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Oregon's IV-E Waiver Demonstration Project: Final Evaluation Report

Relationship-Based Visitation & Parent Mentor Evaluations

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Introduction & Report Overview

The Center for the Improvement of Child and Family Services at Portland State University was contracted by the Oregon Department of Human Services, Child Welfare Division to conduct the evaluation of the Title IV-E Waiver Demonstration Project. The project was funded by the U.S. Department of Health and Human Services, through the Children's Bureau. Oregon's IV-E Waiver Demonstration involved the implementation and evaluation of two innovative service models for families involved in the child welfare system: (1) Relationship-Based Visitation (RBV); and (2) Parent Mentoring (PM). Relationship-Based Visitation (RBV) was provided in 13 Districts and 29 counties; Parent Mentoring was provided in 4 Districts and 7 counties. RBV services were offered to families with children ages 0-12 who were in an out-of-home placement. The model provided an intensive parent coaching model, based on the evidence-based Nurturing Parenting Program (NPP, Bavolek, McLaughlin, & Comstock, 1983; See also: www.nurturingparenting.com) and was delivered during parent-child visitation by contracted (non-DHS) providers. Parent Mentoring employed peer recovery coaches to support parents with substance abuse issues whose children are either receiving in-home or out-of-home services through child welfare. Parent Mentors, who were typically parents who were in their own recovery and who have experience with the child welfare system, utilized a relationship-based, parent-directed, outcome-oriented approach to working with DHS clients to help them sustain their own recovery and successfully retain or regain custody of their children.

This report provides the results of the comprehensive process and outcome evaluations for both RBV and PM services, as well as the results of a cost analysis for both programs. For ease of presentation, the cost analysis methodology and results for both models are presented in a separate section at the end of the report.

Relationship Based Visitation Evaluation

Program Description

Standard visitation services for Oregon's child welfare clients usually take place in a Department of Human Services (DHS-child welfare) office for an hour a week with minimal guidance and direction to parents in improving their parenting skills or interaction with their child. The RBV model was designed to provide parents with an additional and enhanced visit with their child(ren) that included parent education and coaching based on an evidence-based parenting education program. Eligible families were identified and referred for RBV services within 30 days of having a 0-12 year old child entering foster care. Families remained eligible to engage in RBV services as long as their child welfare case remained open.

RBV focused on nurturing a healthy parent-child relationship and facilitating the development of empathic parenting through the use of an evidence-based parent training program called Nurturing Skills (NS). NS is one of the Nurturing Parenting Programs (NPP) developed by Dr. Stephen Bavolek (Bavolek, McLaughlin, & Comstock, 1983; See also: www.nurturingparenting.com). Nurturing Skills programs are commonly used with families whose children live in the home with their parents. While the program has been offered to child welfare clients in previous studies, it has never been provided on a one-on-one basis in a parent-child visitation setting. Due to these novel conditions, for this project, PSU staff worked with Dr. Bavolek and Family Development Resources staff (the distributor for NPP programs) to adapt the NS curriculum for use in one on one sessions with child welfare clients whose children are in foster care. This resulted in the printing of a special curriculum – Nurturing Skills for Oregon Families (NSOF) – for this project.

The RBV program model included the following session structure:

1. A parent coach/educator spent at least 30 minutes in one-on-one time with a parent reviewing a lesson from the NS curriculum
2. 60 – 90 minutes of parenting time (i.e., a parent-child visitation) during which the parent engaged in activities and practiced specific skills associated with the lesson. During this time the coach provided feedback, suggestions, encouragement, etc. as appropriate and needed.
3. The parent coach/educator spent 15 minutes debriefing the visitation with the parent and engaging the parent in planning for the next lesson and visitation.

RBV sessions were conducted, whenever possible, outside of the DHS office, usually at the provider's agency or a community setting (e.g., a church or other community building used by the provider) until the caseworker approved sessions being held in the parents' home. If a child was returned home while their parents were still engaged in RBV services, sessions continued as planned and were conducted in the parent home and adapted to accommodate the presence of the child throughout the session. The RBV model required that at least 2 sessions be conducted in the parent's home after the child was reunified.

Nurturing Skills for Oregon Families has a flexible structure that allowed providers to ensure the specific needs of families were met. Needs were identified via the child welfare assessment conducted by the child welfare caseworker, as well as through administration of the Comprehensive Parenting Inventory (CPI) comprised of 2 standardized measures developed by Stephen Bavolek - the Adult-Adolescent Parenting Inventory (AAPI-2) and Nurturing Skills Competency Scale (NSCS) - and consultation with the parent(s). The RBV service provider and parents worked together to create a Family Nurturing Plan (FNP) by selecting lessons from the NSOF curriculum based on identified needs. The FNP determined the number and sequence of the lessons and the length of the program for each family. For this project a minimum of 16 sessions was required for each family, although in most cases families needed more than 16 sessions to successfully complete the program and acquire the core competencies and skills. Pre-post administration of the CPI allowed parents and staff to measure strengths and deficiencies and changes in parenting attitudes, family life, knowledge and utilization of Nurturing Parenting practices, and provided a source of data for the evaluation.

Evaluation Questions

The evaluation of the RBV program addressed both process and outcome questions that were derived from the RBV Project Logic Model (see attached, Appendix A), and which are detailed below.

Process Evaluation Questions

Process questions focused on key areas of the RBV programs thought to be most important to program success, and included the following:

1. *Fidelity:* To what extent were RBV services implemented with fidelity by contracted providers?
    a. What were the barriers and facilitators of implementation to fidelity?
2. *Collaboration:* To what extent do caseworkers and RBV service providers collaborate to share information about the parents' service needs, progress, and outcomes?
    a. What factors facilitate successful information sharing and collaboration between DHS caseworkers and RBV service providers?
3. *Visitation Best Practice:* To what extent and in what ways were RBV visitation services different from standard visitation? (e.g., Are parents who receive RBV visits more satisfied with visitation than parents receiving visitation as usual? Do RBV visits align with "best practices" in visitation derived from the current literature on effective visitation? Do RBV parents receive more frequent visitation than parents receiving visitation as usual?
4. *Parent Involvement and Engagement:* To what extent do parents actively engage in and complete the RBV program? To what extent and in what ways were parents involved in developing their parenting goals in the RBV programs? What factors help parents be more involved and engaged in working towards their parenting goals? What factors impeded parents' ability to successfully engage in services?

5. *Foster Parent Involvement:* To what extent are foster parents involved in supporting parents' visits with their children? What factors facilitate or impede foster parent involvement? Do foster parents and RBV parents have opportunities to exchange information about the child before or after the visits?
6. *How do these implementation and fidelity factors relate to outcomes?*

Outcome Evaluation Questions

The outcome evaluation included questions related to both shorter term outcomes (primarily related to changes in parents' attitudes, skills, and behavior) as well as longer-term child welfare outcomes.

Intermediate (Parent-Level) Outcomes. The following intermediate outcome questions were addressed in this study to examine the changes in parental attitude, behavior, knowledge and experiences that were hypothesized to lead to changes in child welfare outcomes:

1. Do RBV parents report more positive *parenting attitudes* after participating in the RBV program, compared to parents who received visitation as usual? Specifically, do RBV parents have:
    i. More appropriate expectations for children
    ii. More parenting empathy
    iii. Reduced endorsement of corporal punishment as a discipline strategy
    iv. A more positive understanding parent/child family roles
    v. A more positive understanding of how to support children's autonomy
2. Do RBV parents report more knowledge of positive parenting practices after participating in the RBV program, compared to parents who received visitation as usual?
3. Do RBV parents report using a higher frequency of positive parenting skills after participating in the RBV program, compared to parents who received visitation as usual.
4. Do RBV parents report lower levels of parenting stress compared to parents who received visitation as usual?
5. Do RBV parents report more supportive family and social relationships compared to parents who received visitation as usual?

Longer Term Child Welfare Outcomes: If hypothesized changes in intermediate outcomes are achieved, and in particular if parenting issues are the primary reason for the family's DHS involvement, we would in turn expect child welfare outcomes to be more positive. In particular, we addressed the following longer term outcome questions:

a. Do RBV children spend less time in foster care, compared to children whose parents received visitation as usual?
b. Are RBV children reunified more often, and more quickly, compared to children whose parents received visitation as usual?
c. Are RBV children less likely to come back into DHS supervision, compared to children whose parents received visitation as usual?

Outcome Moderators: What parent characteristics may moderate program effectiveness? Based on discussions with the Nurturing Skills program developer and on previous research, we examined the influence of each of the following variables on longer-term child and parent outcomes:

a. Parental substance abuse
b. Parental depression
c. Presence of intimate partner violence in the home
d. Parental readiness to change parenting practices
e. Previous DHS involvement

Study Overview

Parents with new DHS cases were eligible for RBV services if they had at least one child under the age of 13 in out-of-home placement. All DHS clients eligible for RBV were randomly assigned to either visitation as usual, or to referral to RBV services (intent-to-treat design). Data for the outcome study was collected on all participants from the DHS administrative database, OR-Kids, as well as from standardized pre and post assessments administered by contracted providers for the treatment sample. Additional outcome data were collected from a subsample of participants in the intervention and control groups who participated in telephone interviews conducted by the research team. Telephone interviews occurred at baseline (within 30 days of enrolling in the RBV program) and 9 months after enrollment.

The program fidelity component of the study examined the level of consistency and integrity with which the planned Relationship Based Visitation program was implemented in each of the sites. Level of adherence to the RBV model was assessed using the following types of data: service delivery data collected by contracted providers of RBV, observation of RBV sessions, case file reviews with fidelity checklists, and interviews with providers, caseworkers and parents.

RBV Evaluation Methodology

Outcome Evaluation Study Recruitment & Samples

There are three primary sources of data for the outcome component of the study:

1. **Administrative Data Outcome Sample** – including all eligible children who were randomly assigned to the RBV or Control groups and for whom outcome data were collected from Oregon's administrative data system, known as ORKIDS;
2. **Parent Interview Sample** – a subset of RBV and control group parents, recruited starting in December 2013, who: (a) signed a consent for release of contact information allowing PSU researchers to contact them and invite them to participate in a series of interviews; and (b) who could both be contacted and agreed to participate in the study.
3. **RBV Program Participant Sample.** In addition to the two primary samples described above, subgroup analyses were conducted to examine child welfare (administrative data) outcomes for families who were enrolled in RBV (compared to those randomized

to RBV but not enrolled and the control group). RBV participants also have additional data collected by RBV providers using standardized assessments of parenting-related outcomes. Comparisons within the RBV program group (pre-post) were conducted to examine change over time on these assessments. Additionally, we collected these same assessments for a subgroup of control group parents through the parent interviews described above to allow a quasi-experimental comparison on these outcomes.

The recruitment process and final sample size and characteristics for these groups of study participants are described below.

Administrative Data Outcome Sample

Identification & Random Assignment Methodology

Study identification and recruitment took place starting in June, 2012, and continued through September 30, 2014. Program services continued until March 30, 2015. All clients who were screened and determined to be eligible for RBV services were assigned to either the intervention(RBV) or the control group (visitation as usual). Eligibility for RBV services was determined by the following steps and criteria.

1. Every two weeks, PSU was sent a list of "potentially eligible" cases that was automatically generated from the DHS data system (known as "OR-Kids"). This report included all families with at least one child who was: less than age 13 years old, who had a new removal during the study period, and who had been in care for at least 14 days and no more than 30 day. This information was then uploaded by PSU into an on-line, secure database.
2. The database then generated an automatic email to the DHS branch liaison for RBV, informing them that there are cases awaiting additional screening.
3. Caseworkers or other identified staff then sought additional information to determine eligibility. First, the caseworker identified the adult(s) in the family who would be the target for RBV service (referred to as the "focus adult"). The focus adult had to be approved to safely participate in visits with their children outside of the DHS branch, and must have had an identified need for parenting services as a part of their case plan. Once this information was collected, it was entered by the DHS RBV liaison into the on-line RBV random assignment and tracking system (Randomizer & Participant Management System, or RPMS) and if the client was eligible, they were entered automatically into the random assignment module.
4. Following random assignment, if a focus adult had been assigned to the RBV group, the caseworker contacted the family to obtain their release for a referral to be made to the RBV provider. RBV providers were notified when a family was referred so that they could begin outreach and scheduling of an initial appointment.

The original research plan called for 1-1 assignment of potential participants to the two groups; this ratio was occasionally altered in response to case-flow issues in local programs. All clients

identified as eligible and submitted to random assignment are included in final outcome analyses (intent-to-treat design).

Final Administrative Outcomes Sample & Sample Characteristics

Final Participant/Case Flow Information for RBV is as follows:

1. **Initial Eligibility**: 2,443 initially eligible focus children (cases) were identified in OR-Kids reports and distributed to DHS for further screening.
2. **Secondary Screening**: 2,443 (100%) of these initially eligible focus children (3,104 parents) went on to have their secondary case eligibility determination.
3. **Eligibility:** Of the 3,104 parents, 2,026 were found to be eligible (65%) and randomly assigned. A small number of parents were associated with more than one case, resulting in a de-duplicated count of 2,018 parents.
4. **Random Assignment**: Of the 2,018 randomly assigned parents, 993 (49%) were randomly assigned to the RBV intervention group.
5. **Referral to RBV Services**: Of the 993 parents randomly assigned to receive RBV services, DHS made a referral for 737 (74%) parents.
6. **Intake:** Of the 737 RBV parents randomly assigned AND referred, 511 (69%) completed an intake with an RBV provider. A large proportion of families, however, including 403 adults (41% of randomly assigned to RBV) were exited from the referral process before completing an intake, some before being referred. This occurred most frequently because the child was returned home before the RBV provider could make contact or because the RBV provider was unable to engage the parent.
7. **Exits:** 201 (39% of those who initiated services) parents successfully completed the program (defined as completing the Family Nurturing Plan, being reunified with children, and completing at least two post-reunification visits).

The table below shows the final targeted study enrollment for the total study (based on counts of individual parents de-duplicated if parent was associated with more than one case, *n*=5), as well as the original targets for RBV service enrollment.

Summary of Study and Program Enrollment: At the end of the random assignment and program intake phase, the final sample is as follows:

2,018 parents were randomly assigned; 993 to RBV and 1025 to the control group. Of the 993 parents randomly assigned to RBV, 74% were actually referred to RBV services. The remaining families were either: (1) never referred for an unknown reason; (2) child was returned home prior to referral; or (3) parent could not be located to obtain consent for referral to the program. Our original targeted **study sample** size was 1,662 total participants was therefore exceeded.

Of the 737 parent referred to RBV, 511 had an intake for services (69% of referred). The primary reasons for families not having an intake are: (1) family could not be located/contacted to offer services; (2) family did not show up for intake appointments; (3) family declined to

participate. Thus, our original targeted program sample size of 831 participants was not met. Further, 41% of those randomly assigned to receive RBV services never actually received the program, likely contributing to reduced power to detect effects between the program and control group using an intent-to-treat design.

Table 1-1. Final RBV Study and Program Enrollment.

