparison group scores increased 83.3 percent, but the increase was not significant.</p>	<p>Positive Significant increase for treatment participants from baseline to 90-day and 6-month followup.</p> <p>Scores increased for 88.8 percent of women, 13.8 percent above outcome goal.</p>
Susan B. Anthony Center	Family	80 percent of families will maintain or improve family functioning 6 months after graduation.	Protective Factors Survey (PFS), standard and retrospective versions, administered at baseline and 6-month followup to treatment participants ($n = 53$) and comparison participants ($n = 11$).	<p>Significant difference from baseline to 90-day followup scores for treatment group.</p> <p>Scores for treatment group increased 91.2 percent, $t = 11.52$ ($p = .000$).</p> <p>Scores for comparison group increased 68.8 percent, $t = 1.34$ ($p = .119$). The outcome is successful.</p>	<p>Positive Parent/family functioning significantly improved from baseline to 90-day followup for 91.2 percent of treatment group, 11.2 percent above outcome goal.</p>

Table 29: Permanency Outcomes

Grantee	Client	Outcome	Data Source	Results	Implications
Amethyst	Child	For families with children in placement, 70 percent of children will reunify with families.	Child reunification and permanency measures.	53 children are known to have been in placement. Of those, 13 (24.5 percent) have been reunified.	Negative For families with children in placement, rate of reunification is 45 percent below outcome goal.
Amethyst	Child	Children who have reunified with parents will not re-enter foster care.	Child reunification and permanency measures.	No reunified children have re-entered FCCS care.	Positive
Meta House	Adult	75 percent of mothers whose children were not in their care at baseline will have increased involvement with their children at followup. Increased involvement criteria: 1) retain placement of any children or newborn infants, 2) reunify with one or more children, or 3) granted increased visitation with any children in out-of-home care (e.g., moved from supervised to unsupervised visits).	Intake and Followup Interview (6 months) administered to treatment participants (n = 81).	<p>51.9 percent (n = 42) of women met the objective at followup.</p> <p>Among 75 women who remained in residential treatment for 30+ days,</p> <ul style="list-style-type: none"> • 45.3 percent (n = 34) retained placement of one or more of their children or gave birth to babies who remained in their care. • 30.7 percent (n = 23) increased their level of contact with children who were not in their care at baseline and followup. • 24.0 percent (n = 18) were reunified with one or more of their children or were able to formally increase their level of contact with children in out-of-home care. <p>Among 42 women with one or more children placed in out-of-home care at baseline, 90.5 percent (n = 38) met the objective by followup.</p> <ul style="list-style-type: none"> • 21.4 percent (n = 9) retained placement of one or more of their children or gave birth to babies who remained in their care. • 54.8 percent (n = 23) increased their level of contact with children in out-of-home care. • 33.3 percent (n = 14) were reunified with one or more of their children. 	Negative 23.1 percent fewer women than projected who remained in treatment for 30+ days increased involvement with their children placed in out-of-home care at followup.

Grantee	Client	Outcome	Data Source	Results	Implications
Queen of Peace Center	Child	Average length of stay in foster care.	Adoption and Foster Care Analysis and Reporting System (AFCARS) from Missouri Child Welfare. National Data Archive on Child Abuse and Neglect (NCANDS) from Missouri Child Welfare.	No results reported as of December 31, 2015.	Inconclusive
Renewal House	Child	Increase safety and permanency; reduce risk of re-entry into child welfare by closing DCS cases on 70 percent of families admitted to project with open DCS cases.	Adoption and Foster Care Analysis and Reporting System (AFCARS) from Missouri Child Welfare. National Data Archive on Child Abuse and Neglect (NCANDS) from Missouri Child Welfare Administrative intake and discharge ACCESS databases.	<p>Due to limited AFCARS and NCANDS data, variables from the grantee's Intake and Discharge ACCESS databases were examined.</p> <ul style="list-style-type: none"> • Level 1: Closed DCS Case or No DCS Involvement • Level 2: Open DCS case and/or Physical Custody Achieved • Level 3: No Physical Custody, Open DCS Case, No Visitation OR Supervised Visits Only <p>Family Level of DCS Involvement at Intake and Discharge.</p> <ul style="list-style-type: none"> • Level 1: Intake = 60.6 percent, Discharge = 71.8 percent, 11.2 percent increase • Level 2: Intake = 26.8 percent, Discharge = 16.9 percent, 9.9 percent decrease in mothers who achieved physical custody • Level 3: Intake = 12.7 percent, Discharge = 11.3 percent, 1.4 percent decrease <p>No significant difference in levels at intake (M = 1.52, SD = .71) and discharge (M = 1.39, SD = .68), but data demonstrated a trend (t(1.75) = 70, p = .083).</p>	<p>Positive 71.9 percent (n = 64) of children at discharge had closed DCS cases.</p> <p>Negative 16.9 percent of Level 2 cases and 11.3 percent of Level 3 cases closed at discharge. 35.7 percent (n = 10) of Level 2 and 3 clients had their cases closed while involved with grantee services.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
				<p>DCS Involvement at Discharge. 35.7 percent (n = 10) of Level 2 and Level 3 clients had cases closed while involved with grantee services; 21.4 percent (n = 6) had DSC involvement drop from Level 3 to Level 2.</p> <p>71.9 percent (n = 64) of children at discharge had closed DCS cases; 27.5 percent (n = 25) had open DCS cases, and 2 children were unavailable for interview at discharge.</p>	
Susan B. Anthony Center	Adult	75 percent of mothers at graduation will be employed or in school and have stable housing for their children.*	Administrative grantee/project-specific databases and records for treatment participants who successfully graduated (n = 152).	<p>76.96 percent (n = 117) of mothers at graduation were employed OR in school at discharge.</p> <ul style="list-style-type: none"> • 48.78 percent (n = 74) employed at discharge • 55.3 percent (n = 84) in school at discharge • 27.00 percent (n = 41) employed <u>and</u> in school at discharge <p>76.3 percent (n = 116) of mothers at graduation had stable housing.</p>	<p>Positive 77.0 percent of mothers were employed or in school at graduation, 2.0 percent more than projected.</p> <p>Positive 76.3 percent of mothers had stable housing at graduation, 1.3 percent more than projected.</p>
Susan B. Anthony Center	Adult	50 percent of fathers will maintain involvement in their children's lives 6 months after graduation.	Administrative grantee/project-specific databases and records.	Six fathers graduated from 24/7 Dad service. Some have been discharged for 6 months or longer, but followup data is unavailable from the community partner.	Inconclusive

Grantee	Client	Outcome	Data Source	Results	Implications
Susan B. Anthony Center	Child	50 percent of children living safely at SBAC with mothers will not enter, re-enter or remain in the child welfare system within 12 months of admission.	Florida Child Welfare database (FSFN). ChildNet public child welfare dataset for treatment children in or out of SBAC 1-year post admission date (n = 162).	79.6 percent (n = 129 of 162) of children did not enter, re-enter, or remain in the child welfare system within 1 year of admission to SBAC. 20.47 percent (n = 33 of 162) of children entered, re-entered, or remained in the child welfare system within 1 year of admission to SBAC. Success rates steadily increased from 66.7 to 73.3 percent in prior reporting periods to 79.6 percent in current reporting period.	Positive 79.63 percent did not enter, re-enter, or remain in child welfare within 12 months of admission, 29.6 percent above outcome goal. Positive trend over three reporting periods.
Susan B. Anthony Center	Child	No more than 15 percent of residential family treatment children will enter, re-enter, or remain in the child welfare system 6 months after graduation.	Florida Child Welfare database (FSFN). ChildNet public child welfare dataset for treatment children whose mothers graduated 6 months or before (n = 112).	18.8 percent (n = 21 of 112) of children entered, re-entered, or remained in the child welfare system within 6 months of their mothers graduating. <i>Note: Permanency outcomes were originally designed with the majority of cases staying in placement for at least a year. While some do, many are not staying for a 12-month period or longer, causing overlap.</i>	Negative 18.83 percent (3.8 percent more than estimated) entered, re-entered, or remained in the child welfare system.

* Stable housing could include independent housing; housing with other women, friends, families, extended family, siblings or parents; or in other forms of assistance.

Table 30: Well-being Outcomes

Grantee	Client	Outcome	Data Source	Results	Implications
Amethyst	Child	Increased well-being in at least one functional domain.	Child and Adolescent Needs and Strengths (CANS) Multisystem Assessment. Supplemental interview.	87.5 percent of children age 5 and older showed improvement in at least one domain at 6-month followup. 100 percent of children under the age of 5 improved in at least one domain.	Positive
Meta House	Adult	Women will demonstrate a significant pre and post decrease in their substance use and/or abuse.	Addiction Severity Index (ASI) modified administered at intake and 6-month followup to treatment participants (n = 46).	Paired t-tests indicated significant pre and post improvements. <ul style="list-style-type: none"> Any illegal drug use ($t = 9.10, p < .001$) decreased from an average of 18.50 to 2.16 days. Of 41 women who used illegal drugs at baseline, 80.5 percent (n = 33) did not use drugs, and 19.5 percent (n = 8) used drugs at followup. Five women were abstinent from illegal drug use at baseline and followup. Days of <u>no</u> use ($t = 5.70, p < .001$) increased from an average of 3.89 to 15.11 days. Alcohol use ($t = 3.77, p < .001$) decreased from an average of 6.02 to 1.01 days. Alcohol to intoxication ($t = 2.28, p < .05$) decreased from an average of 3.14 to 1.01 days. Marijuana use ($t = 3.89, p < .001$) decreased from an average of 7.14 to 0.66 days. Cocaine use ($t = 3.53, p < .01$) decreased from an average of 6.38 to 1.35 days. Heroin use ($t = 2.45, p < .05$) decreased from an average of 5.46 to 1.41 days. Use of more than one substance per day ($t = 5.22, p < .001$) decreased from an average of 8.94 to 1.27 days. 	Positive Significant improvement from intake to followup in reduced number of days that women drank alcohol, used marijuana, used cocaine, used heroin, used more than one substance per day, or used any illegal substance. Significant improvement from intake to followup in increased days of using <u>no</u> substances.