DHS Branch	Total Target Study Enrollment TX & Control	Final Study Sample Size (Number Randomized)	Randomly Assigned to RBV thru 3/31/15	Referred to RBV by DHS (% of randomly assigned)	Program Enrollment: Intake completed by RBV program (% of referred)	% of Randomly Assigned to RBV who Entered RBV Service
D1: Clatsop, Columbia, Tillamook	78	140	60	36 (60%)	30 (83%)	50%
D3: Marion, Polk, Yamhill	408	342	182	140 (77%)	114 (81%)	63%
D4: Benton, Lincoln	48	73	45	27 (60%)	13 (48%)	29%
D5: Lane	270	299	135	89 (66%)	75 (84%)	56%
D6: Douglas	78	120	41	41 (100%)	19 (46%)	46%
D7: Coos, Curry	96	75	41	37 (90%)	21 (57%)	51%
D8: Josephine, Jackson	132	252	116	108 (93%)	56 (52%)	48%
D9: Gillam, Hood River, etc.	48	57	32	22 (69%)	17 (77%)	53%
D10: Crook, Deschutes, Jefferson	84	109	52	47 (90%)	23 (49%)	44%
D11: Klamath, Lake	66	91	45	31 (70%)	26 (84%)	58%
D13: Baker, Union, Wallowa	48	29	19	18 (95%)	16 (89%)	84%
D15: Clackamas	120	243	124	57 (46%)	49 (86%)	40%
D16: Washington	186	188	101	84 (83%)	52 (62%)	51%

DHS Branch	Total Target Study Enrollment TX & Control	Final Study Sample Size (Number Randomized)	Randomly Assigned to RBV thru 3/31/15	Referred to RBV by DHS (% of randomly assigned)	Program Enrollment: Intake completed by RBV program (% of referred)	% of Randomly Assigned to RBV who Entered RBV Service
Statewide:	**1,662**	**2,018** **121%** of target study enrollment	**933**	**737** **74%** of randomized to RBV	**511** • **69%** of referred • **61%** of targeted RBV **program** enrollment[1]	**55% of those randomly assigned to RBV group entered RBV service**

Parent Interview: Data Outcome Sample

Parent Interview Identification and Recruitment Methodology

A subsample of parents were recruited during a defined period of time (January 2013 to September 2014) to do telephone interviews for a more in depth outcome evaluation. Telephone interviews took place within 90 days of assignment to either the intervention or control group (baseline) and again beginning 8 months after assignment. In order to recruit these parents the following protocol was followed:

1. Prior to random assignment, caseworkers were instructed to ask all eligible parents to consent to PSU receiving their contact if they are randomly assigned to either the intervention or control group. Those who consented to contact by PSU and were assigned to either the control group or intervention group during the interview recruitment period comprised the eligible interview pool.
2. An advance mailing to parents in the eligible pool included a cover letter describing the project and inviting them to participate in the interview, 2 consent forms and a prepaid return envelope to PSU. Control group parents also received instructions to complete the AAPI and NSCS assessments online if they preferred, in order to shorten the length of the phone interview. RBV providers administered the AAPI and NSCS to intervention group parents at Intake and at completion of the RBV service, so their interviews with PSU were shorter. A few days after mailing the packet, a PSU researcher began the process of attempting to contact the parent by phone to invite them to participate in the interview and to answer any questions they may have.
3. Parents in the intervention group were offered $80 in Fred Meyer gift cards ($40 for each interview) and parents in the control group were offered $120 in Fred Meyer gift cards ($60 for each interview). Control group parents were offered larger incentives because of the longer interviews they were asked to complete (with the AAPI and NSCS). Parents located in areas of the state where there were no Fred Meyer stores were offered the equivalent in Safeway or Walmart gift cards.
4. Attempts to contact parents by phone were made at least 10 times before they were dropped. Attempts were made to acquire up to date contact information from DHS if needed.

[1] Assumes 50% of targeted study enrollment (1662/2=831)will be enrolled in RBV services.

5. Follow up contacts were made starting 8 months after a parents' random assignment date using the same process of sending packets to parents who had completed a baseline interview. More intensive efforts were made over an extended period of time (up to 12 months after random assignment) to contact parents for follow up interviews (e.g., more attempts to contact, contacting alternative contacts who would likely know how to reach them provided by parents at their baseline interview) in order to administer as many follow-up interviews as possible to those who had completed baseline interviews.

A final baseline sample of n=307 parents (158 RBV, 145 control) were interviewed at baseline (within 90 days of random assignment). Our original target sample size for parent interviews was n=400, thus we did not reach this target. We received a total of 680 eligible "consent to contact" authorizations from DHS; of these, 113 were dropped from the parent interview study because their contact information was incomplete or out of date, and another 65 were dropped because they were incarcerated, in treatment, or their location could never be verified. Of the remaining 502 parents, 307 were interviewed or completed at least a partial interview (61.2%) and 178 (34.4%) were not interviewed. Reasons for not completing interviews were as follows: Refused consent (64, 37% of attempted); Passive refusal (79, 46% of attempted); or other reasons/no reason given (30, 17% of attempted). Passive refusals included all parents who were contacted at some point but refused multiple attempts to re-contact and/or who scheduled interviews but repeatedly failed to keep interview appointments. Neither refusal nor passive refusal rates differed significantly for RBV program participants compared to controls.

Follow up interviews were designed to capture outcomes nine months following initial random assignment, and were completed with 227 participants (117 RBV, including 85 RBV participants and 32 randomly assigned to the treatment group who never enrolled[2], and 110 controls). Follow up interviews were attempted with all parents who completed baseline Parent Interviews. The instrument was designed to capture key outcomes using quantitative measures as well as qualitative information about parents' experiences with visitation (RBV visits or visitation as usual). Of the 303 parents for whom follow up interviews were attempted, 227 (74.9%) completed or partially completed the follow up interview. Of those who could not be contacted and interviewed at follow up, 2.8% refused, 41% were considered passive refusals (e.g., contact information appeared to be accurate but parent would not respond or repeatedly rescheduled); 52% had disconnected phones and/or their location could not be confirmed.

Final Parent Interview Study Sample Characteristics

Table 1-2 below shows the demographic and other characteristics for the 195 families who comprised the final interview sample (families with baseline and follow up interviews, including RBV families with intake, n=85; comparison families n=110). Because these samples were not random samples of participants, we conducted baseline equivalency analyses (t-tests for

[2] These families were ultimately dropped from the analysis as the parent interviews were meant to focus and understand the effects of RBV services specifically, rather than test an intent to treat model.

continuous variables and Chi-Squared analyses for categorical variables) to compare the treatment and control groups at baseline on demographic characteristics as well as on baseline parent interview measure scores (Table 1-2 below).

As can be seen, there were a few significant differences between treatment and control participants at the time of the baseline interviews. In terms of demographic characteristics, RBV families were somewhat more likely to be in lower income bracket, compared to comparison families. Comparison families were also somewhat more likely to be categorized as "unknown" in terms of the child's race/ethnicity. Variables that indicated baseline differences between groups were used as controls in subsequent outcome analyses.

Table 1-2. Parent Interview Sample Characteristics (n=195).[3]

	Treatment % or mean (total n=*85*)	Control % or mean (total n=*110*)	Test Statistic	p-value	Alpha (reliability)
Gender – female	82.4% (85)	80% (110)	X^2= 0.17	.68	NA
Race/ethnicity:	(84)	(109)			
White	84.5%	74.3%			
African American	3.6%	0%	Cramer's *V*	.02	NA
Hispanic	7.1%	9.2%	= 0.25		
Native American	3.6%	6.4%			
Other/Unknown	1.2%	10.1%			
Average age at interview	31.7 (84)	31.9 (109)	*t* =-442	.66	NA
% No partner (single, separated, divorced, widowed)	71.4% (84)	71.6% (109)	X^2 = 0.00	.98	NA
% Did not graduate HS	45% (80)	39.8% (108)	X^2 = 0.51	.48	NA
% Unemployed or retired	74.4% (82)	78.9% (109)	X^2 = 0.54	.46	NA
Number of children	3.0 (84)	2.9 (109)	*t* = 0.13	.89	NA
Family Income	(72)	(103)			
< 15K	86.1%	70.9%			
15-25K	2.8%	20.4%*	Cramer's *V*	< .01	NA
26-40 K	5.6%	6.8%	= 0.33		
40-60K	5.6%	0%			
Over 60K	0%	1.9%			
HITS-% above cutoff for DV	20% (14)	18% (16)	X^2 = 0.44	.81	NA

Process Study Recruitment & Samples

A variety of different stakeholders participated in aspects of the process evaluation component. These samples are summarized in Table 1-3 below. Additional methodological details about the components follow this table.

[3] Sample sizes for individual variables may differ due to missing data.

Table 1-3. Summary of Respondent Types and Sample Size for Process Study Components

Process Study Data Collection Method	Time Point	Respondent Type & Sample Size
Interviews with RBV program leadership	Year 1	15 program directors, 14 supervisors
	Year 3	14 program directors 14 supervisors
Interviews/Focus Groups with RBV Staff	Year 1	28 coaches
	Year 3	31 coaches
DHS-RBV Liaisons	Year 2	17
DHS Branch Managers	Year 2	14
Caseworkers	Year 2	26
Social Services Assistant (SSA)/Visit Supervisors	Year 2	19
DHS Central Office	Year 2	3
RBV Visit Observations	Year 1	18
	Year 2	16
RBV case file reviews	Years 1 & 2 (total)	128
RBV Provider Survey	Year 1	89
	Year 2	39
	Year 3	37

Measures & Data Collection

Administrative Outcomes (ORKIDS data)

All children associated with cases that were randomly assigned to either the treatment or control group were included in the administrative outcome sample (intent-to-treat). Through a data-sharing agreement between PSU and DHS, administrative child welfare records were available for all participants. Using these records, the following outcome variables were created:

1. Number of days spent in out of home placements (total)
2. Whether child spent time in relative care
3. Whether child spent time in non-relative care
4. Whether child had a placement occurring after a trial reunification
5. Number of days from random assignment to first trial reunification
6. Whether child had a placement episode with a "reunified" disposition

Table 1-4 below provides the specific operational definitions for each of these outcomes.

Table 1-4. Operational definitions for administrative child welfare outcomes.

Outcome	How it was calculated
Days in foster care	Using foster care placements that occurred on or after randomization, we calculated the total number of days in foster care (including time spent in trial reunification). If placement started before randomization, data of randomization was used instead of placement start date. We excluded children who were still in care at the end of the

Outcome	How it was calculated
	study window (1,184 children, or 40.1% of the 2,949 children who were in foster care post randomization).
Time to first trial reunification	The sum of the total number of days in foster care placements, calculated through the first foster care placement end date that occurred post-randomization and resulted in a trial reunification. For placements starting before randomization date, we substituted randomization date for placement start date. Excludes children who had not had a trial reunification after being placed in foster care by the end of the study window.
Ever reunified	We created a variable (0=no/1=yes) indicating whether the child had any foster care episode that ended after randomization date with a discharge status of "reunification."
Ever in relative care	Using foster care placement data, created a variable (0=no, 1=yes) that indicated whether child ever had a relative placement. Excluded children who were not in foster care post-randomization.
Ever in non-relative care	Using foster care placement data, created a variable (0=no, 1=yes) that indicated whether child ever had a non-relative placement. Excluded children who were not in foster care post-randomization.
Re-report	Using maltreatment report data, created a variable (0=no, 1=yes) that indicated whether there was at least one founded report made after the random assignment date.
Re-removal	Using foster care episode data, we created a variable (0=no, 1=yes) that indicated whether there was any new foster care episode that started after a post-randomization foster care episode that ended in reunification.

Parent Interview Measures

The baseline parent telephone interview was comprised of the following measures (see Appendix B). In addition, for control parents only, we administered the Comprehensive Parenting Inventory (AAPI and NSCS, skills subscale only) so that comparison data would available on these measures (collected from RBV participants at enrollment and discharge from the program). With the exception of the REDI, the HITS, and the Substance Abuse Screening Instrument, all measures were included at both baseline and follow up.

1. ***Protective Factors Survey (FRIENDS National Resource Center, 2005).*** The protective factors survey was used to assess three domains of parenting and family relationships expected to change as a result of the RBV program, as well as two indicators of social support: (1) family functioning/resiliency (5 items); (2) nurturing and attachment (4 items); (3) Parenting practices (6 items); (4) social support (3 items); and (5) concrete support (3 items). The PFS is a reliable and valid measure that has been shown to be sensitive to program effects.
2. ***Parenting Stress Index, Short Form (Abidin, 1995).***The PSI is a reliable and valid measure of parenting stress. We administered four subscales: Parent-Child Dysfunctional Interactions, Parent Perceptions of Child, and Parenting Distress (general and parenting specific), a total of 23 items.
3. ***Patient Health Questionnaire-9 (PHQ-9, Kroenke, Spitzer, &Williams, 2001).*** The PHQ-9 was used to measure depressive symptomatology at baseline. This is a widely used,

validated screening tool for identifying persons who may be clinically depressed consisting of 9 items derived from DSM-IV depression indicators.

4. ***HITS (Hurt-Insult-Threaten-Scream; Sherin, 2003).*** The HITS is a 4-item brief screener for intimate partner violence used to assess the presence of IPV at baseline. It has been found to be reliable and valid, and has been widely used in population and epidemiological studies (Chen, Rovi, Washington, Jacobs, Vega, Pan, & Johnson, 2007).
5. ***Simple Screening Instrument for Substance Abuse (SSI-SA, SAMHSA, 1994)*** was developed by a panel of experts and is comprised of a set of 14 items derived from existing alcohol and drug abuse screening inventories. It has since been widely used and found to be reliable and valid screener for substance abuse problems (Peters & Peyton, 1998). It was used to screen for the presence of substance abuse issues at baseline.
6. ***Readiness for Parenting Change Scale (REDI, Chaffin et al, 2009)*** is an assessment of motivation to engage in a parenting program and make parenting changes. All items (20) from the REDI were included except for the Lies Subscale. Nine of the items on this scale ask about referral and participation in a parenting program and these items were asked only of those who had begun participating in the RBV program. This measure was included only at baseline.

The following additional measures were used in the follow-up interviews with parents who had participated in RBV services (see Appendix C):

7. ***RBV Program Evaluation*** was a 14 item scale developed specifically for this evaluation. The 10 program-related questions from the REDI used in the baseline interview were included plus 4 additional questions used by Stephen Bavolek, PhD, in several of the studies conducted to assess the Nurturing Parenting Program.
8. ***Strengths-Based Practices Inventory*****,** short form (treatment group only; Green, McAllister, and Tarte, 2004). The SBPI is a reliable and validated measure of the extent to which services (in this case, RBV services) are being provided in a manner that is strengths-based, family-driven, and culturally competent.
9. ***Qualitative Parent Feedback.*** Questions were developed specifically for this evaluation to gather information from program participants about the following:
    a. Parent satisfaction with visitation with children
    b. Parent involvement in planning visitation
    c. Parent involvement in developing the Family Nurturing Plan (treatment group only)
    d. Quality of relationship between parent and visitation coach (treatment group only)
    e. What was most helpful and least helpful about RBV services (treatment group only)
    f. How RBV visits compare with DHS visits (treatment group only)

Outcome Measures Collected by RBV Providers

A key component of the RBV program and the NS curriculum is the use of two standardized measures assessing parenting skills and competence captured in the Comprehensive Parenting Inventory (CPI), the Adult-Adolescent Parenting Inventory (AAPI, Bavolek, et al., 1983) and the Nurturing Skills and Competency Scale (NSCS, Bavolek, et al., 1983). The CPI was developed by

Family Development Resources to contain both the AAPI and NSCS in one document without repeating questions about demographics found in both scales. This allowed for a less cumbersome way to administer both scales to parents at one time.

1. Adult-Adolescent Parenting Inventory (CPI: AAPI, see Appendix D).

The AAPI consists of 40 items that comprise a validated measure of 5 domains of parenting beliefs and attitudes that are found to be related to risk for child maltreatment and comprise the core of the Nurturing Skills program: (1) Appropriate Expectations; (2) Empathy; (3) Beliefs about Physical Punishment; (4) Parent-Child Role Reversal; (5) Supporting Children's Autonomy. The AAPI is administered to RBV program participants during the intake process, and repeated prior to program exit. Parents complete a hard copy paper version of the AAPI with the coach present so they can answer any questions the parent may have (e.g., regarding the meaning of a question). The coach then enters the results into a web-based data system (Assessing Parenting at assessingparenting.com) developed and maintained by Family Development Resources. Assessing Parenting generates an individualized Parent Profile illustrating the results of each parents' assessments on a 1 to 10 standard spread of scores grouped into and indicating whether they are low, medium or high risk of maltreatment in each of the domains. These, in turn, are used to select lessons that target areas of need. These data were downloaded from the Assessing Parenting on a regular basis by PSU staff to monitor data collection timeliness and quality. The AAPI was administered to control group parents during a telephone survey, or parents had the option to complete it as a web based Qualtrics survey developed specifically for the purpose of collecting this data from the control group. If the interviewer administered the survey via telephone, they entered the results into the Qualtrics survey in lieu of the parent doing so.