Grantee	Client	Outcome	Data Source	Results	Implications
Meta House	Adult	Women will demonstrate a significant pre and post decrease in their substance use and/or abuse.	Individual interviews with treatment participants (n = 83).	<p>54.2 percent (n = 45) of women in or out of treatment used no alcohol, prescription drugs, or illegal drugs in 30 days prior to the 6-month followup interview.</p> <p>Prescribed drug use occurred primarily in women engaged in treatment (28.9 percent, n = 24) versus not engaged in treatment (1.2 percent, n = 1).</p> <p>Some alcohol or illegal drug use was reported by 15.7 percent (n = 13) of women, with use reported by more women engaged in treatment (10.8 percent, n = 9) than women not engaged in treatment (4.8 percent, n = 4). Five women reported daily use.</p> <ul style="list-style-type: none"> • Level 1: No alcohol, prescription drug, or illegal drug use – without treatment support = 9.6 percent (n = 8) • Level 2: No alcohol, prescription drug, or illegal drug use – while engaged in treatment = 44.6 percent (n = 37) • Level 3: Prescribed drug use only (taken as prescribed) – while engaged in treatment = 28.9 percent (n = 24) • Level 4: Prescribed drug use only (taken as prescribed) – without treatment support = 1.2 percent (n = 1) • Level 5: Some alcohol or illegal drug use – while engaged in treatment = 10.8 percent (n = 9) • Level 6: Some alcohol or illegal drug use – without treatment support = 4.8 percent (n = 4) 	<p>Inconclusive</p> <p>Over half of women abstained from substance use in the 30 days prior to a 6-month followup interview; however, of those that reported alcohol or illegal drug use, more did so while engaged in treatment than without treatment.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Meta House	Adult	Women will demonstrate a significant pre and post decrease in their trauma-related symptoms.	Trauma Symptom Checklist-40 (TSC-40) administered at intake and 6-month followup to treatment participants (n = 73).	<p>Significant pre-post decrease in mean TSC-40 Total Scores (intake M = 48.78, followup M = 29.05, $t = 7.91, p < .001$).</p> <p>Significant improvements in all six subscales.</p> <ul style="list-style-type: none"> Anxiety (intake M = 9.92, followup M = 5.89, $t = 7.09, p < .001$) Depression (intake M = 13.32, followup M = 8.11, $t = 7.89, p < .001$) Disassociation (intake M = 7.89, followup M = 4.65, $t = 6.05, p < .001$) Sexual Abuse Trauma (intake M = 7.84, followup M = 4.51, $t = 5.84, p < .001$) Sexual Problems (intake M = 5.13, followup M = 3.33, $t = 2.76, p < .007$) Sleep Disturbance (intake M = 11.42, followup M = 7.21, $t = 6.27, p < .001$) 	Positive Women experienced an improvement in all trauma symptoms from intake to followup.
Meta House	Child	90 percent of births to pregnant women who deliver while they are in the project and have been in the project for at least 2 months will be within normal weight range for gestational age.	Administrative/grantee project-specific databases and records.	<p>Of 29 babies born to women in OFFSPRG, 13 were born to mothers who were in the project for at least 2 months before giving birth.</p> <p>75.9 percent (n = 22) of births were within the normal weight range for their gestational age.</p> <p>Most low-weight babies were born to mothers in residential treatment less than 2 months (n = 5 of 7) and were born prematurely (n = 6 of 7).</p>	Negative Three-fourths (75.9 percent) of births were within the normal weight range for their gestational age, 14.1 percent below the project goal.

Grantee	Client	Outcome	Data Source	Results	Implications
Meta House	Child	Children served will demonstrate a significant pre and post decrease in trauma-related symptoms.	Trauma Symptom Checklist for Young Children (TSCYC) administered at intake to treatment participants (n = 17) and administered at intake and followup to treatment participants (n = 11).	<p>Some children (mean age=6.0) experienced at least one clinically significant or potentially problematic symptom at the time of admission.</p> <ul style="list-style-type: none"> • 41.2 percent (n = 7) had one or more subscales considered clinically significant (T score of 70+). Most (n = 5 of 7) had more than one clinically significant subscale. • 47.1 percent (n = 8) had one or more subscales considered potentially problematic or sub-clinical (T score of 65 to 69). • 58.8 percent (n = 10) had at least one subscale that fell in the clinical and/or potentially problematic range. <p>No single symptom accounted for clinical or subclinical scores; many children scored in the normal range on the subscales, but almost 30 percent experienced clinically significant posttraumatic stress symptoms of the intrusion type.</p> <p>Few to no pre and post changes in children (mean age=5.64) who experienced clinically significant or potentially problematic symptoms.</p> <p>Four children had one or more subscales considered to be clinically significant at intake; three children's scores fell in the clinically significant range at followup. Some children demonstrated improvement over time, others experienced few symptoms at either point in time, and one child became more symptomatic over time.</p>	<p>Inconclusive</p> <p>Insufficient data were available to conduct a pre-post analysis at the case level, but provided a descriptive picture of trauma-related symptoms at intake and trends between intake and followup.</p> <p>Some children experienced clinically significant symptoms at admission. Each child had a unique symptom picture, but issues of posttraumatic intrusive memories seemed problematic for children. Some children demonstrated symptom improvement over time.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Queen of Peace Center	Adult	Reduced maternal substance use.	Addiction Severity Index (ASI) administered at baseline and 6-month followup to treatment participants (n = 27).	<p>Significant pre-post differences reported.</p> <ul style="list-style-type: none"> • Drug Use: Baseline M = .27, SD = .12; Followup M = .08 SD = .12, $t(27) = 5.80$, $p \leq .01$ • Family/Social: Baseline M = .29, SD = .07; Followup M = .21, SD = .09, $t(27) = 2.74$, $p \leq .01$. • Psychological: Baseline M = .25, SD = .17; Followup M = .18, SD = .19, $t(27) = 2.13$, $p \leq .05$ • Legal: Baseline M = .11, SD = .23; Followup M = .20, SD = .21, $t(27) = -2.72$, $p \leq .05$ <p>Non-significant pre and post differences.</p> <ul style="list-style-type: none"> • Alcohol Use: $t(27) = 1.32$ • Employment: $t(27) = -.40$ • Medical: $t(27) = -1.78$ • Psychiatric: $t(15) = 1.93$ 	<p>Positive</p> <p>Significant improvement in drug use, family/social interaction, and psychological functioning from baseline to 6-month followup.</p> <p>Negative</p> <p>Significant decrease in legal domains from baseline to 6-month followup.</p>
Queen of Peace Center	Adult	Increased social connections and supports.	Maternal Social Support Scale (MSSI) administered at baseline and 6-month followup for treatment participants (n = 27).	<ul style="list-style-type: none"> • Non-significant pre-post improvement ($t(28) = -1.49$, $p = .15$) reported for Very Difficult, Isolated Life: Baseline=28.6 percent, Followup = 13.8 percent • Social Support Level Helpful: Baseline=71.4 percent, Followup = 86.2 percent 	Negative Treatment clients did not improve social support from baseline to 6-month followup.
Queen of Peace Center	Adult	Improved maternal mental health.	Edinburgh Postnatal Depression Scale (EPDS) administered at baseline and 6-month followup to treatment participants (n = 29).	<p>Significant pre-post improvement reported for</p> <ul style="list-style-type: none"> • Anxiety: Baseline M = 5.00, SD = 2.70; Followup M = 3.45, SD = 2.27; $t(28) = 2.25$, $p \leq .05$; percent change=31.0. • Depression: Baseline M = 11.72, SD = 5.50; Followup M = 7.28, SD = 5.92; $t(28) = 3.98$, $p \leq .001$, percent change=37.9. 	Positive Treatment clients demonstrated significant improvement in EPDS depression and anxiety scores from baseline to 6-month followup.
Queen of Peace Center	Adult	Will there be an improvement in maternal mental health?	Primary Care Tool for Assessment of Depression During Pregnancy and Postpartum (PDCAT) administered at baseline and 6-month followup to treatment participants (n = 28).	<p>Nonsignificant pre and post improvement ($t(28) = 0.63$, $p > .05$) reported.</p> <ul style="list-style-type: none"> • Bipolar Symptoms: Baseline = 22.5 percent, 6-months = 10.3 percent • Depressed: Baseline = 49.4 percent, 6-months = 27.6 percent • Suicide Risk: Baseline = 38.9 percent, 6-months = 10.3 percent 	Negative Treatment clients did not improve level of psychological functioning from baseline to 6-month followup.

Grantee	Client	Outcome	Data Source	Results	Implications
Queen of Peace Center	Adult	Improved individual sense of family empowerment.	Family Empowerment Scale (FES) administered at baseline and 6-month followup to treatment participants (n = 29).	<p>Significant pre and post improvement $t(27) = -2.39$, $p < .05$ reported.</p> <ul style="list-style-type: none"> Family: Baseline = 3.93, 6-months = 4.31 <p>Non-significant pre-post difference reported.</p> <ul style="list-style-type: none"> Service: Baseline = 4.06, 6-months = 4.33 Community: Baseline = 2.88, 6-months = 2.85 	Positive Treatment group significantly improved in knowledge of family items from baseline to 6-month followup.
Queen of Peace Center	Adult	Improved parental resilience.	Parenting Sense of Competence Scale (PSCS) administered at baseline and 6-month followup to treatment participants (n = 29).	<p>Significant pre and post improvement reported for self-confidence.</p> <ul style="list-style-type: none"> Raw Score: Baseline = 70.41, 6-month = 74.93 ($p < .05$) Low Self-Confidence: Baseline = 24.7 percent, 6-month = 10.3 percent Moderate Self-Confidence: Baseline = 40.3 percent, 6-month = 37.9 percent High Self-Confidence: Baseline = 35.1 percent, 6-month = 51.7 percent, $t(28) = -2.65$ ($p < .05$) 	Positive Treatment group scored significantly higher in high self-confidence from baseline to 6-month followup.
Queen of Peace Center	Child	Will there be an improvement in index child's cognitive, physical, and socio-emotional health?	Ages and Stages Questionnaire (ASQ-3) administered at baseline and 6-month followup to treatment participants (n = 13).	<p>Significant pre and post improvement reported for three subscales.</p> <ul style="list-style-type: none"> ASQ-3 Fine Motor Baseline = 36.5, Followup = 54.2 ($p < .01$) ASQ-3 Problem Solving Baseline = 40.0, Followup = 52.7 ($p < .05$) ASQ-3 Personal Social Baseline = 46.5, Followup = 56.5 ($p < .05$) 	Positive Significant improvement from baseline to 6-month followup in Fine Motor, Problem Solving, and Personal Social scores for treatment group.
Queen of Peace Center	Child	Will there be an improvement in index child's cognitive, physical, and socio-emotional health?	Ages and Stages Questionnaire – Social/Emotional (ASQ-SE) administered at baseline and 6-month followup to treatment participants (n = 21).	<p>ASQ-SE Baseline.</p> <ul style="list-style-type: none"> No referral needed = 73.7 percent, Referral needed = 26.3 percent <p>ASQ-SE 6 Months.</p> <ul style="list-style-type: none"> No referral needed = 77.8 percent, Referral needed = 22.2 percent <p>T-test data not reported.</p>	Inconclusive Need for mental health referral was lower at 6-month followup than baseline. Unclear if improvement is statistically significant.

Grantee	Client	Outcome	Data Source	Results	Implications
Queen of Peace Center	Child	Will parental knowledge and encouragement of appropriate cognitive, physical, and social-emotional milestones be achieved?	Ages and Stages Questionnaire (ASQ-3) and Ages and Stages Questionnaire – Social/Emotional (ASQ-SE) administered at baseline to treatment participants (n = 39).	<p>Parents consistently rate concerns as “No” in all the domains.</p> <ul style="list-style-type: none"> • Behavior: Yes = 18.0 percent (n = 7), No = 82.0 percent (n = 32) • Gross Motor: Yes = 3.0 percent (n = 1), No=97.00 percent (n = 38) • Hearing: Yes = 5.0 percent (n = 2), No = 95.0 percent (n = 37) • Medical: Yes = 33.0 percent (n = 13), No = 67.0 percent (n = 26) • Speech: Yes = 18.0 percent (n = 7), No = 82.0 percent (n = 32) • Vision: Yes = 13.0 percent (n = 5), No = 87.0 percent (n = 34) • Other: Yes = 23.0 percent (n = 9), No = 77.0 percent (n = 30) 	Inconclusive Parents consistently rate concerns as “No” in all domains, but only baseline data is reported for treatment participants.
Queen of Peace Center	Family	Improved family functioning.	North Carolina Assessment Scale for General Services (NCFAS-G) administered at baseline and 6-month followup to treatment participants (n = 29).	<p>Significant pre and post improvement reported for two subscales.</p> <ul style="list-style-type: none"> • Family Interaction: 50.0 percent, $t(28) = -2.09$ ($p \leq .05$) • Parenting Ability: 68.8 percent, $t(28) = -2.60$ ($p \leq .05$) <p>Non-significant pre-post differences reported for six subscales.</p> <ul style="list-style-type: none"> • Child Well-Being: 37.1 percent • Environment: 17.8 percent • Family Safety: 20.3 percent • Health: 21.8 percent • Social & Community Life: 49.3 percent • Self-Sufficiency: 19.3 percent 	Positive Treatment group significantly improved in Family Interaction and Parenting Ability from baseline to 6-month followup.

Grantee	Client	Outcome	Data Source	Results	Implications
Renewal House	Adult	Increase parent capacity to provide for their children's needs.	Adult Needs and Strengths Assessment (ANSA) administered at intake and discharge to treatment participants (n = 89).	<p>Increase of Adult Supportive Services.</p> <ul style="list-style-type: none"> • Cash Income = 59.1 percent • Child Supplement = 1.4 percent • Employed = 16.7 percent • Food Stamps = 31.0 percent • Medicaid = 15.5 percent • Non-Cash Income = 8.5 percent • TANF = 54.9 percent • TANF Childcare Income = 42.3 percent • TANF Transportation Income = 24.0 percent • WIC = 29.4 percent <p>Change in Child Housing Stability.</p> <ul style="list-style-type: none"> • Stably housed = 93.93 percent • Unstably housed and at risk of losing housing = -6.25 percent • Literally homeless = 0.0 percent • Client does not know = -66.7 percent <p>25.7 percent (n = 28) of children had the same living situation as their mothers at intake.</p> <p>Parent Living Arrangement at Discharge.</p> <ul style="list-style-type: none"> • Don't Know = 14 • Family Temporary = 13 • Family Permanent = 9 • Friends Permanent = 7 • Friends Temporary = 10 • Rental (subsidy) = 8 • Jail or Prison = 3 • Rental (no subsidy) = 2 • Emergency Shelter, Other, Owned by Client (no subsidy), Refused, SA Treatment Center = 1 each 	<p>Inconclusive</p> <p>Increases in all non-clinical supportive services, including employment (16.7 percent) and cash income (59.1 percent).</p> <p>Increase of 93.3 percent for children stably housed at intake and discharge.</p> <p>No evidence that the increases are significant.</p> <p>Negative "Don't know" was the most frequent response to parent living situation at discharge.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Renewal House	Adult	Increase protective factors that impact family functioning (e.g. resilience, parenting skills, social connections/support, less parental stress, and improved physical and mental health).	Addiction Severity Index (ASI) administered at baseline and followup to treatment participants (n = 32). Parenting Stress Index (PSI) administered at baseline and followup to treatment participants (n = 43).	<p>ASI Mean Pre- and Posttest Scores.</p> <ul style="list-style-type: none"> • Alcohol: Pre = .29, Post = .01 • Drugs: Pre = .22, Post = .05 • Employment: Pre = .84, Post = .81 • Family: Pre = .35, Post = .12 • Legal: Pre = .36, Post = .13 • Medical: Pre = .46, Post = .22 • Psychiatric: Pre = .47, Post = .18 <p>PSI-SF Mean Pre- and Posttest Scores.</p> <ul style="list-style-type: none"> • Parental Distress (DC) percent: Pre = 66.36, Post = 43.10, percent change = -35.05 • Parent-Child Dysfunctional Interaction (P-CDI) percent: Pre = 52.23, Post = 42.5, percent change = -18.63 • Difficult Child (DC) percent: Pre = 47.61, Post = 40.53, percent change = -14.87 • Total Stress (TS) percent: Pre = 56.54, Post = 39.13, percent change = -30.79 <p>Mother-Child Dyads with Improved PSI-SF Scores.</p> <ul style="list-style-type: none"> • PD- percent = 90.7 (n = 39) • P-CDI percent = 65.1 (n = 28) • DC- percent = 74.4 (n = 32) • TS- percent = 83.7 (n = 36) 	<p>Inconclusive</p> <p>Improvement in all ASI domains, but no documentation of significance.</p> <p>Improvement in PSI-SF scores, but no documentation of significance.</p>
Renewal House	Child	Increase well-being by assessing at least 90 percent of children to identify supportive service needs.	Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment and supplemental interview administered to treatment participants (n = 110).	<p>89 of 110 (81.0 percent) children assessed. 68 (62.4 percent) children aged 0-4 and 19 (17.4 percent) children aged 5-17 received an assessment at some point during their stay.</p> <p>22 children did not have available assessments at the time of analysis. Of these, 9 (8.25 percent) were in the program for less than 30 days, or were less than 30 days old at discharge and ineligible for assessment.</p>	<p>Inconclusive</p> <p>Result is 9 percent below outcome goal of 90 percent, although children without assessments were either in the program for too short a time or were too young to be assessed.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
Renewal House	Child	Increase well-being by connecting at least 75 percent of children to appropriate supports and services/evidence-based practices that address needs identified in assessments.	Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment and supplemental interview administered to treatment participants.	Three new evidence-based practices (EBPs) for children were integrated into project services and were received by the following number of children: <ul style="list-style-type: none"> • Al's Pals: Kids Making Healthy Choices = 30 • Parent Child Interaction Therapy (PCIT) = 13 • Wellness Recovery Action Plan (WRAP) = 93 	Inconclusive Unclear if number of children receiving EBPs met outcome goal.
Renewal House	Child	Improve attachment in mother-child relationship.	Child and Adolescent Needs and Strengths (CANS) Comprehensive Multisystem Assessment and supplemental interview administered to treatment participants (n = 30).	30 women with children aged 0-4 had no attachment difficulties at pretest. Most dyads showed no attachment problems at intake or post treatment (62 percent; n = 23) for children aged 0-4. Most dyads (71 percent; n = 10) reported mild attachment problems at intake for children aged 5-17.	Positive By discharge, 71 percent (n = 10) of mothers reported no problems, three reported mild problems, and one reported moderate problems.
Susan B. Anthony Center	Adult	85 percent of mothers tested at graduation will be drug free.	Administrative grantee/project-specific databases and records for treatment participants that graduated (n = 90).	Mothers must be drug free for a minimum of 30 days prior to graduation. Of the 152 mothers that <u>graduated</u> , all were drug free.	Positive 100 percent of mothers were drug free at graduation.
Susan B. Anthony Center	Adult	60 percent of those that graduate will maintain sobriety and 65 percent employment or school enrollment 6-months after graduation.	Administrative grantee/project-specific databases and records for treatment participants that graduated (n = 152).	<ul style="list-style-type: none"> • Sobriety data available for 59.0 percent (n-90) graduates; graduated mothers identified as sober and either in school or employed 6-months post-graduation = 26 (28.9 percent). • Mothers identified with clear indication of sobriety and with school or employment data 6-months post-graduation = 90 (100 percent). • Mothers with no employment or education data = 1. 	Positive 60.0 percent of mothers identified as sober <u>and</u> employed <u>or</u> in school.

Grantee	Client	Outcome	Data Source	Results	Implications
Susan B. Anthony Center	Adult	75 percent of mothers served a minimum of 90 days will reduce/improve trauma symptoms and social/emotional functioning.	<p>Symptom Checklist 90-Revised (SCL-90-R) administered at baseline, 90-day, and 6-month followup to treatment participants completing SCL-90-R GSI and PST (n = 28) and PSDI (n = 23).</p> <p>Trauma Assessment for Adults (TAA) administered at baseline to treatment participants (n = 212).</p>	<p>Paired sample t-tests indicated significant improvement in the three SCL-90-R scores.</p> <ul style="list-style-type: none"> • Percent Improvement Baseline and 90-Day Followup: GSI = 83.7 percent, PST = 87.0 percent, PSDI = 78.5 percent • Percent Improvement Baseline and 6-Month Followup: GSI = 88.1 percent, PST = 89.8 percent, PSDI = 85.2 percent • Percent Improvement 90-Day to 6-Month Followup: GSI = 75.0 percent, PST = 82.1 percent, PSDI = 69.6 percent <p>TAA results provided at baseline only.</p> <ul style="list-style-type: none"> • High exposure = 13.2 percent • Medium exposure = 12.6 percent • Low exposure = 21.7 percent • No exposure = 41.5 percent 	<p>Positive</p> <p>Significant improvement in 3 indices of the Symptom Checklist 90-Revised (SCL-90-R) from Baseline to 90-Day and 6-Month Followup.</p> <p>Negative</p> <p>Non-significant improvement in 2 indices of SCL-90-R from 90-Day to 6-Month Followup.</p> <p>Inconclusive</p> <p>TAA results provided at baseline only.</p>
Susan B. Anthony Center	Adult	85 percent of fathers served will improve knowledge, skills, and attitudes on child development and parenting.	<p>24/7 Dad Fathering Inventory.</p> <p>24/7 Dad Fathering Skills Survey.</p>	Outcome unable to be evaluated due to low participation (N = 20).	Inconclusive
Susan B. Anthony Center	Child	85 percent of children after at least 90-days will improve at least two domains of child well-being.	<p>Battelle Development Inventory (BDI-2) administered at baseline and 90-day followup to treatment participants (n = 153).</p> <p>Pediatric Symptom Checklist (PSC) administered at baseline and 90-day followup to treatment participants (n = 72).</p>	<p>61.4 percent (n = 94) of youth demonstrated an improved pre and post BDI-2 score. Success criteria is improvement in two or more of the five BDI domains.</p> <p>66.7 percent (n = 48) of youth demonstrated a pre-post improvement in PSC score. T-test data not reported; unclear if improvement is statistically significant.</p>	<p>Negative</p> <p>61.4 percent improved BDI-2 scores from baseline to 90-day followup, 23.6 percent short of outcome goal.</p> <p>66.7 percent improved PSC scores from baseline to 90-day followup, 15.3 percent short of outcome goal.</p>

Grantee	Client	Outcome	Data Source	Results	Implications
				<p><i>Note:</i> BDI success is measured by improvement using 'cut' not 'raw' scores. Raw scores may increase across administrations, but cut scores indicate if this is a significant developmental improvement for the domain compared to an age specific norm. Using raw scores, the number of youth demonstrating improvement is 76 and percentage improved equals 86.4. However, this does not meet the requirements stated by BDI-2 developers.</p> <p>Difficulty in parents supporting therapeutic and developmental suggestions, lack of developmental knowledge, and turnover in the developmental specialist position contribute to continued difficulty in meeting this outcome. The 85 percent goal was set based on the practice of using raw scores at SBAC. That level of success would be challenging even with a team focused exclusively on developmental concerns.</p>	

Organizational and Systems-level Outcomes

All grantees collected data on organizational and system-level outcomes to assess the extent to which new policies and procedures were developed, public child welfare agencies integrated elements of the service model, and projects impacted child welfare practice in the community. Grantees did not assess or report on efforts to promote sustainability beyond the federal funding period. In addition to these achievements, grantees also documented the ability to achieve service provision outcomes that improved the quality and thoroughness of services provided to adults, children, and other family members.

Results for 17 out of 24 outcome goals were provided. The majority of organizational and system-level outcome achievement was self-reported as positive. Only the Queen of Peace Center provided results that are based on an instrument, the Client Satisfaction Questionnaire (CSQ-8). A minority of results was inconclusive; it was unclear if the results—which documented achievement in providing services, developing policies and procedures, or influencing child welfare—assisted the grantees in achieving the outcome goals.