2. Nurturing Skills Competency Scale (CPI: NSCS, see Appendix D)

The NSCS is also administered to RBV program participants during the intake process, and repeated prior to program exit. The NSCS is a self-report inventory designed to provide comprehensive information about quality of life issues and knowledge and behaviors of Nurturing Parenting skills and strategies. RBV providers entered the results of the NSCS into Assessing Parenting as they did for the AAPI, and a separate Parent Profile was generated. The NSCS profile provided an index of risk in six sub-scales: A. About Me – current life circumstances including marital status, number of children, employment, income, education and military experience; B. About My Childhood – parent's childhood history of abuse, witnessing violence in the family and quality of relationships with their parents; C. About My Spouse/Partner – quality of life with spouse/partner including presence of domestic violence, substance abuse and childhood history of abuse; D. About My Children and Family – history of children in the family regarding abuse, neglect, domestic violence, substance abuse, special needs, mental health, juvenile court involvement; E. Knowledge of Parenting Practices – multiple choice items related to knowledge of parenting skills and strategies; F. Utilization of Nurturing Skills – parents' rating of their frequency of use of a list of 20 nurturing parenting skills and strategies. The NSCS was administered to control group parents during a telephone survey, or they had the option to complete it as a web based Qualtrics survey developed

specifically for the purpose of collecting this data from the control group. If the interviewer administered the survey via telephone, they entered the results into the Qualtrics survey in lieu of the parent doing so. Subscale E, Knowledge of Parenting Practices, was not administered to control group parents as it was comprised of a large number of lengthy multiple choice (rather than Likert-type) scales and would have been difficult to conduct over the phone.

To create subscales for the NSCS, an exploratory principal components factor analysis (with oblimin rotation, allowing for correlated factors) was done with the 20 NSCS skills items as an initial step in scale development. Three conceptually clear factors were extracted (accounted for 53% of the variance in the items): behavior management, self-care, and nurturing skills. Next, we calculated Cronbach's alpha for each scale and all were above .80, an indication of good reliability. Last, we calculated correlations between the three scales and noted a moderate degree of shared variation (r = .45 to r = .64). Items that comprised each subscale are listed below:

1. Behavior Management
    a. How often do I use appropriate consequences as punishments?
    b. How often do I use rewards to reinforce appropriate behavior?
    c. How often do I help my children learn how to manage their behavior?
    d. How often do I give my children choices and consequences?
    e. How often do I refer to our family rules as a guide to discipline?
    f. How often do I make appropriate expectations of my children?
    g. How often do I teach appropriate morals to my children?
    h. How often do I use alternatives to spanking as discipline?
2. Self-care:
    a. How often do I take time to nurture myself?
    b. How often do I find time to get my own needs met?
    c. How often do I have awareness of my personal strengths?
    d. How often do I model appropriate ways to manage stress?
    e. How often do I model appropriate ways to express anger?
3. Nurturing skills:
    a. How often do I respond to my children's feelings with empathy?
    b. How often do I praise my children for "being" wonderful kids, for being loving, etc.?
    c. How often do I hold, rock, sing and read to my young children?
    d. How often do I express unconditional love for my children?
    e. How often do I praise my children for "doing" their best, for cooperating, trying, etc.?
    f. How often do I help my children get their needs met?
    g. How often do I help improve my children's self-worth?

Process Evaluation Data Collection & Measures

The process evaluation was designed to collect data to help understand both (1) the level of fidelity of implementation, as well as the (2) factors that supported (or impeded) the implementation of the RBV model. To address the second goal, the research team utilized the National Implementation Research Network's (NIRN, Durlak & Dupre, 2008; Fixsen, Blasé, & Naoom, & Wallace, 2009) framework for understanding implementation "drivers". In this framework, key contextual factors are hypothesized to relate to an organization's ability to implement evidence based programs and related changes in program practices. These factors include:

1. **Staff Selection & Characteristics**: How are staff chosen, what skills, backgrounds/experiences do staff bring with them? What are staff motivation for their work? How ready are staff for implementing EBPs?
2. **Training** (both pre-service and in-service)-
3. **Consultation and Coaching**, including supervision, support and opportunities to practice new behaviors
4. **Staff evaluation** – assessment of staff practice and regular feedback
5. **Program evaluation** – To what extent does the organization or individual have access to and use information about quality services and fidelity?
6. **Facilitative administration**: To what extent does leadership makes use of a range of data inputs to inform decision making, support the overall processes, and keep staff organized and focused on the desired clinical outcomes.
7. **Systems interventions**- To what extent are there financial, organizational, and human resources required to support the work of the practitioners.

Methods for collecting fidelity and implementation – related data are described below.

RBV Program Service Documentation.

To ensure fidelity of the RBV services and to document changes in parenting demonstrated during RBV program participation, program records were collected and sent electronically via a secure connection to Portland State University. The following documentation forms were developed for the evaluation and provided to PSU on a monthly basis:

1. Visitation Documentation Forms – Quality of Parent Child Interaction ratings

After each visit, the visitation coach rated the quality of the parents' interaction with their children during the visit. A series of scales was developed to address 4 key aspects of parent-child interaction central to the RBV program: (1) Nurturing Relationships; (2) Supporting Children's Learning; (3) Safety/Supervision; and (4) Structure/Discipline. RBV coaches rated the parents on a 4-point scale (0=negative behavior; 1=behavior is absent; 2=some evidence of positive behavior; and 3=consistent evidence of positive behavior). Rating scales were behaviorally anchored with example behaviors. (See Appendix E).

2. Documentation of Progress.

Following each RBV visitation coaches made an assessment of parent progress towards achieving their identified competency goals based on observation and a set of questions addressed to the parent. The results of these assessments were documented on the Monthly Progress Report using a 3-point scale (no progress, some progress, competency achieved). These data were used to create indicators of overall progress for each parent. (See Appendix F.)

Interviews with DHS central office and branch supervisors, caseworkers, and other key staff.

To better understand implementation from the perspective of DHS child welfare managers, caseworkers, and staff, telephone interviews were conducted with DHS branch representatives from each branch working with an RBV provider. Interviews were done with the designated RBV liaison, the branch manager, and 1-2 caseworkers with RBV cases. Interviews were also conducted with 3 DHS central office staff involved with implementing the RBV project.

DHS interviews focused on:

1. The recruitment, screening, and randomization process;
2. The quality of information sharing and collaboration with the RBV provider;
3. Strengths and challenges of the RBV model
4. Suggestions for improvements in the recruitment process and/or model
5. Questions about emerging issues in the DHS branch that may influence the RBV demonstration program, child welfare practice, and in particular, outcomes for families in the Visitation as Usual condition.

Additionally, in order to collect information about the nature of "visitation as usual" interviews were conducted with 1-2 SSAs in each branch. SSAs are the primary staff responsible for transporting and supervising visits. These interviews were used instead of the originally planned comparison visit observations because of the difficulties experienced in trying to schedule and conduct visits with comparison families. Data was thus collected about "typical" DHS parent-child visitation services in 25 counties via 18 interviews and 3 observations. Interviews focused on the following topics:

- Visit frequency, length and location
- Supervision of visits, including who supervises, the levels of supervision, and the extent of any coaching or feedback offered to parents
- Frequency of contact and content of information shared between foster parents and biological parents
- DHS staff perception of primary purpose of parent-child visits.

Annual Provider Surveys

A total of three surveys were conducted with RBV providers, the spring of each year of RBV program implementation (see Appendix G). Surveys included questions about the provider's background and training, as well as questions about the quality of implementation of RBV

services, perceptions of the quality of supervision received, helpfulness of various Nurturing Skills materials and tools, and providers' experience with specific target populations. The baseline survey also included the Evidence Based Practices Attitudes Scale (EBPAS, Aaron, 2004), a validated measure of providers attitudes towards implementing manualized, evidence-based programs. Questions were slightly adapted to fit the RBV context (the measure was original developed for completion by mental health clinicians). The EBPAS asked providers to rate their openness to new interventions and assessed their attitudes towards implementing manualized interventions and evidence based practices on a series of 15 items, for example, "I like to use new types of interventions to help my clients" and "I am willing to try new types of interventions even if I have to follow a manual". Items were rated on a (1-5 scale from "not at all" to "a very great amount. Items were averaged to create an overall Readiness score for each provider, and then averaged across providers to create a site-level score.

The second year follow up survey also included questions about the provider's background and training, as well as coaches' perceptions of the (1) **Quality of supervision** received (1 item, "To what extent have you felt like your supervisor provides good support in helping you implement RBV," rated from 0=Not at all; 3=Extremely); (2) **Quantity of supervision received (**7 items, e.g. How often do you have a scheduled, regular one-on-one time with your supervisor to talk about specific clients or cases?" rated from 0=never, 1=quarterly, 2=every other month; 3=monthly; 4=weekly);); (3) **Quality of coaching practices** (based on self-report of utilization of evidence based coaching strategies during RBV visits, e.g. "How often during a typical RBV session do you provide on the spot coaching and suggestions to the parent during the visit time?" rated on a 3-point scale (not at all, occasionally, frequently)) (6 items); and (4) **Frequency of teaching using the Nurturing Skills curriculum** (2 items, e.g. "To what extent do you usually help parents understand the importance of Nurturing Parenting approaches in a typical RBV visit?" rated on a 3-point scale (not at all, occasionally, frequently).

The third follow up survey included similar questions, asking providers to share their perceptions of the quality and quantity of supervision, report on their use of evidence based coaching strategies during RBV visits, and rate their experience with the Nurturing Skills curriculum. However, the survey items were changed somewhat but a similar set of scales were calculated as follows: (1) **Quality of supervision received** (2 items, e.g., "I am satisfied with the supervision provided to me, rated from 1=Strongly Disagree; 5=Strongly Agree); (2) **Quantity of supervision received** (6 items, e.g., "How often do you have a scheduled, regular one-on-one time with your supervisor to talk about specific clients or cases?" rated from 0=never, 1=quarterly, 2=every other month; 3=monthly; 4=weekly); (3**) Quality of coaching practices** (6 items, e.g. "How often during a typical RBV session do you provide on the spot coaching and suggestions to the parent during the visit time?". At time 2, these items were rated on a 3-point scale (not at all, occasionally, frequently). However, due to limited variability in responses, at Time 3 the response scale was changed to a 4-point scale (not at all, occasionally, often, almost always); (4**) Frequency of teaching using the Nurturing Skills** curriculum (3 items specific to curriculum delivery, e.g., How often, during a typical RBV visit do you use activities from the Nurturing Skills curriculum". Again, at time 2, these items were

rated on a 3-point scale (not at all, occasionally, frequently). However, due to limited variability in responses, at Time 3 the response scale was changed to a 4-point scale (not at all, occasionally, often, almost always).

RBV Site Visits

Site visits with RBV provider agencies were conducted in years 1 (August 2012 – January 2013) and 3 (August 2013 – January 2014). During site visits, a number of different fidelity and implementation-related data were collected, including: (1) Interviews and/or focus groups with RBV program directors, supervisors and coaches (see Appendix H); (2) Observations of 1-2 RBV visits by researchers (see RBV visit Observation Protocol, Appendix I); and (3) Case file reviews (see Appendix J). These are described further below.

RBV Program Staff Qualitative Interviews & Focus Groups.

One on one interviews were conducted with directors and supervisors at each RBV site, except for 1 large agency with multiple supervisors (interviewed together). Focus groups were conducted with coaches. Several smaller agencies, however, only employed one coach. Coaches in these agencies participated in one on one interviews. In the first round of site visits the interview conducted with directors and supervisors was the same (i.e., a Program Leadership Interview). After the first round of site visits, the distinct roles of program directors and leaders was more clearly understood, thus separate and different interviews were developed for directors and supervisors during the second round of site visits.

These semi-structured interviews were primarily qualitative and designed to capture key process variables such as:

1. Quality of relationships with DHS (referral process, communication, information sharing, collaboration)
2. Barriers and facilitators to delivering the NS program to parents
3. Strengths and challenges of the RBV model
4. Suggestions for improvements or changes to the model to improve efficiency and/or effectiveness
5. Perceived support from DHS and PSU for implementation of the model

Observations of RBV sessions.

To better understand the quality of visitation delivered to the intervention group, 1-2 RBV visits at each program were observed. Prior to the site visit, parents were asked by providers if they would be willing to let a PSU researcher observe one of their RBV visits with their child(ren). Site visits were scheduled in part based on the availability of a parent who was willing to have their visit observed by evaluation staff. Parents were informed that the purpose of the observation was to view the protocol that the RBV Provider used during visits, not to evaluate the parent's performance. Parents who completed the observation were given a $20 gift card. Parents signed consent forms indicating their willingness to be observed at the time of the visit. The RBV provider and any other adult family members present at the visit were also asked for their consent to the observation at the time of the visit. If anyone refused consent at any point

the observation did not take place. In the first year of the program, 18 observations were performed. Sixteen additional observations took place the following year. Nearly all RBV programs had at least one visit observed during each of two rounds of site visits. (One program, due to late implementation, only had one observation performed). A standard protocol was used for the observations that included a variety of qualitative and quantitative question (see Appendix I). Visit observation scores were calculated for key implementation indicators, as follows: (1) Quality of visit planning (3 items rated on a scale from 0 to 2); (2) Quality of coaching (4 items rated on a scale from 1 (strongly disagree) to 5 (strongly agree); (3) Level of parent directedness (3 items rated on a scale from 0 to 2); (4) Quality of Nurturing Skills curriculum delivery (4 items rated on a scale from 1-5); and (5) Quality of parent-coach relationship (2 items rated on a scale from 1-5). The purpose of the visits was to provide a small "snapshot" of the type services being provided and to deepen the understanding of the research team into the nature of service delivery. However, because they were neither a representative sample of parents, nor completed with every RBV coach, they are not meant to provide an overall evaluation of the quality of visits conducted. Thus, while these indicators were used as one element of our multi-modal implementation assessment they were not considered as independent indicators of model fidelity; for descriptive purposes only, results from the visit observations can be found in Appendix K.

RBV program case file reviews. A total of 128 RBV case files were reviewed as part of site visits at each site (an average of 7.5 files reviewed per site). Files were evaluated based the presence and/or quality of elements considered relevant to program fidelity, including:

- Referral Forms from DHS and Release of Information Forms indicating consent or no consent to participation in the program evaluation.
- Logs of attempted contacts and actual contacts (by phone and email), with brief notes about content of communications with:
    - Parents
    - Foster Parents
    - Caseworkers and other DHS staff
- Program related assessments – AAPI and NSCS Profiles and PHQ-9
- The Family Nurturing Plan, with selected lessons and completion dates where applicable and notes about parent involvement in developing FNP
- Program Competency Assessment Sheets completed for lessons finished, with indication that Knowledge Questions were answered correctly and competencies assessed as achieved
- Completed visit documentation forms, progress reports, and exit forms (electronic or paper copies)
- Copies of Family Nurturing Journal Sheets handed out with homework assignments.

Results

Process Study Results

The process study was comprised of two key components: (1) Quantitative assessment of fidelity (delivery of services as planned) using a variety of primarily quantitative measures (program documentation, case file reviews, and annual provider surveys); and (2) Qualitative data collected through interviews and focus groups with RBV management and staff, DHS management and staff; and parents. The process study data analysis was ongoing throughout the life of the project, and information was regularly shared with RBV providers, DHS branch staff and managers, and with DHS central office administrators for the purpose of providing feedback about fidelity and implementation. Following Year 2 of implementation, we conducted a multi-modal fidelity and implementation assessment that included operationalizing key fidelity and implementation constructs and assessing the relative performance of each site across these constructs. These constructs were then analyzed using an exploratory network analysis approach. These interim implementation results were reported in prior evaluation reports, and are included in Appendices L-O for reference.