Service Provision

Amethyst planned to assess the degree to which (1) a full array of therapeutic services for children would be added and integrated into residential substance abuse treatment, (2) all children have an assessment and written treatment plan, and (3) the development of Recovery Residences would be the next-step for sober housing for families. Two child treatment plans were completed. Amethyst received a Victims of Crime Assistance (VOCA) grant from the Ohio Attorney General's Office to provide mental health and case management services to children served by the Family Connection grant. The VOCA grant runs from October 1, 2015, to September 30, 2016. Child treatment plans will be completed for children under the new grant. Amethyst reported that 12 clients moved into Recovery Residences.

The Queen of Peace Center planned to assess client satisfaction with services and degree of perceived implementation of planned services by community partners and service providers. A decrease in client satisfaction was experienced from 94 percent of clients "very or mostly satisfied" with services at baseline to 85 percent of clients "very or mostly satisfied" at 6-month followup. However, client satisfaction focused on intake processes at baseline and services received over time at followup; thus, the results may not be comparable. The grantee also planned to assess changes in knowledge, attitude, and/or behavior about perinatal substance use and mental health. The Queen of Peace Center reported attendance rates of 50 to 106 participants at four trainings offered in partnership with the Perinatal Resource Network. Almost all participants (85–100 percent) evaluated the sessions as "excellent" or "very good" in overall value, increased knowledge, and relevance of information to their work. Service providers and community partners indicated direct services on average were implemented according to the plan; however, total implementation, referrals, dissemination, and training were rated as only partially implemented.

The majority of Renewal House's organizational level outcomes were related to service provision. Goals were to fully integrate a trauma-informed approach across all domains; assemble a culturally competent, trauma-informed team of clinical and outreach staff with experience in substance abuse, mental health, family therapy, and child development and welfare; and increase client access to supportive services while living in transitional housing. All clinical staff members received trauma-informed care approach/clinical philosophy training, and 100 percent of women and children in treatment had access to new evidence-based practice programs, such as Parent Child Interaction Therapy (PCIT) and Wellness Recovery Action

Plan (WRAP). Renewal House increased availability of transitional housing for new admissions and was able to serve 95 adults in offsite housing while participating in project services.

Renewal House was also able to lengthen the continuum of care by creating an Alumni Association that serviced 70 parents and facilitated 199 groups. No data were reported for increased outreach and engagement strategies for offsite family members and parent completion of project milestones.

The Susan B. Anthony Center reported achieving multiple organizational and system-level outcomes in regard to service provision. One hundred percent of clients were reported to receive timely services from ChildNet, defined as receiving services within 30 days of referral to public child welfare; this was 15 percent above the outcome goal of 85 percent. Also, 100 percent of clients who were successfully discharged had concrete family needs met, 15 percent above the outcome goal of 85 percent.

Policies and Procedures

Amethyst planned to create joint referral processes between the grantee and the public child welfare agency and planned to train public child welfare staff members about referral criteria and grantee services. Training results were not provided. Out of 107 women referred to Amethyst by public child welfare agencies, only three women entered into RFT services. It is unclear if this number of referrals approaches the outcome goal.

Meta House planned to develop a procedural guide and hold collaborative meetings with key representatives at least monthly to monitor the implementation of the project, clarify roles and responsibilities, assess progress, and identify and resolve cross-systems issues. A procedural guide was developed with values and practices incorporated into work with collaborative partners.

Impact on Child Welfare Practice

A Meta House outcome goal was to conduct collaborative assessments with women to assist in child welfare case planning and in identifying treatment needs. Collaborative assessments were successfully implemented and completed for 100 percent of women in treatment. Meta House also planned to work across systems to develop and strategically disseminate project products and findings to transfer knowledge locally and nationally. Related to this, Meta House planned to develop ongoing cross-system trainings to address child welfare and substance abuse topics. Eleven free-of-charge formal trainings were offered to 191 staff members from public child welfare and other project partners. These cross-systems trainings, along with evaluation team presentations and sharing dissemination products with ACF, contributed to dissemination.

Numerous alcohol and other drug consultations, which included cross-agency collaboration, enabled Renewal House to make progress on its outcome goal of enhanced ability to address parent substance abuse via increased knowledge of partner services and cross-agency referrals; increased number of cross-agency trainings; and increased cross-agency planning and coordinated case management. Multiple interagency partnerships related to grant activities helped enhance partner collaboration through Memos of Understanding regarding treatment coordination and other collaborative activities.

The Susan B. Anthony Center reported tentative achievement of its outcome goal of 90 percent of collaborations benefitting families in RFT. This was based on the grantee perception of its organization being firmly embedded in the community; being able to call on Broward CARES, an advisory group of behavioral health care providers, for assistance; providing assistance to Broward CARES; and having

positive working relationships with Broward CARES and other organizations that can access concrete, therapeutic, and support needs for clients. The Susan B. Anthony Center reports on discussions with Broward CARES suggest that few families needs go unaddressed.

Table 31: Organizational and System-level Outcomes lists planned outcomes, data sources, results, and implications.

Table 31: Organizational and System-level Outcomes

Grantee	Outcome	Data Source	Results	Implications
Amethyst	A full array of therapeutic services for children will be added and integrated into the long-term residential substance abuse treatment offered by Amethyst.	Child treatment plan. Electronic records of services for children.	Amethyst received a Victims of Crime Assistance (VOCA) grant from the Ohio Attorney General's Office to provide mental health and case management services to children served by the Family Connection grant. The VOCA grant runs from October 1, 2015, to September 30, 2016.	Positive
Amethyst	100 percent of children in residence at Amethyst will have an assessment and a written treatment plan.	Child treatment plan.	Two child treatment plans were completed. Treatment plans will be developed for children under the VOCA grant.	Negative Treatment plans developed for fewer than 2 percent of 125 children living in residence.
Amethyst	Engagement and linkage processes will be created by FCCS and Amethyst so families enter into Amethyst residential treatment services.	Administrative grantee/program-specific databases and records.	In total, 107 women have been referred by FCCS into the program. Three of these women entered the Amethyst program.	Inconclusive Unclear if results approached the outcome goal.
Amethyst	Amethyst will train FCCS staff about Amethyst's services and referral criteria annually.	Administrative grantee/program-specific databases and records.	Amethyst's Child Team Coordinator attended an FCCS management meeting in August 2015 to discuss appropriate referrals and provide information about Amethyst's services.	Negative One training provided in 3 years of funding.
Amethyst	Recovery Residences will be developed to serve as next-step, sober housing for families.	Administrative grantee/program-specific databases and records.	Twelve clients moved into Recovery Residences.	Positive

Grantee	Outcome	Data Source	Results	Implications
Meta House	Develop a procedural guide to establish common understanding of values and practices among collaborative partners.	The Collaborative Management Team developed a procedural guide to define roles and responsibilities of collaborative partners and detail procedures for referral, assessment, family team meetings, and access and engagement in treatment and other services in the first 6 months of OFFSPRG.	As the project progressed, there was less need for a formal, written procedural guide. Some procedures were incorporated into routine practices of referring and serving clients across systems. As relationships developed, informal communication and cross-system practices have increased (e.g., staff-to-staff phone referrals). The project discontinued refining the original procedural guide and now focuses on outlining steps and lessons learned to create a common understanding of values and practices among collaborative partners.	Positive Procedural guide was developed with values and practices incorporated into work with collaborative partners.
Meta House	Develop ongoing cross-system trainings to address child welfare and substance abuse topics.	Eleven formal trainings were provided free of charge to 191 staff members from most of the collaborating systems, with strong attendance by child welfare staff.		Positive Multiple trainings offered to staff members from project partners.
Meta House	Hold collaborative meetings with key representatives at least monthly to monitor the implementation of OFFSPRG in order to clarify roles and responsibilities, assess progress, and identify and resolve cross-systems issues.	The Collaborative Management Team, which identifies and resolves issues or needs affecting project implementation and provides opportunities for cross-system learning and communication, met monthly and was attended by representatives from Meta House, BMCW, private child welfare agencies, LaCausa, Milwaukee County Behavioral Health, Children’s Court, and UWM’s Milwaukee Child Welfare Partnership. Meetings clarified roles and responsibilities, assessed progress, and addressed cross-systems issues. The Steering Committee, which provided higher-level oversight and accountability for the project, met once every 6 months. OFFSPRG’s Project Director had ongoing communication with leaders of each system.		Positive Steering Committee meets every 6 months, but Collaborative Management Team meets monthly to monitor project implementation.
Meta House	Conduct collaborative assessments with women to assist in case planning and identifying treatment needs.	Comprehensive behavioral health assessments completed with 100 percent of women admitted to OFFSPRG. Meta House used assessment results to identify family treatment needs; results were shared with child welfare partners.		Positive Comprehensive assessments completed for 100 percent of treatment participants.

Grantee	Outcome	Data Source	Results	Implications
Meta House	Work collaboratively to develop and strategically disseminate project products and findings to transfer knowledge locally and nationally.	<p>Cross-systems trainings transferred knowledge about substance abuse, mental health, and treatment to local child welfare managers and caseworkers.</p> <p>Evaluation team presented preliminary evaluation findings to the internal Meta House Study Team and external Collaborative Management Team.</p> <p>All dissemination products shared with ACF as part of semi-annual reporting.</p>		<p>Positive</p> <p>Cross-systems trainings, evaluation team presentations, and sharing dissemination products with ACF contributed to dissemination.</p>
Queen of Peace Center	Client Satisfaction with services.	<p>Client Satisfaction Questionnaire (CSQ-8) administered to treatment participants at baseline (n = 66) and 6-month followup (n = 29).</p>	<p>Baseline measurement assessed intake process to determine if clients thought their needs were heard and if they were accurately assessed for treatment planning.</p> <ul style="list-style-type: none"> • Very satisfied = 47.0 percent • Satisfied = 47.0 percent • Indifferent = 4.5 percent • Quite dissatisfied = 1.5 percent <p>6-Month followup assessed satisfaction with services received over time for treatment.</p> <ul style="list-style-type: none"> • Very satisfied = 66.7 percent • Mostly Satisfied = 18.5 percent • Indifferent or Mildly Dissatisfied = 14.9 percent • Quite dissatisfied = 0.0 percent 	<p>Inconclusive</p> <p>Decrease indicated from 94 percent of clients very or mostly satisfied with services at baseline to 85.2 percent of clients very or mostly satisfied at 6-month followup. Baseline and followup measurements assessed different types of services.</p>

Grantee	Outcome	Data Source	Results	Implications
Queen of Peace Center	Change in knowledge, attitude and/or behavior about perinatal substance use and mental health.	Attendance sheets. Post-training evaluation questionnaire. Documentation of systems change.	<p>Perinatal Resource Network and Queen of Peace Center offered four professional development sessions on Working Together.</p> <ul style="list-style-type: none"> • Bridging the Gaps Between Primary & Behavioral Care for Perinatal Women and Families – Part 1 (n = 106) • Part 2 (n = 50) • Bridging the Gap in Medicaid Coverage for Pregnant Women (n = 60+), • Taking Care of Yourself to Better Care for Mothers & Families (n = 75) <p>Percent of Excellent and Very Good ratings. Overall value of workshop.</p> <ul style="list-style-type: none"> • Part 1 = 85 percent • Part 2 = 85 percent • Bridging the Gap = 88 percent • Taking Care of Yourself = 100 percent <p>Increased knowledge of integration of primary and behavioral health care.</p> <ul style="list-style-type: none"> • Part 1 = 87 percent • Part 2 = 84 percent • Bridging the Gap = 88 percent • Taking Care of Yourself = 89 percent <p>Usefulness of information to work</p> <ul style="list-style-type: none"> • Part 1 = 86 percent • Part 2 = 89 percent • Bridging the Gap = 92 percent • Taking Care of Yourself = 89 percent 	<p>Positive</p> <p>Sessions were well attended and evaluated positively in regard to overall value of workshop, increased knowledge of integration of primary and behavioral health care, and usefulness of information to work.</p>

Grantee	Outcome	Data Source	Results	Implications
Queen of Peace Center	Degree that implementation matches the plan. Types of deviation from the plan. Factors leading to deviations. Impact of deviations on planned program and evaluation activities. Changes that were most helpful in improving service delivery.	Electronic, Web-based survey completed by direct service providers and community partners (n = 11).	Mean implementation score of 18 activities = 2.83, SD = .64 on a scale of 1 = not implemented at all, 2 = partially implemented, 3 = implemented, and 4 = surpassing implementation expectations. Direct services activities mean = 3.12, SD = .10. Referrals and dissemination/training activities mean = 2.35, SD = .88.	Negative Project not fully full implemented as specified. Implementation varied, with direct services implemented and referrals/dissemination training partially implemented.
Renewal House	Fully integrate a trauma-informed approach across all domains. Assemble a culturally competent, trauma-informed team of clinical and outreach staff with experience in substance abuse, mental health, family therapy, and child development and welfare.	Creating Cultures of Trauma-Informed Care Self-Assessment Scale (CCTIC-SAS).	All Renewal House clinical staff members received basic training in the Trauma-Informed Care Approach/Clinical Philosophy. Over the life of the grant, 86 evaluations were collected at 6 time periods over the life of the grant. The average length of time for respondents in the program was 5.19 months (SD = 4.26). Because the CCTIC-SAS is implemented on a quarterly basis, many clients represented in the survey are duplicates; there is no way to determine which surveys are duplicates and which are unique.	Positive Trauma-Informed Care Approach/Clinical Philosophy training provided to all grantee clinical staff members.

Grantee	Outcome	Data Source	Results	Implications
Renewal House	Increase outreach and engagement strategies for off-site family members.	Administrative grantee/project-specific databases and records. Interviews with project leaders, staff members, and grantee partners.	Implementation interviews completed February 2015. No results reported as of December 31, 2015. No baseline information for off-site family involvement was captured due to the structure of grantee databases. 77 unduplicated family members were served throughout the project.	Inconclusive
Renewal House	Lengthen continuum of care by at least 5 months, provide related recovery support.	Administrative grantee/project-specific databases and records.	See above—New Beginnings Phase. Alumni Association established for former clients, their children, and their families. 70 parents participated in Alumni services. Grantee facilitated 199 groups. Participation in New Beginnings phase varied over the project, but increased overall for Alumni Association.	Positive
Renewal House	Increase parent completion of project milestones by 10 percent at each level.	Administrative grantee/project-specific databases and records.	At the inception of the grant, data points were not collected that allowed for baseline data. No results provided as of December 31, 2015.	Inconclusive
Renewal House	Increase client access to supportive services while living in transitional housing.	Not applicable.	Client access to supportive services increased per the additional funded staff members and the new Evidence-based Practice (EBP) programs (e.g., Parent-Child Interaction Therapy (PCIT), Wellness Recovery Action Plan (WRAP). All (100 percent) clients and children enrolled had access to these services during the reporting period.	Positive 100 percent of treatment participants, including children, had access to new EBP programs (e.g., PCIT, WRAP).
Renewal House	Provide continuing care and recovery support services to parents who have graduated to permanent housing.	Administrative grantee/project-specific databases and records.	Participants who move into permanent off-site housing while remaining in project services retain access to adult and child case management, therapeutic services, New Beginnings group, and all alumni activities.	Positive

Grantee	Outcome	Data Source	Results	Implications
Renewal House	Enhanced ability to address parent substance abuse via 1) increased knowledge of partner services and cross-agency referrals, 2) increased number of cross-agency trainings, and 3) increased cross-agency planning and coordinated case management.	Frey's Levels of Collaboration Scale Interviews with project leaders, staff members, and grantee partners. TN DCS Consultation Database.	TN DCS consultants completed 127 alcohol and drug consultations, which included cross-agency collaboration. 30 grantee clients were referred by TN DCS consultants. TN DCS consultants provided 11 trainings to DCS staff members. No results reported for Frey's Levels of Collaboration Scale or interviews.	Positive Numerous AOD consultations included cross-agency collaboration. Inconclusive No data for collaboration scale or interviews to supplement database.
Renewal House	Enhanced partner collaboration through MOUs regarding treatment coordination and other collaborative activities.	Interviews with project leaders, staff members, and grantee partners.	Renewal House has three interagency partnerships/MOUs related to Footprints grant activities.	Positive Grantee had multiple interagency partnerships related to grant activities.
Renewal House	Increase availability of transitional housing for new admissions.	Administrative grantee/project-specific databases and records.	New Beginnings Phase, which extends the care continuum up to 5 months, allows participants to move into permanent off-site housing while participating in project services. Grantee partnered with a local affordable housing provider – Urban Housing Solutions (UHS) – to increase access to local housing units. New Beginnings planned to serve 13 families during the first 6 months following their move from transitional to permanent housing. As families moved to permanent housing, the availability of the 17 on-site transitional housing apartments for new admissions increased. Grantee served 4 adults in New Beginnings in Year 1 of the project, then 14, 30, 15, and 32 adults in the four subsequent 6-month reporting periods.	Positive

Grantee	Outcome	Data Source	Results	Implications
Susan B. Anthony Center	85 percent of concrete family needs will be met by graduation.	Person Served Preparation for Discharge.	Of 152 persons successfully discharged, 100 percent (n = 152) had needs met.	Positive 100 percent of discharged clients had concrete family needs met.
Susan B. Anthony Center	85 percent of families referred to child welfare received timely services by ChildNet. <i>Note:</i> Timely services defined as receiving services within 30-days of referral to ChildNet.	ChildNet public child welfare dataset.	Of 132 referred and consented, 5 of which were subsequently enrolled at SBAC, all 132 received services within the expected time frame.	Positive 100 percent of clients received timely services.
Susan B. Anthony Center	90 percent of collaborations have benefited residential family treatment families.	Discussion of SBAC's relationship with Project CARES, the main collaborative in the area. Review of Broward CARES activities, in which SBAC is a fully vested partner seeking system change.	SBAC is firmly embedded in the community; is able to call on Broward CARES Collaboration for assistance; provides assistance to Broward CARES; and has positive working relationships with CARES and other organizations that can access concrete, therapeutic and support needs for clients. SBAC seeks to improve visibility, influence, networking, sustainability and leadership in the community and has instituted a plan; plan intersects with a dissemination outcome where SBAC significantly increases community contact. Discussion with CARES and SBAC suggests that very few needs go unaddressed.	Positive Collaboration tentatively viewed as successful at this time.

Cost Study Methodology and Results

The 2012 Family Connection funding announcement required the RFT grantees to “conduct a cost analysis that will provide state, local, and tribal policy makers with the information they need to make more thoughtful decisions about resource allocations in their communities.” During the 3-year funding period, different types of cost studies were performed and based on individual project objectives, structures, and services provided. Analyses were conducted at the project and case levels. Information gained from the analysis of project expenditures was used to inform local project administrators, key project partners, and future partners and funders.

Four of the five grantees included a summary of their cost study activities and findings in their final reports. The fifth grantee (Amethyst) reported cost study data in the final (September 2015) semi-annual progress report. In this section, the approaches, objectives, and findings of the cost studies are described.

Cost Study Designs

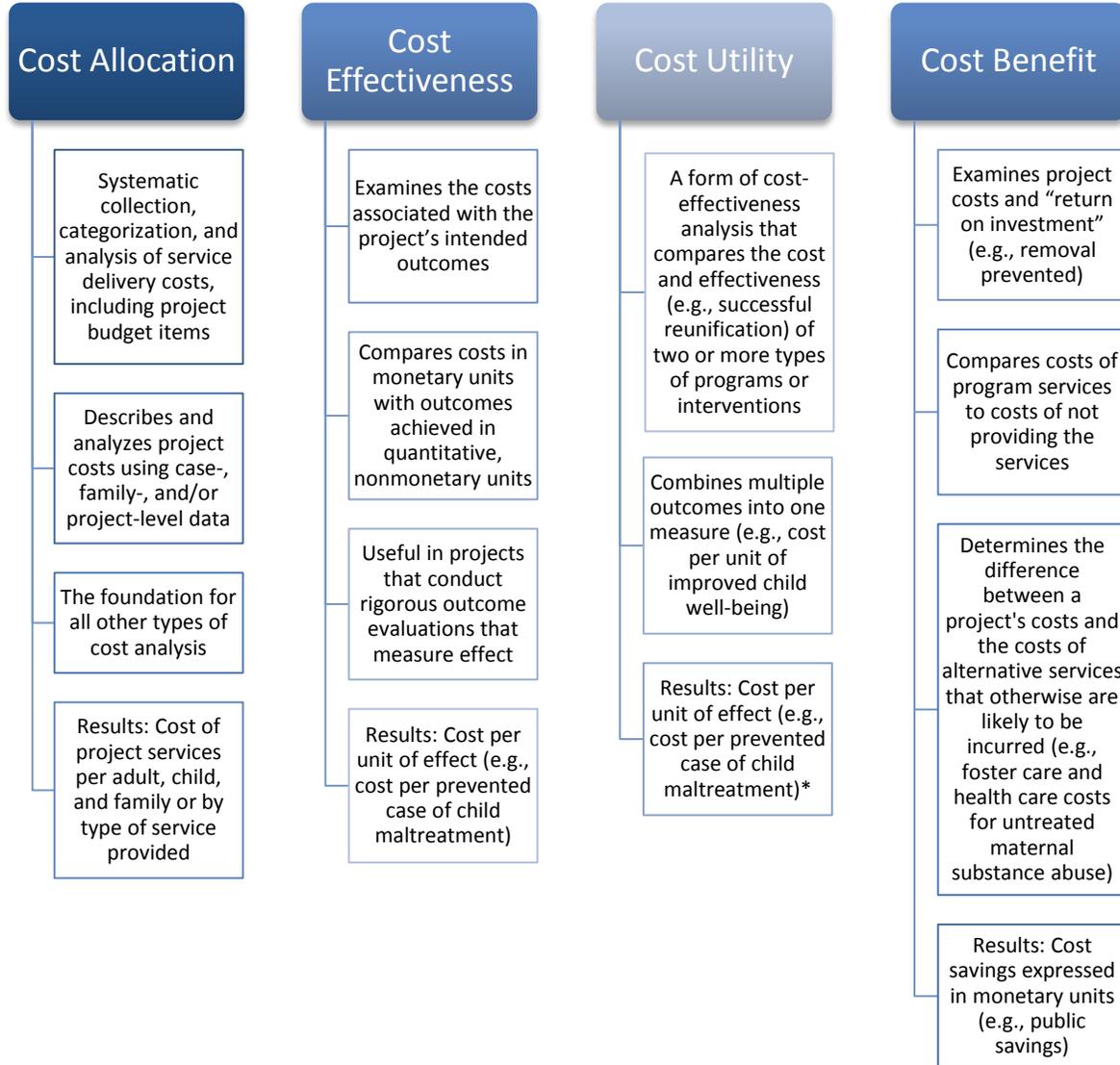
All grantees included cost study designs in their evaluation plans in order to determine the costs to provide RFT services to women and children. Figure 15: Cost Study Designs outlines the most common cost study approaches and the types of inferences that can be drawn from each method. These approaches include cost allocation, cost effectiveness, cost utility, and cost benefit. Cost analyses were made at the project and family levels.