Below we report the overall process study results as of the end of program implementation, organized by process study research questions, as follows:

1. *Fidelity:* To what extent were RBV services implemented with fidelity by contracted providers?
2. *Collaboration:* To what extent did caseworkers and RBV service providers collaborate to share information about the parents' service needs, progress, and outcomes?
    a. What factors facilitated successful information sharing and collaboration between DHS caseworkers and RBV service providers?
3. *Visitation Best Practice:* To what extent and in what ways were RBV visitation services different from standard visitation? (e.g., were parents who received RBV visits more satisfied with visitation than parents receiving visitation as usual? Did RBV visits align with "best practices" in visitation derived from the current literature on effective visitation? Did RBV parents receive more frequent visitation than parents receiving visitation as usual?
4. *Parent Involvement and Engagement:* To what extent did parents actively engage in and complete the RBV program? To what extent and in what ways were parents involved in developing their parenting goals in the RBV programs? What factors helped parents be more involved and engaged in working towards their parenting goals? What factors impeded parents' ability to successfully engage in services?
5. *Foster Parent Involvement:* To what extent were foster parents involved in supporting parents' visits with their children? What factors facilitated or impeded foster parent involvement? Did foster parents and RBV parents have opportunities to exchange information about the child before or after the visits?

Below we first present data related to program fidelity as measured through the service delivery documentation and Annual Provider Surveys. Next, we present qualitative data reflecting the strengths and facilitators of implementation as well as the challenging, using the categories outlined previously.

Program Fidelity: To what extent were RBV services delivered as planned?

Program Services Documentation.

To assess the extent to which the programs were implementing the RBV program as intended, a set of fidelity goals were established at the outset of the project. These goals are listed in Table 1-5 below. These indicators were based on the program documentation provided to the PSU evaluation team (Visitation Documentation Forms [Appendix E], Monthly Progress Reports [Appendix F], AAPI/NSCS assessments [Appendix D], and Exit Forms [Appendix P]). The evaluation team provided fidelity ratings to each RBV program twice per year throughout the implementation phase of the project to help identify areas in need of improvement. Results from the final, overall fidelity ratings are shown in Table 1-5. As can be seen, while some program areas were implemented quite well, others remained challenging throughout the implementation of RBV.

Note that in addition to examining fidelity at the program level, fidelity indicators were calculated on the family (parent) level and used to examine the relationship of program fidelity to outcomes (see Results).

As shown in Table 1-5, early engagement of families in RBV services proved challenging. Of families who were referred by DHS, only 69% successfully completed an intake. Reasons for this included a variety of factors; most often, families could not be contacted or located by RBV providers to set up an initial appointment. However, once an intake was completed, the large majority (94%) of families did engage in at least some RBV sessions.

In terms of fidelity to the model, RBV providers were almost always able to complete the AAPI and NSCS pretest (intake) assessments with parents. Post-tests, not surprisingly, proved more challenging, with only about a third completing the post-tests. Many families left the RBV services prior to completing all planned sessions, making completing post-tests difficult. Providers also did a good job implementing RBV visits using the 3-component (lesson, visit, debrief) structure. About two thirds of RBV sessions (63%) lasted 120 minutes. Further, most visits involved opportunities for sharing information between the biological and foster parents (84%). Of all families who received RBV visits, 192 were reunified (40%); of these the great majority received post-reunification visits as per the model (86%).

The most challenging aspects of implementation were the frequency of sessions, with only 17% of families receiving 90% of their scheduled visits, and only 18% receiving at least one visit per week. As shown in Table 1-5 below, the average number of RBV sessions (including parent-

child visit time and a lesson) received by families was 14.5 with a range of 0 to 61. Average duration of sessions was 111 minutes, approaching the goal of 120 minutes.

As shown in Table 1-5 about two thirds (68%) of the focus adults were rated as being at least "moderately" or "very" engaged in the RBV session. However, progress was modest, with only 31% making "moderate" or "high" progress during the session. Engagement overall (Table 1-6) was high, with families averaging 2.5 out of a possible 3; progress was lower, with an average rating of 2 ("some progress").

Table 1-5. Final state-level fidelity ratings

RBV Initial Engagement Indicators	**Fidelity Goal**	**Statewide Actual**
1. Number of eligible parents referred to RBV providers	N/a	741
2. % of referred parents with successful intake	90%	69% (511)
3. % of those with an intake who started RBV visit sessions	N/a	94% (480)
RBV Model Delivery Indicators Of parents who had an intake (*n*=515):	**Fidelity Goal**	**Statewide Actual**
4. % of intakes within 2 weeks of receipt of referral	90%	38%
5. % of parents with complete AAPI at pre-test	100%	99%
6. % of parents with complete NSCS pre-test	100%	98%
7. % of parents with complete AAPI post-test	80%	38%
8. % of parents with complete NSCS post-test	80%	37%
9. % of focus adults received 90% of scheduled RBV sessions	80%	17%
10. % of focus adults receiving an average of one RBV visit per week	80%	18%
11. Average length of RBV session greater than/equal to 120 minutes	80%	63%
12. % of focus adults receiving pre-visit lesson at least 75% of the time	90%	89%
13. % of focus adults receiving debriefing session at least 75% of the time	90%	87%
Of parents reunified during RBV service (n=192, 42% of those with service):		
14. % of focus adults receiving 2 or more post-reunification visits	90%	86%
15. % of visits in which foster and biological parents shared information	80%	84%
Services Engagement Indicators Of those who began having sessions after intake during their most recent RBV episode (*n*=411):	**Fidelity Goal**	**Statewide Actual**
16. % of focus adults with moderate or high engagement during visits	80%	68%
17. % of focus adults with moderate or high progress during visits	80%	31%

Table 1-6: Descriptive Statistics Selected Fidelity Indicators

Fidelity Indicator	N	Min	Max	Mean	Median	Std. Dev
Number of RBV sessions received (lesson+visit)*	439	0	61	14.5	13.0	10.9
Duration of sessions (minutes/hours)	416	30 min	245.8 min 4.1 hrs.	111.1 min 1.9 hrs.	115.4 min 1.9 hrs.	21.1 min
Parent engagement rating	419	0	3.0	2.5	2.8	0.62
Parent progress rating	437	0	3.0	2.0	2.0	0.70

Annual Provider Surveys

As stated above, annual provider surveys were conducted in each of the three years of the program. The surveys included questions about provider's backgrounds and training, shown below. As of the second survey, 59% of coaches (16) had been with the program since the beginning and attended the original (first) RBV training.

Table 1-7. Provider Survey: Coach Demographics Statewide (N=27)

Demographic Characteristic	% (n)
Gender:	
Female	89% (24)
Male	11% (3)
Race/ethnicity:	
White	78% (21)
African American	7% (2)
Hispanic	11% (3)
Native American	4% (1)
Asian or Other/Unknown	0% (0)
Service Language:	
English Only	85% (22)
Spanish	15% (4)
Age:	
Mean	38 years
Range	22-59 years

The baseline survey included an assessment of provider readiness to implement evidence based practices (the EPAS, Aarons, 2004); follow up surveys (the first following 1 year of implementation, the second after 2 years of implementation) measured self-reported practices related to key fidelity components. Scales were developed from survey questions to assess program fidelity.

From the baseline survey, scores on the EBPAS readiness measure were summed to develop an overall readiness score for each of the programs represented; if there were multiple respondents per site, the indicators were aggregated (averaged) by site so there was one score per site for each indicator.

For the second and third provider surveys, items constituting scales were combined and averaged to create mean scores for each scale. If there were multiple surveys per site, the indicators were aggregated (averaged) by site prior to score calculation. So that scale scores could be compared across the two time points for the statewide analysis, scores were standardized and a t-test comparing the scores for providers at Time 2 to providers at Time 3 were calculated.

The tables below shows the mean score for these domains for Years 2-3 for all sites (Table 1-8) and for individual sites (Table 1-9). As can be seen, the only statistically significant change reported was related to the quantity of supervision, specifically, coaches reported getting less supervision at Time 3 than was the case at Time 2.

Finally, to explore whether providers' initial readiness was associated with aspects of service delivery, we calculated correlations between EBPAS scores, Quality of Coaching, and Frequency of NPP teaching. No correlations were statistically significant, indicating the EBPAS measure was not associated with coaches' self-reported delivery of services.

Table 1-8: Provider Survey Years 1, 2 & 3 Results Scale Statistics

Scale Name		N	Min	Max	Mean	Std. Dev	Mean change	Test Statistic	p-value
Readiness to Implement (Survey 1)		17	11.5	13.7	12.36	.56	N/A	N/A	N/A
Quantity of supervision	Survey 2	11	1.70	3.66	2.82	.65	-.47	*t*=-2.507	.03*
	Survey 3	15	1.17	3.54	2.28	.78			
Quality of supervision	Survey 2	12	-2.72	0.61	0	1	-.12	*t*=-.371	.72
	Survey 3	15	-2.42	0.90	0	1			
Quality of coaching	Survey 2	11	-2.03	1.05	0	1	.31	*t*=1.003	.34
	Survey 3	15	-1.99	1.56	0	1			
Teaching Nurturing Skills	Survey 2	11	-2.25	1.61	0	1	.28	*t*=.653	.53
	Survey 3	15	-1.58	1.95	0	1			

*results significant p<.05

Table 1-9: Year 1, 2 & 3 Provider Survey Results by Program Site

District	Readiness to Implement Site Mean	Quantity of supervision Site Mean		Quality of supervision Standardized Site Mean		Quality of coaching Standardized Site Mean		Teaching Nurturing Skills Curriculum Standardized Site Mean	
	Year 1	Y2	Y3	Y2	Y3	Y2	Y3	Y2	Y3
1a	12.3								
1b	12.5		1.83		0.24		-0.97		-0.87
3	11.8	3.66	3.54	0.61	0.57	-0.37	-0.24	-0.45	0.37
4a	12.3	2.61	2.38	0.61	0.57	-2.03	-0.36	-0.96	-0.17
4b	12.4		1.83		0.24		-1.99		-0.87
5	13.0	3.42	2.69	0.38	0.46	0.45	-0.04	0.32	-0.52
6	12.3	3.14	1.67	0.61	0.24	1.05	1.56	1.61	1.25
7	11.5	3.00	1.50	0.61	-1.09	1.05	0.55	0.32	0.54
8a	11.6	1.70	1.17	-0.22	-0.42	-0.37	1.06	0.32	1.25
8b	12.8	1.70	1.83	-0.22	-2.42	-0.37	-0.46	0.32	-1.58
9	12.1		1.20	-2.72	-1.75		1.06		-0.17
10	12.6	3.36	2.42	0.61	0.24	0.34	1.06	0.32	0.19
11	11.8		3.50		0.90		-1.48		-1.22
13	13.7	2.43	2.67	-1.06	0.90	0.82	0.04	-0.32	1.95
15	13.0	3.00	3.00	0.61	0.90	-1.31	0.55	-2.25	0.54
16	12.1	3.04	3.04	0.19	0.41	0.74	-0.34	0.76	-0.70

*First provider survey not obtained from District 1b; Second provider survey not obtained from Districts 1a, 1b, 4b & 11, resulting in missing data

When asked in the third provider survey to reflect back and assess to what extent more training or support in various topics would have helped them be more successful with RBV parents, providers identified four areas where they would have especially appreciated training/support:

1. Working with children with behavioral or other challenges (54% of providers)
2. Working with parents with substance abuse issues (50% of providers)
3. Helping children and parents manage behaviors and emotions during visits (43% of providers
4. Working with parents of school-aged children (36% of providers).

Analysis of Implementation Drivers

Qualitative Data Analysis Approach

Interviews with RBV staff, supervisors, and managers, as well as parent interviews and interviews with DHS staff were content coded by the research team. Interviews were read by 2-3 interviewers who met initially to develop a coding scheme framed around the key Process Study research questions. Codes were developed to examine the following specific areas related to the NIRN framework for RBV: (1) Staff characteristics (years of experience, training needs, and type of degree; (2) Supervision and Staff Coaching: specifically, the quality and frequency of supervision; (3) Training: quality of training received; (4) Leadership and Organizational Support. These NIRN categories were used as a framework for data analysis.

After initial codes were developed, interviews were read by pairs of researchers. The primary reader content coded responses for each interview, summarizing key themes in a separate document. These documents were then reviewed by the second researcher who cross-validated the initial summary, expanding where appropriate or indicating areas in need of further discussion. The pair then met to discuss the summary documents and reach consensus in areas of disagreement. Qualitative analyses were ongoing throughout the life of the project, and a number of interim results from these analyses were included in prior Semi-Annual Reports.

Below, we summarize the following across all coded documents:

1. Overall Facilitators of RBV Implementation
2. Overall Challenges in RBV Implementation
3. Quality of Collaboration Between DHS and RBV Providers
    a. Facilitators of Collaboration
    b. Challenges in Collaboration
4. Parent Involvement and Input in RBV Services
    a. Facilitators of Parent Involvement
    b. Challenges to Parent Involvement
5. Level of Involvement of Foster Parents in RBV Visits
    a. Facilitators of Foster Parent Involvement

b. Challenges to Foster Parent Involvement

6. Quality of RBV Visitation and Differentiation from Visits as Usual

1. Facilitators of RBV Implementation & Fidelity

1. *Flexibility & Ability to Individualize.* The dominant theme related to success in implementing RBV was flexibility on the part of the provider. Making adaptations on a case by case basis was essential for working around special conditions (e.g., having the children present for the entire session or cognitive challenges and severe life stressors for the parent) or for scheduling around children's, parents' and foster families' busy schedules. However, at the same time that the ability to be flexible seemed to be important to making sure services were delivered, adapting to these types of conditions sometimes affected the order or length of each component of an RBV session. Thus, while it helped to ensure that some form of service was delivered, it may have actually reduced the level of fidelity to the model. For example, in a few cases, workers described needing to schedule the parenting time/parent-child visit on a different day than the lesson time with the parent. The debrief component also was modified considerably, with coaches sharing examples of doing debriefs by telephone as a frequent modification when parents needed, or wanted, to leave immediately following the parent-child visit.

2. *Staff Characteristics and Retention*. Another key factor that contributed to successful implementation was having long-term and effective coaching staff. When asked what strengths and skills were important for doing RBV work, agency leaders most commonly mentioned characteristics related to the ability to engage and develop a relationship with parents. Being supportive, creative, empathic and nonjudgmental and utilizing a strengths-based approach were at the top of the list. Leaders also looked for coaches with previous experience in working with high risk populations and being able to work with parents with a wide variety of personalities. Supervisors also described the importance of staff having confidence and mastery of the rather complex program curriculum and/or experience with parenting education or parenting support programs.

   Hiring for a "good fit" was seen as an important factor in staff retention. A "good fit" was described as having a coach with the needed strengths and skills as well as what one supervisor referred to as "a calling for this type of work." Three agencies lost coaches shortly after the service began because the coaches soon realized they weren't particularly suited for and did not enjoy working with the challenging population that was being provided RBV services.

3. *Supportive Work Environment*. Another key factor that appeared to contributing to staff retention was having a supportive and collegial work environment. Support was found in regular staff meetings or having others at the agency who were knowledgeable about the service that a coach could talk to or brain storm with and also in getting good training both in RBV and skills related to delivering RBV services. Good supervision, including reflective supervision and clinical supervision were also cited as important factors for retention. A

positive work environment, a balanced case load, and meeting individual needs through flexible work schedules and support for professional development contributed to retention as well.

Ironically, however, support for professional development, an element of a supportive atmosphere, was also a reason for staff turnover as some coaches left to pursue educational goals or to advance in their careers. The part time positions for coaches in several agencies contributed to turnover as coaches tended to leave those positions for longer term and higher FTE positions as they became available. Life changes and a relatively low salary were also mentioned as contributing to turnover.

4. *Quality of Supervision.* In addition to their role in creating a generally supportive working environment, supervisors were critical for providing more direct and RBV specific support in implementation. Interestingly, only about half of the coaches reported that their supervisors were knowledgeable specifically about the RBV model. This was due largely to supervisor turnover and the lack of ongoing training in RBV available from the State Office. About a third of coaches reported that their supervisors had very little knowledge of the details of the RBV program, making it difficult for these supervisors to actively support staff in terms of model fidelity.