Cost Allocation. At a minimum, all grantees conducted a cost allocation analysis to determine the average cost per family served. Cost allocation analysis has been described as a critical first step in any economic evaluation because it provides the essential foundation for all other types of analysis.¹² Information gained through these analyses included the cost of project services per adult, child, and family, or by type of services provided. Costs of activities and services over time were also examined based on participants’ average length of stay, and this provided additional context for understanding service costs. Amethyst and Renewal House calculated project and family level cost of treatment per household using the annual figures. The Queen of Peace Center conducted a ‘snapshot’ analysis of project costs incurred in a 6-month period during the second year of the grant. The Susan B. Anthony Center’s analyses included determining the number and type of services at the client level that could be aggregated.

Cost Effectiveness. This form of analysis examines the costs associated with the projects’ intended outcomes (e.g., improved maternal health and birth outcomes). Two projects (Queen of Peace Center and Susan B. Anthony Center) sought to identify the costs associated with key outcomes for women, children, and family members served. The Queen of Peace Center conducted a cost effectiveness analysis at project and family levels to estimate program costs by service category for a sample of clients served who were successful or unsuccessful at discharge. The Susan B. Anthony Center implemented a modified cost effectiveness analysis method. The cost study included four rounds of data collection from staff in a time study, tracking from staff in 15-minute intervals (equivalent to standard billing time).

¹² Foster, E. M., Porter, M. M., Ayers, T. S., Kaplan, D. L., & Sandler, I. (2007). Estimating the costs of preventive interventions. *Evaluation Review*, 31, 261-286.

Figure 15: Cost Study Designs



**It can be difficult to value an intervention's effect on human service program outcomes, such as a child's quality of life.*

Cost Benefit. Studies of this type compare project costs with the return on investment (i.e., outcomes). Cost benefit analyses focused on comparing project costs to the costs of other interventions that are likely to be required if clients do not receive services. In the context of RFT, alternative costs examined were those associated with untreated substance abuse. Two projects (Meta House and Renewal House) conducted cost benefit analyses, assessing the costs of program participation compared to other alternative services. Meta House assessed the potential cost savings of program participation compared to costs associated with children being placed in out-of-home care and poor birth outcomes. Renewal House assessed costs per family per day compared to the costs of other types of treatment (e.g., foster care, prison, high-intensity services) provided to families similar to those residing in Renewal House. Both grantees developed specialized databases to track and monitor case-level data for program participants. Meta House maintained case-level data in its electronic health records system. Renewal House developed

an ACCESS cost study database to track billable service hours (e.g., case management, individual therapy) and nonbillable service hours (e.g., providing supervision, completing paperwork) for its staff to reflect the provision of clinical services for families.

Cost Utility. Cost utility analyses compare the cost and effectiveness of two or more types of programs or interventions. None of the RFT grantees conducted this type of analysis. However, recognizing the continued interest of federal and future funders in more rigorous project evaluation (including cost evaluation), several grantees planned to implement more sophisticated analyses of program costs, such as cost utility, in their post-grant work. Table 32: Grantee Study Designs provides an overview of the types of analyses conducted by grantees, their data sources, and the time period in which data were collected. The findings of the analyses are described by grantees in the final segment of this section.

Table 32: Grantee Study Designs

Grantees	Objectives	Analysis				Timeframe
		Cost Allocation	Cost Effectiveness	Cost Utility*	Cost Benefit	
Amethyst	<ul style="list-style-type: none"> Determine annual cost of treatment per household and per family member Determine annual cost of the project 	•				18-month project expenditure 10/1/2013 - 3/31/2015
Meta House	<ul style="list-style-type: none"> Identify total annual cost of project implementation Determine average cost per unit of service Explore potential cost savings of participation in residential treatment as compared to costs associated with potential negative consequences of continued substance use; examined scenarios - <ol style="list-style-type: none"> Poor pregnancy and birth outcomes Child welfare placement/out-of-home care Criminal justice system involvement 	•			•	12-month summary of project expenditure 1/1/2013 - 12/31/2013
Queen of Peace Center	<ul style="list-style-type: none"> Estimate total cost of the intervention by calculating direct service costs plus overhead costs Estimate average cost per family served Assess whether the intervention was cost effective in increasing protective factors, decreasing risk factors, optimizing child development, enhancing family strengths, and enhancing child permanency and safety 	•	•			6-month summary of project expenditure 9/30/2014 - 3/31/2015
Renewal House	<ul style="list-style-type: none"> Estimate per unit costs (associated with given time unit for a service) Compare estimated costs to actual project costs for a 1-year period Determine total cost per service category and participant (i.e., mother, children, and families) 	•			•	12-month summary of project expenditure 10/1/2013 - 10/31/2014

Grantees	Objectives	Analysis				Timeframe
		Cost Allocation	Cost Effectiveness	Cost Utility*	Cost Benefit	
Susan B. Anthony Center	<ul style="list-style-type: none"> Determine how staff time is spent on direct, indirect, and administrative tasks; income generating and non-income generating Determine estimated income from clinical staff to off staff/other costs Determine ratio of income generation to staff compensation 	•	•			4 one-week data collection intervals 1/1/2015 - 6/30/2015

*Cost utility analyses were not conducted by grantees.

Cost Study Data Sources and Timeframes

All grantees tracked project expenditures for direct services and indirect services. Services included in the cost analyses were specific to the local project; however, commonalities were also identified. In general, direct service activities require project staff members to have contact and engage with clients. For example, common direct service costs incurred by RFT grantees included costs for participant-level interventions (such as individual and family counseling), relapse prevention, and parenting education services. Indirect service activities were those conducted on behalf of the client (without participants' involvement) and include activities that support the project and its services. Common indirect service activities include organizational and administrative tasks, staff training, expanding resources, and evaluation activities. Direct and indirect costs that contributed to service delivery and were assessed in the cost analyses are summarized in Table 33: Cost of Services Examined in Grantees' Cost Studies.

Grantees described the services included in their cost studies with varied levels of detail. Amethyst, Meta House, the Queen of Peace Center, Renewal House, and Susan B. Anthony Center also included other types of cost data. For instance, Amethyst examined personnel and nonpersonnel direct costs. Personnel costs included client services provided by family counselors, family service coordinator, parent educator, engagement specialist, licensed practice nurse, family case managers, contingent babysitters, and some support staff (e.g., filing staff). Nonpersonnel direct costs included project supply costs, such as contingency management expenses, client activities, client meetings/gatherings, and expenses from outside project providers.

Meta House incorporated data from fundraising activities that included contributions from in-kind donations, grants, special events, corporate donations, major gifts, donations from the United Way, and in-kind specified assistance. The Queen of Peace Center included project overhead costs data that were not classified as either direct or indirect services, such as costs associated with nonclinical personnel (i.e., maintenance and kitchen staff); residential upkeep and maintenance; utilities for office space and residential space; office space for counseling and case management services; travel costs; consumable supplies (e.g., paper, postage); and nonconsumable supplies (e.g., computers, software, program vehicles). The Susan B. Anthony Center included administrative costs, such as billing, budgeting, committee meetings, data entry, human resources administration, maintaining the facility, payroll, staff meetings, trainings, travel time, donations, evaluation or research, report writing, supervision, intern activities, event activities, and residential services.

Table 33: Cost of Services Examined in Grantees' Cost Studies

Grantee	Direct Costs	Indirect Costs
Amethyst	<ul style="list-style-type: none"> • Personnel: Client services by family counselors, family service coordinator, parent educator, engagement specialist, licensed practice nurse, family case managers, contingent babysitters, and some support staff • Non-personnel: Project supply costs for contingency management, client activity, client meetings/gatherings expenses, and the expense of outside programming providers such as Local Matters 	<ul style="list-style-type: none"> • Staff training for client treatment programs • Training workbooks and materials
Meta House	<ul style="list-style-type: none"> • Client services by counselors, child and family therapists, consumer peer specialists, psychiatrists, and nurses • Furniture, food, and supplies • Residential space (e.g., client rooms, staff offices, group rooms) • Outside vendor services (e.g., urinalysis) 	<ul style="list-style-type: none"> • Administrative tasks by managers, clerical staff, evaluation staff, and maintenance staff • Administrative business expenses (e.g., audit and accounting expenses, insurance, equipment)
Queen of Peace Center	<ul style="list-style-type: none"> • Adult case-management services • Housing case-management • Assessment of client needs • Formal diagnosis procedures/testing • Provision of counseling/support • Life skills information/education • Parenting information/education • Transportation services • Case management for children of client • Therapeutic childcare 	<ul style="list-style-type: none"> • Clinical documentation • Consultation/collaboration • Locating resources • Management Information System data entry • Organizing meetings and committees • Outreach, marketing, engagement, and recruitment • Scheduling appointments on behalf of client • Staff member travel Treatment plan review
Renewal House	<ul style="list-style-type: none"> • Assessment services • Case management services • Direct care services (e.g., parenting groups, relapse prevention group) • Individual services (e.g., DBT, medication management) • Family services (e.g., Parent Child Interaction Therapy, Celebrating Families) • Children's program services (e.g., Al's Pals) 	<ul style="list-style-type: none"> • Operational oversight • Building maintenance • Clinical supervision • Department of Children Services (DCS) consultation • DCS staff training • Participating in DCS child and family team meetings

Grantee	Direct Costs	Indirect Costs
Susan B. Anthony Center	<ul style="list-style-type: none"> • Bio-Psychosocial assessment • Case management • Court appearance • Drug screening • Education sessions • Individual and family therapy • Intervention • Medication monitoring • Nursing services • On call phone • Outreach application • Parenting/Developmental classes • Peer support • Vocational classes 	<ul style="list-style-type: none"> • Administrative meetings • Advocating for clients with other agencies, courts, shelters, employers and others as part of case management • Clinical documentation data collection • Coordinating services, sustainability planning and implementation • Data tracking and entry specific to project implementation and evaluation activities • In-house and outside consultations to support holistic treatment program • Locating and tracking resources

Cost Study Results

The findings are summarized by grantees in the remainder of this section. Table 34: Key Case and Project Level Cost Findings highlights commonly reported findings, including average costs per participants served (i.e., women, children, family members); average lengths of stay in each residential family treatment project; and total operating costs incurred by projects.