   Several of the larger agencies had staff with mental health and/or trauma informed practice expertise who were able to provide clinical supervision to coaches, something that was reported by staff as being extremely beneficial in the few agencies where this mental health consultation/supervision was available. Supervisors also played an important role in fidelity by regularly reviewing paperwork and files with staff. About half of supervisors reported actively using the RBV Fidelity Reports provided by the evaluation team to review service delivery successes and challenges with their staff, which may have supported higher fidelity for some programs.

2. Barriers to Successful Implementation and Fidelity

In terms of the biggest barriers to successful implementation, the following factors were identified from the qualitative interviews.

1. *Need for Additional Training .* A major issue in program implementation was the need for additional training and support in the model specifically. Unfortunately, the state was unable to provide training on the model in an ongoing way for new staff; ongoing trainings were provided only annually (twice over the 3 years of the program) and identifying high quality trainings in the Nurturing Parent program who could "translate" the services into the visitation context provided challenging. Generally, the level of ongoing implementation support related to training in the model specifics was less than what RBV supervisors and coaches appeared to need.

   Related specifically to the RBV project, some coaches desired more training on coaching and providing feedback to parents and communication skills (e.g. facilitating difficult

communications between birth parents and foster parents). Interestingly, this mirrored feedback from a few parents that at times coaches were less sensitive in providing feedback than might be optimal (see Parent Interview Feedback). A few coaches would have liked more in-depth training on the Nurturing Parenting curriculum and more suggested activities related to curriculum competencies for the parents and children to do during their visits. Other coaches would have liked ongoing webinars or Q & A sessions such as those provided in the first 6 months of the project, or more opportunities to talk to others providing the service around the state. Some coaches were proactive in seeking help on RBV specific issues (e.g. documentation or fidelity issues related to service) and emailed or called their PSU liaisons or others on the PSU evaluation team, or the DHS Waiver manager.

Broader training needs were also cited, such as training on re-engaging parents, preparing families for reunification, court testifying or specific skills such as Parent Child Interactive Training skills, as well as how to work with parents with substance abuse issues, domestic violence or sexual abuse.

2. *Session Structure Challenges*: For the most part, providers valued and appreciated the structure of Lesson-Visit-Debrief in an RBV session, and recognized the importance of each component. However, as noted above, they also indicated that strict fidelity to the planned model was often challenging, and reported the need to be flexible and adapt the structure in various ways, including the order and the length of each component. Many of them also discussed an additional component that often seemed necessary before a parent could settle into going through a lesson. This was referred to in a variety of ways - a check in, venting, or talking about recent or current stressors. A number of providers simply adapted to this need by providing extra time up front, extending the one on one time with the parent to 45 or even 60 minutes. This extra time also provided a cushion for parents who arrived late. With a 30 minute lesson time, if a parent arrived late it could result in no time for a lesson. Getting through lessons in the allotted time of 30 minutes, as well as when children were present through the whole session was the most common challenge mentioned about the structure of an RBV session. As described earlier, providers most often addressed this by lengthening the lesson time to 45 minutes or an hour. Scheduling around foster parents', biological parents' and school age children's schedules also presented challenges that sometimes resulted in lessons and visits being scheduled on different days. Having children present for the entire session also required flexibility and creativity and changing the structure of a session to get through the lesson and do the debrief.

3. *Challenges Conducting AAPI and NSCS Assessments.* Coaches mentioned a number of challenges related to administering the AAPI and NSCS assessments, especially at the beginning of the service. Coaches reported that some parents were worried about being judged, or afraid that it might be used against them and harm their child welfare case. Some found the wording of the questions difficult, and struggled to understand them. Coaches talked about the instruments not being culturally sensitive, feeling they were

designed for white, middle class parents. One coach noted that a Native American was offended by some of the questions, especially about spanking. Coaches also felt that the instruments were not developed to coincide with trauma informed practice and several mentioned that they had clients who were triggered by some of the questions, such as those related to personal history or family circumstances (in the NSCS)[4]. (This was also noted by the Interviewers who administered the AAPI and NSCS via telephone to control group parents.) They also complained about it being too long.

Some coaches felt that the assessments were not useful in identifying the needs of the family because parents may not be answering truthfully and the results are thus inaccurate. They also encountered parents who disagreed with the profiles produced from their answers, or who were discouraged by their results/profile. Other coaches felt that the assessments did not measure "real" progress, and/or felt that the program just taught to the test, especially since the knowledge questions that were used to assess achievement of a competency associated with a lesson were taken directly from the assessments.

A significant challenge in completing post-RBV assessments was when parents were reunified with their children prior to this reassessment, or when their case was closed without a positive outcome. Further, a number of parents stopped participating due to replace and other factors. Re-assessments were also seen as difficult, if not impossible, in those cases where services were stopped by DHS because the agency was seeking to terminate parental rights.

4. *Challenges Implementing Debriefing Time*. Coaches described several challenges related to doing the Debrief component of the session, but most were also aware of the importance of it and were creative in adapting to circumstances. As indicated in the Fidelity Indicators, most did conduct regular debriefs, but qualitative feedback suggested that this was often in ways different from the original implementation plan. First, coaches reported shortening the debrief session (would could have impacted the fidelity indicator related to the overall duration of visits). Creative strategies utilized by coaches included doing the debrief via follow up phone calls if the parent couldn't stay or the child was present until the end, or talking to the parent while helping them put the child in the car to leave, or having the transporter walk ahead with the child while the coach talked to the parent. A few coaches talked about doing the debrief during the parent-child visit or doing the debrief for the last session at the beginning of the next session. Some reported preferring this latter approach if a parent's emotions were "too raw" at the end of a visit; this was contrary to one of the key purposes of the debrief which was to provide emotional support to parents after the visit.

[44] It should be noted that since the RBV program was implemented, the NSP curriculum has undergone a significant revision in part to address concerns related to the need to be more trauma-focused and to incorporate research related to brain development and trauma.

5. *NPP Curriculum Concerns*. Finally, some caseworkers and RBV providers expressed concerns about the curriculum used in RBV and the process and/or tools providers use to set the course of RBV services. Several coaches either felt the curriculum as too complicated, especially for parents with cognitive challenges, or felt that some parents' were "offended" by the "Easy Reader" version (an optional tool specifically developed for parents with cognitive challenges or delays).

   Caseworkers reported needing and wanting more information about the Curriculum and related assessment process. Caseworkers with misgivings about the curriculum, processes or tools often lacked information about the program or had unanswered questions. A caseworker commented, "*I would like a better understanding of what the evaluation process is between the [RBV provider] and the parent –how do they evaluate where they are at with their parenting? How are they going to identify what they are going to work on with the parent? And what curriculum or what practices do they use to implement that guidance and instruction?*" Another caseworker shared, "*With [Dad], I felt like the curriculum might be too complicated for him. I looked online about the Nurturing Parenting curriculum. I also hoped the provider would explain to me how she would apply the curriculum. But she never did.*"

6. *Lack of Caseworker Knowledge & Understanding of the Program.* One factor that seemed to have a substantial influence on implementation, especially during the first year of the project, was the lack of understanding among DHS caseworkers about the RBV program, and corresponding reluctance to approve families for eligibility and to make the needed referrals to the program. Statewide rollout of the program happened very quickly, and dissemination relied primarily on a "top down" communication method, at least at first. The State Waiver Manager and evaluation team met with DHS District Manager team, the attended statewide Supervisor's meetings, and held conference calls with leadership at individual Districts implementing RBV. This strategy worked well in some Districts, but in others front line staff were either unaware of RBV, or, in some cases, had concerns and were reluctant to engage. These concerns mostly had to do with the provision of visits outside of DHS, despite the fact that a trained RBV coach would be present throughout the visit. Over time, more caseworkers learned about the program and were more willing to refer, although caseworker turnover continued to present a challenge in "getting the word out" to DHS staff. Even two years into the project, caseworkers shared concerns about their lack of understanding of the model. One caseworker shared, "*I don't know what hours the classes are, or if it's even a class*," demonstrating a lack of awareness about the RBV model.

7. *Lack of Transportation.* Providers were not paid to transport parents or children to RBV visits, and many reported that relying on DHS for transportation support was difficult. For children, this often meant relying on foster parents to transport to the RBV site; alternatively overburdened DHS transport services were used, and coaches reported that these often resulted in cancelling or delaying RBV visits. Providers also noted the difficulty

for parents in getting to RBV visits, as most could not provide either transportation payments, bus tickets, or other transportation supports.

DHS caseworkers also reported struggling with transportation to facilities outside the DHS office. One noted, *"I have to figure out who is going to transport for this thing – I'm going between the parent trainer, parent, the foster parent, etc. That is incredibly time consuming. I become the middle-man in all aspects and I don't think that's appropriate*," said one caseworker. Especially in more rural districts, transportation issues were problematic. "*We are a small rural branch. I had to arrange a complex series of transportation to get everybody to the visits. I had to coordinate with the provider. She sometimes cancelled and rescheduled and that made it really difficult, to have to rearrange transportation,"* said one caseworker. Many caseworkers said they wished RBV programs could provide the transportation. RBV program managers also expressed this, with one stating *"If I could have changed on thing about RBV, it would be for us to be able to provide transportation".*

8. *Family and Parent Issues*, most frequently substance abuse, mental health challenges, and cognitive delays were seen as major barriers to initial engagement and retention in RBV services. Parents who went into residential treatment were eligible to continue or return to RBV services, but often were never successful engaged or re-engaged.

9. *Increased Workload.* Both coaches and caseworkers mentioned the additional workload related to RBV. Coaches in particular noted that the paperwork was significantly more than what was usually required by DHS. Caseworkers were more concerned about the increase in workload on the front end, at the time of eligibility determination and referral, but generally noted that over time the program had not resulted in workload increases. Some caseworkers suggested RBV actually reduces the burden on DHS. For some, and contrary to the original model that called for RBV to provide more visits that standard DHS procedures, the decreased workload was seen as due to RBV reducing the number of visits DHS needed to schedule, supervise, and provide physical space for. One caseworker explained, "*It's [RBV] assisted with pressure and lack of resources with DHS being able to provide adequate visitation. So the fact that it's in a different location, without other families and distractions, all of it has been wonderful..."* For other caseworkers, this had to do with reducing the amount of casework provided; "*I would say its decreased my workload in the sense that they [parents] have someone else that they can call in a crisis or for support and that it's not all falling to me. That's incredibly helpful for reducing casework,"* said a caseworker.

3. Collaboration: To what extent did caseworkers and RBV service providers collaborate to share information about the parents' service needs, progress, and outcomes?

Collaboration between RBV and DHS was hypothesized to be a central component of successful implementation. It seemed apparent given the model that there might be underlying tensions between the primary priority for caseworkers (safety for children) and primary priorities for RBV providers (improving parenting and parent-child attachment). Therefore, we included a

number of questions to understand the nature of collaboration as well as what factors supported more positive, or more challenging, collaboration.

3a. What factors facilitated successful information sharing and collaboration between DHS caseworkers and RBV service providers?

1. *History of Relationship.* Although a number of factors appeared to contributed to successful collaboration between DHS and RBV providers. The strongest and most successful collaboration seemed to exist when provider agencies had been providing services for DHS clients for years and so had a strong foundation with DHS for working together. This was the case in several counties.

2. *Leadership support for collaboration.* One of the most important roles played by program leadership was their support in helping to work through the process of collaboration with DHS. They did this in a variety of ways, including addressing higher level agency and policy issues, nurturing the overall relationship between their agency and DHS, as well as addressing RBV specific issues in that relationship (e.g., improving referrals, communication, or, in a few instances, facilitating conflict resolution between coaches and caseworkers or DHS supervisor.). This work was viewed as creating a context that prevented supervisors and direct service staff from getting "bogged down" in having to negotiate and work through these issues.

3. *Co-location of RBV staff at DHS*. A few providers had office space at the DHS branch and those who did described how it supported frequent communication between coaches and caseworkers. It also allowed coaches to more easily access parents to initiate contact (e.g. when they came to the branch to visit their children) and set up intake appointments for RBV. A few providers also succeeded in getting scheduled to do regular presentations at the branch(es) in their service area and this helped to improve communication, awareness and understanding of RBV services.

4. *Developing the relationship over time*. About a third of the providers mentioned that over time their relationships with DHS had improved as evidenced by more regular referrals and better communication between the DHS liaison and coaches, and between coaches and caseworkers. Strategies that contributed to improved relationships included leaders and coaches proactively working to improve relationships with DHS staff, coaches having office space in the branch, communicating with the State Waiver Manager to problem solve specific issues, and having regular (usually weekly) meetings between providers (usually a supervisor and/or coach) and a DHS staff person.

5. *Trust-building, Responsiveness and Communication.* Both DHS caseworkers and RBV providers felt that the collaboration was working well when both parties were responsive to each other's requests (for meetings, information, etc.) and when they felt as if they were "on the same page" in regards to the family's needs and goals. Some caseworkers also

appreciated RBV providers who were proactive in seeking out opportunities to engage in other DHS-related activities with the family, such as family meetings: "*I appreciate that the provider has actively inquired about attending meetings (FDMs) that would help her understand the parent*," explained a caseworker. Caseworkers especially seemed to appreciate when RBV providers quickly communicated via telephone or email any immediate or pressing concerns with the family. This may have helped support a feeling of trust in the relationship by clearly indicating that the RBV provider was alert to safety concerns that are the fundamental priority to caseworkers.

Another aspect of good communication was related to the type of information provided by RBV providers, in particular the Visit Documentation Forms and Monthly Progress reports. Some caseworkers reported that this information was extremely beneficial to the case, and appreciated that the reports were more detailed and easier to understand than the primarily narrative reports they typically received. Said one caseworker, *"They're (reports) really useful. They're pretty detailed and pretty insightful*." Another caseworker offered, "*Information on the forms is extremely useful. It's been very useful to see the strengths of the parents, the areas in which parents can grow and to see that process over weeks and months. The information is not only helpful for DHS but also for Attorneys and Judges."* One caseworker even suggested, *"We were able to do a return to parent and the reason we were able to do that was because we had the RBV documentation."*

Communication was also key to overcoming challenges related to ensuring the DHS staff understood the program well enough to be willing to approve families for eligibility and make the needed referrals. Doing this communication with DHS staff often took considerable effort on the part of the RBV providers, who reported putting together packets of information materials and disseminating them to caseworkers, and making repeated presentations at local DHS staff meetings. Because of relatively high levels of turnover among DHS caseworkers, doing this communication about the RBV program and its models and goals was most successful when RBV providers met regularly with DHS staff teams.

3b. What were the barriers and challenges in collaboration?

While the majority of RBV providers noted some positive aspects of their collaboration with DHS/Child Welfare, most also noted significant challenges. In fact, when asked what the biggest challenges were in providing RBV services, the partnership with DHS was one of the two challenges most frequently mentioned. Three major challenges in collaboration were mentioned most frequently: (1) Delays in getting referrals and/or getting referrals with adequate information about the family; (2) Lack of communication and information sharing between RBV providers and caseworkers; and (3) Lack of trust between RBV providers and caseworkers.

1. *Delays in Referrals.* As is clear from the data on eligibility and referral to the program, ensuring families were successfully referred to RBV providers was an ongoing challenge, especially in some Districts. Lack of knowledge or understanding of the RBV program was clearly a factor in these delays. As described previously, caseworkers' lack of knowledge

and understanding of the program was an important factor across multiple domains of implementation, but was perhaps particularly important at this early and critical stage of the program process. Providers mentioned that caseworkers didn't seem to know about RBV services until one of their families was randomly selected to receive services. In most counties it seemed that the RBV program was small in comparison to other services and programs that clients were receiving and so it "fell off the radar". A couple of providers were told by DHS staff that the fact that caseworkers had no control over selecting families who would be offered or receive RBV services also contributed to their lack of interest and awareness. Missing information on the referral form, especially contact information for the parent, sometimes made it difficult for providers to contact parents and offer services. In many cases, this was an area of improvement over time as communication improved between liaisons and providers. In a few instances, providers mentioned that although a family may have been assigned to receive RBV services and had been referred, the branch did not have the resources available to provide transportation for the child to the RBV facility and therefore was unwilling to make a referral. Finally, providers mentioned that staff turnover in DHS liaison positions (central to the referral process) also contributed to challenges with communication and referrals. Providers worked hard to establish and build relationships with DHS liaisons and then when there was turnover, they felt as though they were starting all over.