Table 34: Key Case and Project Level Cost Findings

Grantee	Case Level	Project Level
Amethyst	Average participant cost <ul style="list-style-type: none"> • Per woman (N = 126): \$14,389 • Per family member (N = 251): \$7,223 Average Length of Stay <ul style="list-style-type: none"> • Per woman: 67 days • Per child: 60 days 	Operating costs (across all 3 years) - \$1,812,955 <ul style="list-style-type: none"> • Direct services costs: \$1,335,049 • Indirect services costs: \$477,906
Meta House	Average participant cost <ul style="list-style-type: none"> • Per woman (N = 155): \$17,300* • Per child (N = 42): \$5,800 Average Length of Stay <ul style="list-style-type: none"> • Per woman: 69 days • Per child: 60 days 	Operating costs (12 months only) - \$2,930,000 <ul style="list-style-type: none"> • Direct project costs: \$2,523,598 • Indirect costs: \$404,244
Queen of Peace Center	Average participant cost <ul style="list-style-type: none"> • Per individual served: \$2,377.95** Average Length of Stay <ul style="list-style-type: none"> • Per woman: Not specified • Per child: Not specified 	Operating costs (across all 3 years) - \$211,637 <ul style="list-style-type: none"> • Direct project costs: Not specified • Indirect costs: Not specified
Renewal House	Average Cost <ul style="list-style-type: none"> • Per woman (N = 56): \$5,480*** • Per child (N = 57): \$1,804 Average Length of Stay <ul style="list-style-type: none"> • Per woman: 118 days • Per child: 106 days 	Operating costs (12 month only) - \$542,991 <ul style="list-style-type: none"> • Direct service costs: \$493,628 • Indirect costs: \$49,363

Grantee	Case Level	Project Level
Susan B. Anthony Center	<ul style="list-style-type: none"> Not applicable (Case level data not reported.) 	<p>Income and non-income generating staff costs</p> <ul style="list-style-type: none"> Estimated income (billed services) for 20 staff that provided clinical and other services during the four weeks of data collection was \$93,586.31. Staff costs for staff that generated income (billable services) during the 4-week period were \$69,729.78. Staff costs of administrative and other non-billing staff were \$57,661.33. Total staff costs for the 4 weeks were approximately \$127,391.11. The income to cost ratio then shifts to 3:4, indicating the need to maintain other funding sources to cover staff costs.

*Average daily cost per family served: \$252.18 per woman and \$96.57 per child.

**Based on 89 individuals served: 43 women, 32 children, and 14 collaterals.

***Including indirect costs; \$4,982 if direct costs only.

Amethyst. Amethyst analyzed cost data based on project expenditures of direct and indirect services for personnel and nonpersonnel costs over the course of 18 months. Cost data were reported in dollars paid by the grant, cost in dollars paid from matching funds, the number of full-time and part-time employees, personnel costs for direct and indirect services, and direct nonpersonnel costs accrued from October 1, 2013, through September 30, 2015.

Amethyst calculated the total project costs, direct costs, and indirect costs through March 15, 2015. The cost per household and per family member was calculated based on 126 households and 251 residential family members. Direct and indirect project costs were tracked using Sage accounting software, and all financial information was recorded as expenses were incurred. Project costs were regularly monitored by the fiscal department and coded by the grant accountant. Personnel cost information was tracked by project staff members, and client service data were tracked using the ECHO software clinical records system. The federal portion and matching funds from Amethyst were also calculated for all project costs. Project expenses and figures for the federal and matching funds are reported in Table 35: Amethyst, Inc. Summary of Project Expenditures by Service Type and Cost per Household and Family Member.

Table 35: Amethyst, Inc. Summary of Project Expenditures by Service Type and Cost per Household and Family Member

Service Type	Overall Costs*	Cost Per Household	Cost Per Family Member
Direct	\$1,182,014	\$9,381	\$4,709
Indirect	436,543	3,465	1,739
Total Costs	1,618,557	12,846	6,448

*The federal portion of direct costs was \$856,768, and the Amethyst "match" amount was \$325,246.

Meta House. The cost study conducted by Meta House included two components: a cost allocation analysis to document the costs of providing residential treatment and a cost offset analysis to explore cost savings of residential treatment when compared to common costs incurred for families not served. Cost allocation analysis of year-end financial statements was conducted from independent auditor reports, based on staff time expenditure data.

Meta House determined the total operating budget of the project and its average costs per family served in 2013 (using the 2013 Consumer Price Index). The total operating budget included all project costs (direct costs), management costs (indirect costs) associated with providing the residential drug treatment project, and the value added via donated resources or in-kind contributions. The annual audit included data drawn from daily activity logs that were completed by all service providers and entered into Meta House's electronic health records system (in addition to administrative and accounting data). Direct and indirect costs were reported to reflect 2013 dollars. Annual audit reports documented six categories of both direct and indirect costs: salaries, wages, benefits, and payroll; outside vendors; room and board; business expenses; supplies and incidentals; and professional development. Based on this analysis, the total operating cost for the Meta House residential treatment project was \$2.93 million in 2013. Direct costs comprised 86 percent of the total, and indirect costs equaled 14 percent of the cost. Additional project costs were managed through in-kind contributions, such as donated materials and/or services (accounting for an additional \$23,000 in cost). The grantee-reported staff salaries, wages, and benefits represented the largest proportion of the costs to operate the project (i.e., 73 percent of the total cost, or \$2.14 million).

Meta House's cost offset analysis explored the potential cost savings of participation in RFT when compared to costs associated with the potential negative consequences of untreated/continued substance use. The data for this component of the study were obtained from a variety of local and regional secondary data sources whenever possible (e.g., area hospital pricing data, county and state budget numbers, etc.). Potential cost savings of project participation were determined by examining the costs associated with three alternative scenarios related to continued substance use.

1. Poor pregnancy and birth outcomes—Analysis estimated costs could vary from \$11,100 for a simple birth scenario to \$155,300 for more intensive needs. Additional costs for a more complicated delivery include, for example, preterm birth, opioid use, and/or need for neonatal intensive care.
2. Child welfare involvement—Costs associated with negative permanency outcomes (e.g., entry or prolonged placement in out-of-home care) were examined. Annual out-of-home care costs were estimated to range from \$9,718 to \$108,826. However, based on the limited available data, the identified costs are considered to underestimate the true costs of out-of-home care.
3. Criminal justice system involvement—Four possible scenarios of criminal justice involvement were generated for women who continued to use substances, ranging from a nonviolent criminal offense eligible for treatment alternatives and diversion to a major felony conviction. Estimated criminal justice costs could range from \$7,502 to \$59,070. Information was limited to known and available data and most likely underrepresents the full cost of handling these cases in the criminal justice system.

The analysis indicated the potential cost savings of residential treatment may be “substantial” as compared to the costs of poor birth outcomes, out-of-home care placement, and/or criminal justice involvement. The grantee also reported, given the limited availability of child welfare and criminal justice data, that it is likely the overall cost savings may be even greater.

Queen of Peace Center. The Queen of Peace Center conducted a cost analysis of 6-month project expenditures during the second half of grant Year 2. The objectives of the cost study were to estimate the total cost of the intervention by calculating direct service costs plus overhead costs; estimate the average cost per family served; and assess whether the intervention was cost effective in increasing protective factors, decreasing risk factors, optimizing child development, enhancing family strengths, and enhancing child permanency and safety. The cost study data were prospectively collected and data collection was completed by March 31, 2015.

The total cost of the intervention was calculated by adding direct-service costs and overhead costs. These costs were not included in the report, but the grantee reported the total funding amount received for the project. In addition, the average costs of service calculations were based on the total funding amount divided by the total number of individuals served. The total funding amount and average costs per individual served in the second half of Year 2 of the grant are summarized in Table 36: Queen of Peace Center Total Cost and Average Cost per Individual Served. Cost data to confirm whether the intervention was cost effective in improving child and family outcomes were not reported by the Queen of Peace Center.

Table 36: Queen of Peace Center Total Cost and Average Cost per Individual Served

Number of Individuals Served	Total Funding Amount	Average Cost Per Individual Served
89*	\$211,637.15**	\$2,377.95

* Includes 43 women, 32 children, and 14 collaterals.

**Total funding from ACF and Comprehensive Substance Abuse Treatment and Rehabilitation Services (CSTAR).

Renewal House. Renewal House conducted a time study focused on understanding the costs of specific services. The cost study was to produce an estimate of per unit costs (i.e., costs associated with a given time unit for a given service) and to compare the estimated costs to actual project costs over a 1-year period (October 2013 to October 2014). Similar to the other RFT grantees, Renewal House estimated total costs for adults (i.e., mothers), children, and other family members. However, these costs were first determined per service category, based on client participation in each service category, service minutes, and standard per unit costs for each service. Calculated costs were then used to estimate average cost per project participant. Renewal House staff categorized a majority (55 percent) of their time as case management services, while the smallest portion of their time was spent conducting family services (2.5 percent).

Renewal House served 56 mothers, 57 children, 24 offsite family members, and 12 alumni, and employed five DCS consultants over 1 year and 30 days (October 1, 2013, to October 31, 2014) at an estimated cost of \$542,990.91 including estimated indirect costs of 10 percent. From this total, adult clients accounted for \$375,273.05 and child clients accounted for \$40,034.05. Actual costs associated with the same time period were very close to the estimated costs. This cost analysis relied on the structure of available data during the grant period. A more complete understanding of the cost structure of the Renewal House Footprints Project awaits further analysis and additional exploration of indirect costs.

Susan B. Anthony Center. This time study began with time tracking from staff in units (15-minute intervals equivalent to standard billing time). Spreadsheets were used for tracking of direct/indirect costs and administrative costs. Whenever possible, the spreadsheets were populated with drop-down menus for consistent reporting. If, for example, the clinician saw a person served for an individual session, he/she might select “individual therapy” for the first 45 minutes under direct services and “documentation” for the next 15-minute interval. The time study included project codes (e.g., aftercare, residential); service

recipient codes (e.g., person served, child); location codes (e.g., community, home visit); encounter codes (e.g., in person, telephone); indirect service; direct service; and administrative codes. The time study data were collected on four separate weeks in 4 months. Each week selected was in different months (with different weeks in a month) to better capture routine variance, such as monthly staff meetings.

Analysis of findings was rudimentary at the close of the grant period and focused on unit cost by the average salary/benefits of staff types (administrative, clinical, medical, support, clerical, etc.). Thus, as reported by the grantee, a 45-minute therapy session/15-minute recording and other tasks will cost more per unit for a \$45,000/annual therapist than a \$30,000/annual peer mentor. A clinician and a support person (e.g., peer mentor or case manager) may do the same psychoeducational group, yet have a different unit cost. Accounting for this variability was necessary to estimate personnel costs related to serving families.

Cost findings were as follows for each of the questions of interest to the grantee:

1. On average across weeks, clinicians who billed for services spent 85.0 percent of their time providing billable services. Indirect services consumed the majority of the 15.0 percent remaining time, which included documentation (71.7 percent), clinical or other meetings (13.3 percent), and providing consultation to other staff (11.1 percent). It appears that clinical and other direct services providers have the time needed for service provision.
2. The estimated income (billed services) for the 20 staff who provided clinical and other services during the 4 weeks of data collection was \$93,586.31.
3. Staff costs for staff who generated income (billable services) during the 4-week period were \$69,729.78. This is approximately a 4:3 (income to cost) ratio. When adding in the staff costs of administrative and other nonbilling staff (\$57,661.33), the total staff cost for the 4 weeks is \$127,391.11. The income to cost ratio then shifts to 3:4, indicating the need to maintain other funding sources to cover staff costs.

Section 6: Conclusions

The Final Cross-site Evaluation Report of the 2012 Comprehensive Residential Family Treatment Projects documents that the five grantees successfully met the requirements of the grant and, as a result, were more effective in providing critical services to parents and children. As stated in the authorizing legislation,¹³ the purpose of the 3-year grant was to support RFT projects in expanding the availability of effective, comprehensive, residential treatment services for families involved, or at risk of becoming involved, in the child welfare system. Process and outcome data presented describe several areas of success as well as challenges that future projects may also encounter. In this section, the conclusions drawn are based on information gained from the five demonstration projects.

Key Findings and Implications

Addressing the Needs of High-risk Chemically Dependent Women and Their Children

Findings regarding the population, service models, interventions, and activities reflect the complex nature of RFT. A high-risk population of chemically dependent women was served, most with co-occurring mental health disorders, who had lost or were at risk of losing custody of one or more children. A majority had multiple areas of need, such as living at or below the poverty level, unstable housing or homelessness, acute and chronic health problems, histories of trauma and abuse, limited education, unemployment, and prior incarcerations. All of these factors placed mothers and their children at higher risk of involvement in multiple systems (i.e., child welfare, TANF, and criminal justice).