2. *Lack of Adequate Communication and Information sharing.* Communication and information sharing between RBV providers and DHS staff was also reported a significant challenge in some cases, although this appeared to be more related to differences in individual behavior than to particular districts or locations. Providers, for example, expressed frustration with caseworkers who did not respond to phone calls or emails. Caseworkers described dissatisfaction with RBV providers who frequently rescheduled visits or appointments or who did not provide timely communication about what happened during visitation sessions.

   Some caseworkers also questioned the quality of the information that they received from RBV. Caseworker comments included, *"Sometimes they seem hesitant to voice concern; I'd like them to feel comfortable calling me and letting me know,"* and *"I think that they're afraid of putting something negative in the [reports] that will come back in the trial. I can understand that, but it's also important to have accurate reporting."*

   While some caseworkers really appreciated the RBV paperwork (as described above), others found RBV documentation problematic. Sometimes this arose from a sense that the documentation was too strengths based, or not critical/balanced enough. A caseworker explained, *"They need a section in there where they can identify an area that outlines more criticisms – more areas of things that parents need to work on. I think they focus more on the positive things that mom was doing and not enough on what she's not doing. …I wanted to know – what is she not doing or what does she need to focus on?"* If caseworkers suspected the RBV provider of not being critical enough in their appraisal of a parent's

behavior in a visit, they mistrusted the provider reports. However, while some caseworkers perceived the RBV coach as not being completely forthcoming in their report, other caseworkers conceded that parents may actually behave differently when they are at the RBV visit than they do at DHS.

In most cases, caseworkers simply felt the reports lacked sufficient narrative. *"I felt like it was pretty minimal. They are very brief updates. It would be more useful if there were more details, more narrative,"* said one caseworker. *"I like that there is a summary, but there's times when I wish it was more detailed than it is. I'd like more details about the visit,"* said another caseworker. Caseworkers thought more narrative description would help them better understand what the parent is doing at the RBV visit and how they might be progressing. In some areas, RBV providers responded to these concerns by adding additional narrative to the RBV reports provided.

3. *Different Priorities & Distrust.* One of the most difficult challenges to address in terms of collaboration occurred when it was clear that there was a distrustful, and sometimes even antagonistic, relationship between caseworkers and RBV providers. Most often, this had to do with caseworkers' perception that RBV providers were allied with parents, sometimes to the degree that caseworkers were distrusting of information provided by RBV providers. One caseworker exemplifies this attitude, saying, *"It's [RBV] an opportunity for a parent to have someone on an allegedly professional level be [the parents'] buddy, not be critical, and give only positive feedback to DHS. I do not think that's helpful."* This caseworker's comment also points to a common issue in branches where caseworkers reported challenges in developing a good working relationship with the RBV provider --often conflict arose when RBV providers have a different (usually "strengths based") practice orientation towards working with parents than DHS. For example, one caseworker explains, "*Visits are for the children. RBV needs to understand that. Visits are not for the parent."* As providers of a parenting service delivered in the context of visitation, RBV programs tend to have a different perspective on this issue.

   Other caseworkers questioned the professionalism and/or qualifications of RBV professionals. Two caseworker comments are illustrative; *"Coaches do not understand safety issues in visits…it would be nice to know what the training and expertise are of the people working with our families and what is the understanding they have of safety and welfare," and "It's an opportunity for a parent to have someone … not be critical, and give only positive feedback to DHS. I do not think that's helpful."* Generally, it seems the strengths-based approach to services of some RBV providers creates tension with some caseworkers in the field. Some were disturbed by what they saw as too much focus on parent strengths and not enough focus on what parents needed to change.

4. Parent Involvement and Engagement: To what extent were parents involved and engaged in RBV services?

The RBV program generally, and the NS/NPP program specifically, was designed based on the assumption that involving parents in creating and individualizing their goals and work in the program was central to program success. At the same time, the level of individualization needed to take into account the documented safety concerns and conditions for return specified by DHS. Thus, there was the potential for family perspectives on what they needed to accomplish within RBV to differ from the priorities stated by DHS. To examine how providers engaged parents and what challenges and successes occurred in this area, the evaluators asked providers a number of questions about how they involved parents, and what the challenges were to doing so. Parent interviews also asked parents to describe their level of involvement in aspects of the RBV services. Below we summarize these findings.

4a. What factors helped parents be more involved and engaged in working towards their parenting goals?

1. *Persistent and positive outreach.* In terms of initially engaging families in the RBV program, RBV coaches reported that persistent and creative outreach efforts were important. At the start of service, persistence in contacting a parent was often necessary, and some coaches who had difficulty contacting parents would meet them at their scheduled DHS visit to introduce themselves and provide information about RBV. Many coaches noted that once parents started the service, most of them enjoyed it and wanted to stay engaged.

2. *Developing Positive Relationships with RBV Participants*. Developing a positive relationship with the parent, being supportive and using a strengths based approach were the strategies most often described and utilized by coaches to successfully engage families.

3. *Creating Multiple Opportunities for Family Input into Services.* Coaches appeared to be largely successful in engaging parents in developing their Family Nurturing Plan (FNP, the plan that guided the lessons and activities during RBV enrollment). Some successful strategies mentioned included:

    - Showing the parent the Table of Contents from the key curriculum guide, along with the list of Lesson topics and asking them to choose those that they were most interested in.
    - Suggesting some lessons to include in the curriculum after they reviewed the parent profiles (from the assessments) then inviting the parent to select others that they would like to include.
    - Developing different colored "flash cards" for each competency area in the curriculum. The competency was listed on one side of the flash card and the lessons associated with that competency were listed on the other. The coach laid the cards out on a table and invited the parent to select the areas and then the lessons in which they were most interested. This approach was very popular and adopted by several agencies after the provider agency that developed it shared it on a provider list serve.

The most successful examples seemed to balance letting parents make choices, and then having the RBV coach suggest additional choices, if needed, based on the AAPI results and/or DHS information regarding safety concerns. Further, RBV providers who facilitated frequent opportunities to review the FNP with the family, and to revise either the content or order of lessons based on the coach's observations, information from the caseworker, and/or conversations with parent.

4. *NS/NPP Materials.* Another core component of the RBV program were the materials provided by NPP curriculum developers; most important among these was the Parent Handbook, which was meant to engage families in working outside of the RBV lesson in activities, provide opportunities for parents to reflect on the lessons and activities, and to read and learn about key aspects of Nurturing Parenting. However, ensuring that parents were provided, and actively using these materials could be challenging and RBV providers reported a variety of strategies for helping parents engage with these program materials. All parents received a copy of the Parent Handbook in one way or another, with about half of the providers giving parents the complete handbook at the beginning of services. Others, noting that parents often forgot to bring the handbook with them to sessions, or when they sensed that parents' lives were so chaotic and unstable that it would be a burden for them to keep track of too many materials, would copy and give to the parents the relevant pages out of the handbook for each lesson as it was presented. Coaches also reported being strategic in using the Core Handbook vs. the "Easy Reader" version, which was specifically developed in a child welfare context for parents with low literacy and/or cognitive challenges. They described being sensitive to the fact that some parents could react negatively to the Easy Reader version if they felt it was below their ability level.

4b. What factors impeded parents' ability to successfully engage in services?

From the RBV providers' perspective, the biggest challenge in engaging families had to do with the initial outreach and engagement process. As noted above, most felt that once parents starting working with them and developing positive relationships, maintaining ongoing engagement was relatively easier. A number of the barriers to early referral have already been described. Additional challenges described by providers included insufficient contact information provided by DHS, parents with no working phone, and homelessness. Participant enrollment in residential treatment was also sometimes a barrier to engagement, especially if caseworkers did not communicate with providers about when parents were done with treatment.

Another key family engagement aspect of the NSP curriculum was the Family Nurturing Journal. However, this proved somewhat challenging to implement in the RBV context. First, it was not available in Spanish. Second, the FNJ included a regular "assignment" on the Family Nurturing Journal that asked parents "to spend time each day practicing nurturing skills with the child". Given that these parents did not generally have custody of their children, this was not possible.

Some providers edited the FNJ documents, either taking that practice out or adding something else that they could do.

5. Foster Parent Involvement: To what extent were foster parents involved in supporting parents' visits with their children?

Another element of the RBV program was related to supporting information-sharing and relationship development between foster parents and biological parents. As evidenced in the fidelity data, RBV providers were generally successful in at least providing opportunities for information exchange. Admittedly, however, there was little guidance built into RBV about the specific strategies for engaging foster parents and supporting foster parent-biological parent relationships. By far, the most frequent strategy employed was to encourage communication and information sharing when foster parents dropped off and/or picked up children for their RBV visits. However, the extent to which coaches proactively and/or creatively approached this communication differed considerably.

5a. What factors supported foster parent involvement?

1. *Proactive efforts by coaches to engage foster parents.* In some cases coaches directly facilitated conversations, or created space for a longer transition, even suggesting that a foster parent come a little early. One coach noted that some foster parents have been willing to come early and meet with the biological parent for as long as 30 minutes. Relative foster parents, in particular, were seen as generally (although not always) more willing to do this, as well as to stay through the visits.

In cases where the foster parent did not transport the child coaches would facilitate communication by relaying information back and forth or using a journal or notebook that could be passed back and forth from bio parent to foster parent.

Some coaches talked about the importance of helping foster parents understand why a child may be acting our after visits, or how to emotionally support the child around separation from parents, or helping to reframe a parent's view of the foster parent. Others shared information about the RBV program and the importance of communicating with the parent (e.g., it helped the child to see them communicating).

Typically, the types of information that were exchanged included information about the child's behavior, medical appointments or school events, or feeding and sleeping schedules for infants. When a parent had a question or concern, coaches would help the parent formulate the question or support them in communicating about it.

2. *Creative ways to foster information exchange.* A number of RBV providers began creating journals or binders for providing written information exchange between foster and biological approaches. This strategy was especially useful when foster parents didn't transport children. In these cases, the SSA or other adult could bring the notebook back and forth between the foster parent and the biological parent at the RBV session.

5b. What barriers were there to foster parent involvement?

The biggest challenge around foster parent-bio parent communication was when children were transported by someone else other than the foster parent in which case there was no opportunity for in person communication. As described above, providers did use notebooks and journals or relayed information back and forth in this cases. One provider was instructed by DHS staff not to talk to foster parents nor promote communication between bio parents and foster parents. This seemed to reflect a general stance of caseworkers at this branch protecting foster parents. Several other providers noted that some caseworkers seemed to be protective of foster parents and discouraged communication. Occasionally a foster parent would refuse to meet or communicate with the bio parent. And several providers noted that it could be more challenging working with relative foster parents because of family dynamics and history.

6. Strengths of the Model & Visitation Best Practice: To what extent and in what ways were RBV visitation services helpful and/or different from standard visitation?

6a. Overall strengths of the program

DHS caseworkers described the RBV programs as particularly important in terms of providing parents a positive opportunity to engage with a beneficial parenting services: Some caseworkers felt the educational style of RBV could be especially helpful. One explained, *"It's a hands-on parenting service, rather than sitting in a classroom. For our parents with lower IQ or who have a hard time paying attention, it's a better way to learn those concepts."*

Some caseworkers also noted that RBV provided parents a positive opportunity to engage with a service and be successful. *"Because parents really enjoy the program, they are more likely to show up for (RBV) visits than visits at a DHS office,"* said one caseworker. Another caseworker shared, *"One parent I had was really resistant to a lot of professionals and ended up doing so well and absolutely respected the [RBV] provider and if I had sent her to a parenting class it would have been a failure."*

Parent interviews provided a valuable source of information to help contextualize and understand which of the aspects of the RBV model were seen as most important. Analyses of 85 parents' responses found that the following were described as being "the most helpful part of RBV":

1. *One-on-one time with coaches.* The most common theme in parent interviews was appreciation for and recognition of the value of the one on one time parents had with their coaches.

   > *The one-on-one with someone from the program.*
   > *The lessons, and having her review how I implemented them during the visits. Having him actually work with me and my children together and the skill training. Lesson planning and time with the coach after visits. He was absolutely awesome.*

2. *Individualized approach* to parenting education and skills development. Parents appreciated that their lesson plans were tailored to their specific needs and interests and that they had input into developing the plan.

She had the lesson plans…based on my circumstances and my situation and she really paid attention and based our lesson plans on what I was going through.

The ability to choose what to work on and have someone explain ways to introduce it to my children.

3. *Practice time*: Opportunities to practice what they were learning with their children during the visits. Numerous parents mentioned the importance of engaging in the planned activities with their children, and getting to practice and try out what they had learned in the lesson.

   Practice time with the kid after a lesson. Just being able to implement it or try to use it with the kid.

   Practice time with my child is most helpful. Being able to share what I learned, having someone there to coach me.

4. *The relevance of the curriculum.* Parents mentioned numerous topics in the curriculum that were helpful to them. Most frequently mentioned was developing a new understanding of their children's behavior through empathy and knowledge of child development, the importance of taking care of themselves, and a new understanding of and approach to discipline.

   They showed me it was OK to take care of myself and not feel guilty about it. I had to take care of myself before I could take care of my daughter.

   They helped me take a different look at how to speak to and handle my children.

   Helping me understand certain behaviors…why he does what he does.

   Added on to my knowledge of taking care of children and nurturing them and helping them learn and grow; changed my way of thinking; gave me more insight in how to deal with my children.

   Learning to be consistent; learning how to do time-outs that are effective and do time-ins.

In addition to the visits and lessons/education, both DHS caseworkers and RBV parents talked about the additional benefits associated with the post-reunification support provided by RBV. For example, one caseworkers noted: "*I see it as helpful in getting the kids home and even providing support even once they get home*," Specifically referring to the importance of having ongoing support post-reunification. Parents saw this as beneficial as well. Some parents felt

that coaches were advocates and played a role in children returning home sooner either by providing positive reports of their progress directly to caseworkers, at family meetings, or even in court and by providing support in the home after children were returned.

> *My coach came to the house and helped with getting the house ready, brought a food box because I hadn't yet gotten food stamps and offered help with anything else I needed during the transition.*
>
> *They made the transition period from being in the foster home to being back a lot easier.*

6b. Alignment with Visitation Best Practices

One of the goals of the RBV program was to provide visits that were in alignment with current models of best practice in visitation. As such, visits were expected to: (1) increase in frequency, with RBV comprising an additional weekly visit; (2) be offered in family-friendly, naturalistic settings; (3) Provide age-appropriate activities to encourage parent-child interactions; and (4) be supported by the presence of a visitation coach.

DHS Caseworkers were asked to describe the ways they saw the RBV program helping families and children involved with child welfare. Several of the key benefits described indicated that caseworkers did perceive RBV as delivering services in alignment with visitation best practices, specifically:

- RBV offers parents an extra visit
- RBV provides visitation in a natural environment (non-DHS location)
- RBV gives parents one-on-one, hands-on, skill focused parenting help

In those places where RBV was used as an additional visit, caseworkers thought extra visits, especially in a natural environment (non-DHS location), were helpful for families. One caseworker suggested, *"The fact that it's [the visit] in a different location, without other families and distractions, it has been wonderful for all the families involved*." Two caseworkers explained how an extra visit benefits families, saying, *"It [extra visit] helps strengthen their attachment with the kids,"* and *"It gives them extra time with the kids and more individualized support in the parenting of the kids."*

The caseworker quoted above hints at how caseworkers also thought the one-on-one, hands-on, skill focused parenting help benefited families. Another caseworker said, *"It [RBV] provides case specific one-on-one parenting supports to parents who need help."* A different caseworker shared, *"Its additional parent education on-the-spot, with mentoring and fostering appropriate relationships with the child. Maybe sometimes [DHS staff] aren't able to have that direct an interaction."*

Parents also described a number of ways in which RBV visitation differed from their regular DHS supervised visits in ways that suggestion alignment with best practices. Specifically, parent described the following:.

1. *Family Friendly Environment*: RBV visits took place in a more comfortable, family friendly and relaxed setting, sometimes in the parent's home. It was also a relief to not be observed through a window. Parents also noted that this was beneficial for children, helping them feel more comfortable:

   "They were worlds apart. RBV was comfortable, homey environment, loving, open staff, and the guidance was really nice."

   "One big difference is that even though I was still having someone supervise, it wasn't behind the glass, and my daughter felt more comfortable. It was a more comfortable setting."

   "The children seemed more relaxed during the RBV visits….they seemed more willing to talk than at DHS."

2. RBV visits were more structured, which may be important for a trauma-informed practice.
   "I really like the RBV ones because they were more structured. The kids knew what to expect."

3. *Educational Component*: There was an educational, coaching and supportive aspect to RBV visits. Coaches were described as particularly helpful when they provided positive feedback, were engaged in visits, and provided good guidance and suggestions to parents

   "…if something's going wrong there is someone who can help walk you through what the problem is.."

   "RBV visits were more personal. I developed an honest relationship with the teacher, and she developed one with my children. She knows the whole family better than anyone."

   "They guided me through the visits and if I had any rough spots, they helped me to approach them and deal with them in the right way.
   The coach gave great feedback on how we are doing on progress."

4. *Emotional Support from Coaches*. Many parents emphasized how helpful and important it was to feel supported by a coach who was not judgmental and recognized their strengths and helped them through their struggles, whether through listening, problem solving, or directing them to resources. A few noted that their self-esteem and sense of self-worth improved as they worked with the coach.

   "I was never talked down to; I never felt judged. She helped me realize that I could be the same parent I was before I started using. She reassured me when I was losing hope."

"The support. They're there for you and they help you through situations that might seem difficult at the time. It's like they help you have a positive outlook on things, even when it's kind of hard to look at it like that. "

"My coach was really great. She was there for me. I get emotional talking about it. She did all these things to help me be a better parent. I really grew a lot.
They were positive supports and helped lift me up and my self-esteem."

6c. What challenges were there in RBV visits?

While the majority of DHS caseworkers who were interviewed were positive in their assessment of the RBV program, some caseworkers expressed concerns about the RBV visits. Sometimes concerns described by caseworkers were the "flip side" of the strengths of the program. For example, while many caseworkers felt the non-DHS setting for the visit was helpful to families, others felt concerned that visits occurred in natural settings. Said one caseworker, "*It's not appropriate for these families to be having such "casual" visits with their children… It's in a church, it's in the community. I don't know, to me that's an uncontrolled setting with someone who may or may not know the needs of the family."* As described previously, these concerns about the RBV visits were a particular challenge in those sites in which caseworker concerns were a barrier to making program referrals. Parents, at least those we interviewed, had very little negative to say about the RBV visits generally. A few parents suggested that coaches' feedback was sometime intrusive into the parent-child activity.

Outcome Study Results

Administrative Data Results - Child Welfare Outcomes

Approach to Administrative Data Analysis

Administrative child welfare records were extracted from Oregon's SACWIS, known as OR-Kids. DHS staff received reports from the PSU Evaluation Team with lists of eligible cases that were randomly assigned to either the Control or Relationship Based Visitation (RBV) group. Any children involved in these cases were flagged in the OR-Kids system, and the flags were used to extract records for these children. History in the child welfare system was assessed using foster care episodes, family stressors, and maltreatment report data recorded since 2000. Foster care placements associated with RBV involvement were defined as occurring 60 days prior to randomization date through June 2015.

We examined differences in groups based on two stratification schemes for children with two different follow-up periods. The intent-to-treat (ITT) stratification included all children that were randomized (RBV, *n*=1,751 vs. Control, *n*=1,887). The treatment-on-the-treated (TOT) stratification broke the RBV group into two smaller groups: those who had an RBV intake (Intake, *n*=957) and those who did not (No Intake, *n*=794). The two follow-up periods were: at least one year of post-randomization follow-up time (randomized by June 2014, *n*=3,464, or 95% of the total sample) and at least two years of post-randomization follow-up time

(randomized by June 2013, *n*=1,900, or 52% of the total sample). Thus, each analysis was conducted four times for each of the following samples:

1. ITT 1-year follow-up (RBV, *n*=1,694; Control, *n*=1,770)
2. ITT 2-year follow-up (RBV, *n*=972; Control, *n*=928)
3. TOT 1-year follow-up (RBV Intake, *n*=929; RBV No Intake, *n*=765; Control, *n*=1,770)
4. TOT 2-year follow-up (RBV Intake, *n*=544; RBV No Intake, *n*=428; Control, *n*=928)

Administrative Data Samples Baseline Equivalence

Given the randomized control design, we did not expect to see any baseline differences between the groups. To test this assumption, the first step in the analysis process was to examine whether the RBV group was statistically equivalent to the Control group on a number of history and demographic factors in two samples: (1) children with at least one year of post-randomization follow-up time; and (2) children with at least two years of post-randomization follow-up time. Table 1-10 and Table 1-11 (for the 1+ year and 2+ year samples, respectively) present the sample characteristics for the ITT groups and *p*-values for the statistical tests conducted to determine whether the Control and RBV groups were significantly different in each of the two samples; Table 1-12 and Table 1-13 (for the 1+ year and 2+ year samples, respectively) present the same information for the TOT groups.

A number of other family stressor variables were also tested for baseline equivalence, and none were statistically significant so they were omitted from the tables below for brevity: child emotionally or behaviorally disabled, parent had developmental disability, heavy child care responsibility, family financial stressors, social isolation, head of household unemployed, child developmental disability, child mental illness, new baby/pregnancy, single parent, and recent relocation).

For the Intent to Treat group at one year post randomization, there were only two significant baseline differences: Control children were somewhat more likely (89%), compared to RBV children (87%) to have had a prior neglect report, and were more likely to have had a prior foster care placement (25% vs. 20% for RBV). Additionally, RBV cases had a longer follow up time period in the data. These differences remained for the sample who had two years of follow up data except for the difference in length of follow-up period.

For the TOT group at one year post randomization, not surprisingly, a few more baseline differences emerged. Children whose parent had completed an RBV intake were slightly, but significantly younger (5.47 years) compared to RBV families without intake (5.95 years) and controls (5.93 years). Intaked RBV families were also somewhat more likely to have had a prior physical abuse report (44% vs. 40% for non-Intake RBV families and 39% for controls) and somewhat less likely to have had a prior neglect report (86% vs. 88% and 89%, respectively). These findings remain significant in the 2 year TOT sample; additionally, within the 2 year sample RBV families and Control families had fewer total prior reports (4) compared to RBV families who did not receive an intake (5 prior reports, on average).

To improve estimates of effects of RBV and to control for baseline inequivalence, the following child-level variables were included as covariates or predictors in the final child welfare outcome models:

- ITT 1- and 2-year follow-up samples: previous foster care
- TOT 1-year follow-up sample: previous foster care, child age, previous neglect report, parent history of abuse, and parent history of law enforcement involvement
- TOT 2-year follow-up sample: previous foster care, child age, previous neglect report, and number of previous reports

Previous neglect report and previous threat of harm report were highly correlated so only previous neglect report was retained as a covariate. Length of follow-up time (number of days from randomization to the end of the study window) was also included as a covariate in the models testing differences in days spent in foster care.

Table 1-10. Relationship Based Visitation vs. Control Group Baseline Equivalence Tests: Intent-to-Treat 1+ Years of Follow-Up Time

Characteristic		RBV %, mean, or median (*n*)	Control %, mean, or median (*n*)	Test Statistic Statistic (*df*)	*p*-value
Child age		5.7 (1,694)	5.9 (1,770)	*t*(1, 3,462) =1.60	.11
Child gender: Female		49% (824)	47% (839)	X^2=0.56	.46
Child race	White	73% (1,241)	73% (1,294)	*V*=0.04	.38
	Black/African American	3% (44)	2% (37)		
	Hispanic	15% (255)	17% (293)		
	American Indian/Alaskan Native/Native Hawaiian/Pacific Islander	4% (68)	4% (74)		
	Other/Unknown	5% (86)	4% (72)		
Length of follow-up time (randomization to end of study window) in days		778.8* (1,694)	750.6 (1,770)	*t*(1, 3,462)= -3.50	.001*
Number of reports prior to program randomization		4 (1,675)	4 (1,745)	*U*=0.06	.95
Days from earliest report to program randomization		966 (1,661)	957 (1,724)	*U*=-0.27	.79
Prior Threat of Harm Reports		83% (1,402)	82% (1,433)	X^2(1)=1.51	.22
Prior Mental Injury Reports		12% (199)	11% (196)	X^2(1)=0.35	.55
Prior Neglect Reports		87% (1,461)	89%* (1,560)	X^2(1)=3.92	.05*
Prior Physical Abuse Reports		42% (704)	39% (682)	X^2(1)=3.08	.08
Prior Sexual Abuse Reports		21% (357)	21% (360)	X^2(1)=0.24	.62
Previous foster care		20% (295)	25%* (383)	X^2(1)= 10.63	.003*
Parent involvement with law enforcement[1]		46% (366)	49% (391)	X^2(1)=2.29	.13
Parent involvement with alcohol &		77% (614)	75% (600)	X^2(1)=1.72	.19

Characteristic	RBV	Control	Test Statistic	*p*-value
drug abuse[1]				
Parent history of abuse[1]	25% (202)	28% (221)	$X^2(1)=1.59$	.21
Parent involvement with domestic violence[1]	41% (331)	40% (317)	$X^2(1)=0.24$	.63
Parent mental illness[1]	28% (225)	28% (219)	$X^2(1)=0.03$	.87
Inadequate housing[1]	20% (164)	22% (172)	$X^2(1)=0.40$	.53

***** Differences are statistically significant at least $p<.05$

[1] Differences tested at the case level, $n=1,597$

Table 1-11. Relationship Based Visitation vs. Control Group Baseline Equivalence Tests: Treatment on the Treated 1+ Years of Follow-Up Time

Characteristic		RBV (Intake)	RBV (No Intake)	Control	Test Statistic	*p*-value
		%, mean, or median (*n*)	%, mean, or median (*n*)	%, mean, or median (*n*)	Statistic (*df*)	
Child age		5.5[a] (929)	6.0[ab] (765)	5.9[b] (1,770)	$F(2, 3,461)=3.76$	.02*
Child gender: Female		48% (366)	49% (458)	47% (839)	$V=0.02$	.64
Child race	White	72% (665)	75% (576)	73% (1,294)	$V=0.05$	.40
	Black/African American	3% (25)	3% (19)	2% (37)		
	Hispanic	16% (145)	14% (110)	17% (293)		
	American Indian/Alaskan Native/Native Hawaiian/Pacific Islander	4% (40)	4% (28)	4% (74)		
	Other/Unknown	6% (54)	4% (32)	4% (72)		
Length of follow-up time (randomization to end of study window)		794.5[b] (929)	759.8[a] (765)	750.6[a] (1,770)	$F(2, 3,461)=10.62$	.001*
Number of reports prior to program randomization		4 (921)	4 (754)	4 (1,745)	$H(2)=1.27$	.53
Days from earliest report to program randomization		997 (908)	911 (753)	957 (1,724)	$H(2)=0.40$	.82
Prior Threat of Harm Reports		84% (781)	82% (621)	82% (1,433)	$V=0.03$	.22
Prior Mental Injury Reports		12% (115)	11% (84)	11% (196)	$V=0.02$	.59
Prior Neglect Reports		86%[a] (793)	88%[ab] (668)	89%[b] (1,560)	$V=0.04$	.04*
Prior Physical Abuse Reports		44% (402)	40% (302)	39% (682)	$V=0.04$	.07
Prior Sexual Abuse Reports		23% (209)	20% (148)	21% (360)	$V=0.03$	.28
Previous foster care		21%[ab] (165)	20%[b] (130)	25%[a] (383)	$V=0.06$	.005*

Characteristic	RBV (Intake)	RBV (No Intake)	Control	Test Statistic	*p*-value
Parent involvement with law enforcement[1]	52%$_b$ (221)	47%$_a$ (170)	46%$_a$ (366)	*V*=0.05	.12†
Parent involvement with alcohol & drug abuse[1]	77% (328)	78% (286)	75% (600)	*V*=0.04	.36
Parent history of abuse[1]	31%$_b$ (131)	25%$_a$ (90)	25%$_a$ (202)	*V*=0.06	.08†
Parent involvement with domestic violence[1]	41% (176)	39% (141)	41% (331)	*V*=0.02	.69
Parent mental illness[1]	29% (123)	26% (96)	28% (225)	*V*=0.02	.74
Inadequate housing[1]	22% (93)	22% (79)	20% (164)	*V*=0.02	.82

†Differences in pairwise comparisons but not overall test, $p<.05$

***** Differences are statistically significant at least $p<.05$

[1] Differences tested at the case level, n=1,597

Table 1-12. Relationship Based Visitation vs. Control Group Baseline Equivalence Tests: Intent-to-Treat 2+ Years of Follow-Up Time

Characteristic		RBV %, mean or median (*n*)	Control %, mean, or median (*n*)	Test Statistic	*p*-value
Child age		5.4 (972)	5.7 (928)	$t(1,898)=1.39$	.16
Child gender: Female		47.3% (459)	48.7% (452)	$X^2(1)=0.39$	.53
Child race	White	73.3% (712)	71.3% (662)	*V*=0.06	.20
	Black/African American	2.6% (25)	2.0% (19)		
	Hispanic	15.3% (149)	18.4% (171)		
	American Indian/Alaskan Native/Native Hawaiian/Pacific Islander	3.5% (34)	4.2% (39)		
	Other/Unknown	5.3% (52)	4.0% (37)		
Length of follow-up time (randomization to end of study window)		952.4 (972)	946.3 (928)	$t(1, 1,898)=-1.03$	.30
Number of reports prior to program randomization		4 (962)	4 (913)	*U*=0.53	.60
Days from earliest report to program randomization		929 (954)	900 (899)	*U*=-0.30	.76
Prior Threat of Harm Reports		86% (830)	83% (758)	$X^2(1)=3.83$	.05*
Prior Mental Injury Reports		13% (123)	10% (92)	$X^2(1)=3.39$	.07
Prior Neglect Reports		85% (821)	90%* (819)	$X^2(1)=8.13$	.004*
Prior Physical Abuse Reports		42% (409)	39% (352)	$X^2(1)=3.05$	.08
Prior Sexual Abuse Reports		22% (209)	22% (205)	$X^2(1)=0.14$	.70
Previous foster care		21% (178)	28%* (217)	$X^2(1)=8.76$	.003*

Characteristic	RBV	Control	Test Statistic	*p*-value
Parent involvement with law enforcement[1]	47% (201)	43% (201)	$X^2(1)=0.27$	.61
Parent involvement with alcohol & drug abuse[1]	78% (363)	76% (325)	$X^2(1)=0.47$	.49
Parent history of abuse[1]	27% (126)	25% (107)	$X^2(1)=0.48$	.49
Parent involvement with domestic violence[1]	42% (194)	43% (181)	$X^2(1)=0.04$	.84
Parent mental illness[1]	29% (136)	26% (111)	$X^2(1)=1.17$	.28
Inadequate housing[1]	21% (95)	17% (73)	$X^2(1)=1.61$	.20

***** Differences are statistically significant at least $p<.05$

[1] Differences tested at the case level, $n=888$

Table 1-13. Relationship Based Visitation vs. Control Group Baseline Equivalence Tests: Treatment on the Treated 2+ Years of Follow-Up Time