While most women served were single, family members were also provided access to services to further strengthen families. Children who lived with their mothers in the treatment program were predominantly preschool age or younger. However, additional children in guardianship arrangements were included among family members served. The children were at higher risk of physical and developmental conditions, including behavioral disorders, physical health and medical complications, and developmental delays. Fathers and other family members served (e.g., grandparents) were demographically similar to the mothers and often lacked access to necessary social and emotional supports.

Comprehensive Adult and Child Intervention Models and Services

Comprehensive programs were implemented in order to be responsive to the co-occurring needs of adults and children. In addition to addressing the needs of chemically dependent mothers, projects were intentionally designed to improve the safety and well-being of children affected by parental substance abuse and to promote permanency. Services offered addressed a wide range of adult, child, and family-level needs. Adult services included, but were not limited to, substance abuse treatment, mental health treatment, parenting skills building, education and employment services, and basic life skills development (e.g., household management). Wide ranges of child services were also provided, typically including health, developmental, educational, socioemotional, and therapeutic services (e.g., Parent/Child Interaction and play therapy). Family-level services were most often supportive, therapeutic, and recreational, and created opportunities for positive family interactions (e.g., Family Nights).

Evidence-based, promising, and best-practice service models accepted in both the substance abuse and therapeutic fields were implemented. These practices and the resulting outcomes were particularly effective, due to developers' long-standing understanding of the "culture of addiction and recovery,"

¹³ Fostering Connections to Success and Increasing Adoption Act of 2008 [Public Law 110-351].

issues of women with co-occurring trauma and drug use, high-risk children, and children challenged by diverse stressors. For example, grantees included several interventions that were guided by recommendations of SAMHSA and CSAT. In addition to being comprehensive, services provided were gender-specific, trauma-informed, and strengths-based. The combination of services provided to parents, children, and family members varied by grantee. However, common, core elements offered across projects included drug and alcohol counseling, mental health assessment and treatment, and parenting education.

Services were provided in a variety of drug- and alcohol-free groups and private housing settings (e.g., group homes and apartments), with families moving from more restrictive to independent settings, based on the mothers' progression from intensive to less intensive treatment. A key indicator of the grantees' ability to implement responsive residential treatment services was the amount of time participants were engaged in services (i.e., the number of days families remained in treatment) and rates of successful discharges. The treatment programs varied in structure and length (average lengths of service ranged from 85 to 630 days), making comparison of time in service difficult. However, rates of successful completion¹⁴ allowed for some level of comparison. Reported rates of completion ranged from 56 percent to 70 percent of women served.

Expanding Service Provision through Collaboration

As intended in the grant, the RFT projects succeeded in expanding capacity to meet families' needs by forming partnerships with key organizations, particularly child welfare agencies that were likely to be serving the same families. Cross-site evaluation of the activities and results found that by working in collaboration with local service providers, child welfare agencies, and community partners, the RFT projects improved system- and organization-level processes that were associated with improved client outcomes. Specifically, project leaders reported that the greatest benefit obtained from these collaborations was having a better understanding of one another's programs and services. This additional knowledge enabled grantees to bridge service gaps, improving their ability to link women and children to appropriate services in a more effective and timely manner, which may contribute to improved outcomes. Collaborative provision of services required strong communication between grantees and partners, buy-in at all levels, and a strong commitment to shared goals for families.

Promoting, Guiding, and Sustaining Effective Project Implementation

Implementation of services required ongoing outreach, engagement, and retention of the target population of substance-dependent mothers with children. Challenges were experienced in providing services to these unique, hard-to-reach families with the most substantial barriers being the covert nature of substance abuse, resistance to services, and lack of support systems that might enable parents to enter treatment (e.g., friends or relatives to act as alternative caregivers). Grantees found the most effective client engagement strategies to be forging positive relationships with the clients and families that included assistance with basic needs. Participation in services was maximized throughout the grant period via flexibility in program practices and adaptation of service delivery when appropriate to best meet clients' needs (e.g., expanding hours, providing transportation assistance, etc.). A majority of grantees planned to sustain these grant-funded services after the close of the funding period. The top services identified by

¹⁴ Grantees had differing definitions of "successful completion/discharge" based on their service structures. The majority of projects offered tiered levels of services, with several defining successful discharge as completion of more intensive treatment modes to outpatient day treatment, after-care treatment, or the end of individual- to family-focused treatment.

leadership as priorities to sustain included substance abuse treatment and education, parenting education, and counseling/mental health services.

Project Impacts on Adults, Children, and Families

The adult, child, and family outcomes across the projects were diverse, both within and between grantees, making it difficult to compare outcomes. Outcomes indicated some improvements, but small samples, lack of statistical significance, and lack of comparison groups made the findings generally inconclusive. However, based on the complexity of family residential treatment and the short duration of measurement, some positive trends were noted. The most successful adult outcome was abstinence from substance abuse over the course of treatment, and two grantees documented significant improvement at the 6-month followup.

Maintaining custody of the children also demonstrated a positive trend. A majority of women maintained custody of their children during treatment, and two grantees documented a majority of residents avoided child removal 12 months following admission to treatment. Reports of child maltreatment were generally low. For those women whose children had been removed, the rate of reunification was less than expected across several grantees. Other permanency outcomes, such as education, employment, or housing, showed minor improvement. Adult well-being outcomes were generally mixed across grantees. Positive outcomes included improved parenting skills, but maternal mental health outcomes varied. Child outcomes demonstrated improved relationships with the parent and increased self-confidence; however, improved birth outcomes for set benchmarks and decreases in emotional/behavioral and trauma symptoms remained elusive. Family outcomes improved, including positive family interactions or protective factors that impact family functioning.

Organizational and System-level Change

The projects yielded impacts beyond the individuals served, prompting outcomes related to organizational and system-level change. New evidence-based practices were successfully integrated into the service array for training staff members and use by project partner agencies. The referral processes were improved through enhanced communication activities with caseworkers or increased collaboration among referring organizations.

Improved collaboration and coordination among grantees and project partners were critical for project implementation. Frequent communication, trust in one another's knowledge, and shared commitment to serving families contributed to reinforcing existing relationships and contributed to new ones. Staff turnover was the main challenge, as it delayed or decreased the quality of services and impeded collaboration and coordination within projects or between project partners. Policies and procedures were modified around service delivery, quality assurance, and cross-system implementation.

The level at which elements of the comprehensive model were integrated into the child welfare agencies' or the project partners' service delivery systems varied. According to the child welfare agencies, improving staff's knowledge about the alcohol and drug issues of clients served and related treatment options, expediting alcohol and drug assessments, and providing treatment to clients and their children in residential settings were among the most important accomplishments. Child welfare practices were impacted by engaging a unique and difficult-to-treat population, expanding treatment options, and integrating service delivery systems through collaboration. This resulted in reduced maternal substance use, maintenance of the family unit during treatment, and improved family functioning and well-being.

Cost Study Impact

Cost studies were included in local evaluations in order to determine the costs to provide RFT to women and children. Analyses of costs were conducted at the project and case levels. At a minimum, each of the projects completed a cost allocation analysis. Information gained through these analyses included the cost of project services per adult, child, and family or by type of services provided. Costs of activities and services over time were also examined based on participants' average length of stay, which provided additional context for understanding service costs. Four of the five grantees included more advanced analyses in their studies. One grantee conducted a project-level cost effectiveness analysis that compared the amount of time staff spent on income-generating versus nonincome-generating tasks. At the case level, cost effectiveness was used to assess whether residential treatment intervention was effective in improving child and family outcomes. Cost benefit analyses examined potential cost savings of participation in residential family treatment when compared to the costs associated with negative consequences for women and children associated with continued substance use (e.g., poor birth outcomes, placement of children in out-of-home care, and criminal justice system involvement).

Information gained from the analysis of project expenditures was beneficial at the individual grantee levels. Cost study data were used to inform local project administrators, key project partners, and future partners and funders. However, cost findings were not comparable across grantees, due to differences in their projects' structures and varying cost analysis designs.

Summary

Findings from the Cross-site Evaluation of the 2012 Comprehensive Residential Family Treatment Projects indicate that grantees achieved the objectives of the 3-year grant, expanding the base of services available to chemically dependent women and children at high risk for involvement in the child welfare system. Partnerships established with child welfare agencies, community organizations, and local service providers enabled grantees to respond to the complex needs of adults and children impacted by multiple risk factors. As previously noted, services are in short supply due to their costs, complexity, and potential resistance of families who do not want to leave their current residence. However, these services are often the most effective resources for parents with co-occurring substance use and mental health disorders. Most importantly, comprehensive child and family services implemented by the grantees provided secure and supportive environments to mothers and children that contributed to improved safety, well-being, and permanency.

Grantee Recommendations

Recommendations and lessons learned from the 2012 grantees address future projects, the Children's Bureau, and the larger child welfare community.

Recommendations to Future Projects

- Open, consistent communication across organizations and systems was the most frequently cited recommendation for effective services across projects. Ensuring effective communication between leadership, service providers, partners, and evaluation teams was the key to successful implementation and outcomes. Staff capacity for positive, family-centered interactions with the service population were also recommended.
- Collaboration and cross-system implementation provided additional experiences in understanding the perspectives of mothers in treatment and assisted in further development of

an integrated service delivery system. Collaboration provided new opportunities for partnerships and increased family engagement in services, due to increased support provided by coordinated services. Relationships between projects, partners, evaluators, and child welfare agencies would be improved with fewer staff turnovers.

- Service recommendations focused on providing comprehensive, trauma-informed interventions that address both adult and child-level needs. Flexibility is particularly important in providing services to this high-risk population of women and children. Services provided should reduce barriers to families obtaining assistance (e.g., transportation and childcare). Direct service providers, such as caseworkers and managers, also emphasized that the approach to working with families should be respectful, supportive, and responsive to individual and family needs.
- Establishing a recruitment and retention plan with special emphasis on aftercare was a specific service recommendation. Regarding recruitment, ensure that all Memorandums of Understanding are actionable and all referring partners understand the project goals and implementation strategies. For retention, begin contact planning, incentives, and followup processes (including data collection) approximately 2 months prior to discharge.
- Evaluation recommendations included to provide written protocols for data collection, data entry, and support to ensure quality data; simplify evaluation designs; limit secondary data due to lack of access; ensure ease of access to families; and review specific plans with staff regarding data collection and followup for comparison or control groups.
- Shared, electronic data systems (specifically, electronic health records) were recommended to facilitate data collection and reporting. Using data for implementation support and evaluation, as well as budget and expenditures, allows for timely decision making and effective leadership.

Recommendations to the Children’s Bureau

- Increase the grant period from 3 years to 5 years to allow for changes and recommendations to be tested and more fully implemented.
- Mandate a 12-month followup process for mothers who complete a program to assess the longevity of treatment gains.
- Schedule project quarterly calls to problem-solve issues, provide project updates, or share practices benefiting projects.

Recommendations to the Larger Child Welfare Community

- Training around trauma-related issues and ensuring that services are trauma-informed are crucial to child welfare. Routinely emphasize the importance of understanding the impact of trauma on mothers and children, as well as the collective impact on families. Also, understand and address the impact of secondary traumatic stress on staff.
- Further understanding of family functioning and how it is affected by substance abuse, mental health, trauma, poverty, and other factors would greatly benefit the child welfare community.