Characteristic		RBV (Intake)	RBV (No Intake)	Control	Test Statistic	*p*-value
		%, mean, or median (*n*)	%, mean, or median (*n*)	%, mean, or median (*n*)	Statistic (*df*)	
Child age		5.0_b (544)	6.0_a (428)	5.7_a (928)	$F(2, 1,897) = 7.78$	.001*
Child gender: Female		48% (259)	47% (200)	49% (452)	$V=0.02$	.80
Child race	White	73% (396)	74% (316)	71% (662)	$V=0.05$	.43
	Black/African American	2% (13)	3% (12)	2% (19)		
	Hispanic	15% (82)	16% (67)	18% (171)		
	American Indian/Alaskan Native/Native Hawaiian/Pacific Islander	4% (23)	3% (11)	4% (39)		
	Other/Unknown	6% (30)	5% (22)	4% (39)		
Length of follow-up time (randomization to end of study window)		959.6_b (544)	943.3_a (428)	946.3_a (928)	$F(2, 1,897) = 2.39$	.09†
Number of reports prior to program randomization		4_a (541)	5_b (421)	4_a (913)	$X^2=8.68$	.01*
Days from earliest report to program randomization		882 (533)	964 (421)	900 (899)	$H(2)=3.51$	.17
Prior Threat of Harm Reports		86% (464)	86% (366)	83% (758)	$V=.04$	.16
Prior Mental Injury Reports		12% (65)	14% (58)	10% (92)	$V=.05$	.13
Prior Neglect Reports		$83\%_a$ (450)	$88\%_{ab}$ (371)	$90\%_b$ (819)	$V=.08$	.002*
Prior Physical Abuse Reports		$40\%_{ab}$ (216)	$46\%_a$ (193)	$39\%_b$ (352)	$V=.06$	.05*
Prior Sexual Abuse Reports		20% (108)	24% (101)	22% (205)	$V=0.03$	.33
Previous foster care		$20\%_b$ (96)	$23\%_{ab}$ (82)	$28\%_a$ (217)	$V=0.08$	.01*
Parent involvement with law enforcement[1]		50% (131)	47% (96)	47% (201)	$V=0.03$	.70

Characteristic	RBV (Intake)	RBV (No Intake)	Control	Test Statistic	*p*-value
Parent involvement with alcohol & drug abuse[1]	77% (201)	80% (162)	77% (325	*V*=0.03	.64
Parent history of abuse[1]	30% (79)	23% (47)	25% (107)	*V*=0.06	.17
Parent involvement with domestic violence[1]	44% (113)	40% (81)	43% (181)	*V*=0.03	.73
Parent mental illness[1]	30% (79)	28% (57)	26% (111)	*V*=0.04	.48
Inadequate housing[1]	21% (55)	20% (40)	17% (73)	*V*=0.05	.41

***** Differences are statistically significant at least $p<.05$

[1] Differences tested at the case level, $n=888$

Analysis Results for Administrative Child Welfare Outcomes

After examining baseline equivalence, we followed a multi-step process for analyzing data using two samples, cases with at least one year of follow-up time (randomized on or before June 2014), and cases with at least two years of follow-up time (randomized on or before June 2013).

1. Simple intent-to-treat (ITT) analyses (RBV vs. Control) testing differences in outcomes (*t*-test, chi-squared)
2. Simple treatment-of-the-treated (TOT) analyses (RBV no intake vs. RBV intake vs. Control) testing differences in outcomes (ANOVA, Cramer's V)
3. ITT analyses with covariates testing differences in outcomes after adjusting for baseline differences (ANCOVA, logistic regression)
4. TOT analyses with covariates testing differences in outcomes after adjusting for baseline differences (ANCOVA, logistic regression)
5. Nested ITT analyses with covariates testing differences in outcomes after adjusting for baseline differences and accounting for case-level clustering (General Linear Mixed Model, GLMM)
6. Nested TOT analyses with covariates testing differences in outcomes after adjusting for baseline differences and accounting for case-level clustering (General Linear Mixed Model, GLMM)

To test the assumption that covariates must have homogeneity of slopes in each group (ITT=Control vs. RBV; TOT=Control vs. RBV No Intake vs. RBV Intake), group X covariate interactions were tested for each outcome. Significant interactions were tested as moderators in the models. We also examined a number of moderators of program effects (from OR-Kids family stressors data) including: history of inadequate housing; history of parent alcohol and drug abuse; history of parent mental illness; and history of domestic violence in the family. Main effects for program are reported in Tables 1-14 – 1-17, and moderated effects for program are summarized in Table 1-18. The tables include unadjusted means and percentages, and significance tests from steps 5 and 6 (which included adjustments for covariates and case-level clustering).

As can be seen in the Table 1-14 – 1-17 below, results follow a similar pattern across all of the iterations of the treatment vs. control comparisons (ITT and TOT) and for the two follow up periods. Generally, and counter to expectations, RBV children tended to spend more time in foster care compared to controls. In the ITT models, for children with at least one year of follow-up data, RBV children spent an average of 417 days in an out of home placement, compared to only 384 days for control children; however this difference was not statistically significant. For children with two years of follow up data, the magnitude of the difference was similar, (476 days vs. 443 days), and also not significantly different. For the TOT analyses, RBV children whose parents had had an intake stayed in care for significantly more days (448 days in 1 year sample; 501 days in 2 year sample) than either randomized controls (386 and 443 days); or the RBV/unserved families (373 days and 442 days). Additionally, RBV children who had an intake took longer to reach their first trial reunification, compared to RBV/non-intaked families or controls (note that only the RBV intake vs. RBV non-intake contrasts were significant). For the two year TOT group, the significant contrast was between the RBV intake group compared to the RBV-no intake group.

Table 1-14. Intent-to-Treat Child Welfare Outcomes: 1+ Years of Follow-up Time

Outcome		RBV % or mean (*n*)	Control % or mean (*n*)	Test Statistic (*df*) value	*p*-value
Days in foster care[1]		417.07[†] (851)	384.8 (885)	*F*(1, 1,036) = 2.88	.09[†]
	Median	369	346		
	SD	235.9	228.2		
	Min/Max	2 - 1,118	1 - 1,068		
Time to first trial reunification[2]		234.16 (757)	229.08 (794)	*F*(1, 929) = 0.30	.59
	Median	196	200		
	SD	181.7	172.7		
	Min/Max	1 - 1,120	1 - 1,009		
Ever reunified[3]		52.7% (740)	55.8% (785)	*F*(1, 2,805) = 1.16	.28
Ever in relative care[4]		55.5% (757)	56.5% (762)	*F*(1, 2,705) = 0.17	.68
Ever in non-relative care[4]		67.2% (918)	68.1% (921)	*F*(1, 2,712) = 0.15	.70
Re-removal[5]		13.9% (103)	12.4% (97)	*F*(1, 1,518) = 0.24	.63
Re-report[6]		12.3% (201)	11.7% (198)	*F*(1, 2,878) = 0.22	.64

Notes. All models contained previous foster care involvement (yes/no) and child race (White, African American, American Indian/Alaskan Native/Native Hawaiian/Pacific Islander, Hispanic, Other) as covariates. Different subscript letters denote significantly different means or percentages. *SD*=standard deviation.

[†] $p<.10$, *$p<.05$ or less

[1] Sample based on a subset of children with at least 1 year of post-randomization follow-up time and were not in foster care episode at the end of the RBV study window (*n*=1,736 or 50% of the 1-year follow-up sample, *n*=3,464). This model also included length of follow-up period as a covariate.

[2] Sample based on a subset of children with at least 1 year of post-randomization follow-up time and had a trial reunification placement by the end of the RBV study window (*n*=1,551 or 45% of the 1-year follow-up sample, *n*=3,464).

[3] Sample based on a subset of children with at least 1 year of post-randomization follow-up time and exited from foster care to be reunified by the end of the RBV study window (*n*=2,812 or 81% of the 1-year follow-up sample, *n*=3,464).

[4] Sample based on a subset of children with at least 1 year of post-randomization follow-up time and were in an out-of-home placement at some point post-randomization (*n*=2,712 or 78% of the 1-year follow-up sample, *n*=3,464).

[5] Sample based on a subset of children with at least 1 year of post-randomization follow-up time that were reunified and then had a new foster care episode before the end of the RBV study window (*n*=1,525 or 44% of the 1-year follow-up sample, *n*=3,464).

[6] Sample based on a subset of children with at least 1 year of post-randomization follow-up time with maltreatment report records (*n*=3,324 or 96% of the 1-year follow-up sample, *n*=3,464).

Table 1-15. Treatment-of-the-Treated Child Welfare Outcomes: 1+ Years of Follow-up Time

Outcome		RBV Intake	RBV No Intake	Control	Test Statistic	*p*-value
		% or mean (n)	% or mean (*n*)	% or mean (*n*)	(*df*) value	
Days in foster care[1]		448.08_b (491)	373.68_a (359)	386.32_a (881)	$F(2, 1{,}021) = 6.67$	.001*
	Median	401	318	346		
	SD	224.8	228.2	228.2		
	Min/Max	15 – 1,118	2 – 985	1 – 1,068		
Time to first trial reunification[2]		243.45_b (480)	210.14_a (301)	225.57_{ab} (843)	$F(2, 973) = 3.94$	.02*
	Median	218	155	200		
	SD	182.8	178.2	172.7		
	Min/Max	2 – 1,120	1 - 782	1 - 1,009		
Ever reunified[3]		54.1% (419)	51.0% (321)	55.8% (785)	$F(2, 2{,}795) = 0.75$	.48
Ever in relative care[4]		53.9% (411)	57.7% (346)	56.5% (762)	$F(2, 2{,}695) = 0.69$	.50
Ever in non-relative care[4]		69.1% (527)	64.7% (391)	68.1% (921)	$F(2, 2{,}702) = 0.96$	.38
Re-removal[5]		13.4% (56)	14.6% (47)	12.4% (97)	$F(2, 1{,}509) = 0.11$	.90
Re-report[6]		13.2% (119)	11.2% (82)	11.7% (198)	$F(2, 2{,}873) = 0.29$	.75

Notes. All models contained previous foster care involvement (yes/no) child race (White, African American, American Indian/Alaskan Native/Native Hawaiian/Pacific Islander, Hispanic, Other), child age, parent involvement with law enforcement (yes/no), previous neglect report (yes/no), and parent history of abuse (yes/no) as covariates. Different subscript letters denote significantly different means or percentages. *SD*=standard deviation

**p*<.05 or less

[1] Sample based on a subset of children with at least 1 year of post-randomization follow-up time and were not in foster care episode at the end of the RBV study window (*n*=1,736 or 50% of the 1-year follow-up sample, *n*=3,464). This model also included length of follow-up period as a covariate.

[2] Sample based on a subset of children with at least 1 year of post-randomization follow-up time and had a trial reunification placement by the end of the RBV study window (*n*=1,551 or 45% of the 1-year follow-up sample, *n*=3,464).

[3] Sample based on a subset of children with at least 1 year of post-randomization follow-up time and exited from foster care to be reunified by the end of the RBV study window (*n*=2,812 or 81% of the 1-year follow-up sample, *n*=3,464).

[4] Sample based on a subset of children with at least 1 year of post-randomization follow-up time and were in an out-of-home placement at some point post-randomization (*n*=2,712 or 78% of the 1-year follow-up sample, *n*=3,464).

[5] Sample based on a subset of children with at least 1 year of post-randomization follow-up time that were reunified and then had a new foster care episode before the end of the RBV study window (*n*=1,525 or 44% of the 1-year follow-up sample, *n*=3,464).

[6] Sample based on a subset of children with at least 1 year of post-randomization follow-up time with maltreatment report records (*n*=3,324 or 96% of the 1-year follow-up sample, *n*=3,464).

Table 1-16. Intent-to-Treat Child Welfare Outcomes: 2+ Years of Follow-up Time

Outcome		RBV % or mean (*n*)	Control % or mean (*n*)	Test Statistic (*df*) value	*p*-value
Days in foster care[1]		476.44_b (560)	443.81_a (555)	*F*(1, 660) = 2.76	.09†
	Median	453.5	434		
	SD	246.6	249.0		
	Min/Max	10 – 1,118	1 – 1,068		
Time to first trial reunification[2]		252.81 (468)	254.30 (436)	*F*(1, 523) = 0.03	.85
	Median	221	217		
	SD	197.17	196.5		
	Min/Max	1 – 1,120	1 – 1,009		
Ever reunified[3]		57.8% (463)	61.9% (452)	F(1, 1,524) = 1.01	.32
Ever in relative care[4]		57.9% (453)	59.1% (414)	*F*(1, 1,477) = 0.20	.66
Ever in non-relative care[4]		68.6% (540)	71.2% (502)	*F*(1, 1,485) = 0.72	.40
Re-removal[5]		16.2% (75)	15.7% (71)	*F*(1, 908) = 0.04	.85
Re-report[6]		15.6% (146)	15.4% (134)	*F*(1, 1,553) = 0.01	.91

Notes. All models contained previous foster care involvement (yes/no) and child race (White, African American, American Indian/Alaskan Native/Native Hawaiian/Pacific Islander, Hispanic, Other) as covariates. Different subscript letters denote significantly different means or percentages. *SD*=standard deviation

† *p*<.10

[1] Sample based on a subset of children with at least 2 years of post-randomization follow-up time and were not in foster care episode at the end of the RBV study window (*n*=1,115 or 59% of the 2-year follow-up sample, *n*=1,900). This model also included length of follow-up period as a covariate.

[2] Sample based on a subset of children with at least 2 years of post-randomization follow-up time and had a trial reunification placement by the end of the RBV study window (*n*=904 or 48% of the 2-year follow-up sample, *n*=1,900).

[3] Sample based on a subset of children with at least 2 years of post-randomization follow-up time and exited from foster care to be reunified by the end of the RBV study window (*n*=1,531 or 81% of the 1-year follow-up sample, *n*=1,900).

[4] Sample based on a subset of children with at least 2 years of post-randomization follow-up time and were in an out-of-home placement at some point post-randomization (*n*=1,484 or 78% of the 1-year follow-up sample, *n*=1,900).

[5] Sample based on a subset of children with at least 2 years of post-randomization follow-up time that were reunified and then had a new foster care episode before the end of the RBV study window (*n*=915 or 48% of the 1-year follow-up sample, *n*=1,900).

[6] Sample based on a subset of children with at least 2 years of post-randomization follow-up time with maltreatment report records (*n*=1,806 or 95% of the 2-year follow-up sample, *n*=1,900).

Table 1-17. Treatment-of-the-Treated Child Welfare Outcomes: 2+ Years of Follow-up Time

Outcome		RBV Intake	RBV No Intake	Control	Test Statistic	*p*-value
		% or mean (*n*)	% or mean (*n*)	% or mean (*n*)	(*df*) value	
Days in foster care[1]		501.33_b (325)	442.02_a (235)	443.81_a (555)	*F*(2, 657)= 4.10	.02*
	Median	468	405	434		
	SD	237.0	255.9	249.0		
	Min/Max	63 – 1,118	10 – 985	1 – 1,068		
Time to first trial reunification[2]		263.39_b (287)	236.03_a (181)	254.30_{ab} (436)	*F*(2, 52) = 3.85	.03*
	Median	224	199	217		
	SD	198.9	193.9	196.5		
	Min/Max	5 – 1,120	1 – 782	1 – 1,009		
Ever reunified[3]		57.9% (265)	57.7% (198)	61.9% (452)	*F*(2, 1,515) = 0.45	.64
Ever in relative care[4]		55.6% (253)	61.0% (200)	59.1% (414)	*F*(2, 1,468) = 0.77	.46
Ever in non-relative care[4]		69.9% (318)	66.9% (222)	71.2% (502)	*F*(2, 1,476) = 1.03	.36
Re-removal[5]		16.6% (44)	15.7% (31)	15.7% (71)	*F*(2, 903) = 0.02	.98
Re-report[6]		16.0% (84)	15.2% (62)	15.4% (134)	F(*2*, 1,549) = 0.05	.95

Notes. All models contained previous foster care involvement (yes/no) child race (White, African American, American Indian/Alaskan Native/Native Hawaiian/Pacific Islander, Hispanic, Other), child age, previous neglect report (yes/no), and number of previous maltreatment reports as covariates. Different subscript letters denote significantly different means or percentages. *SD*=standard deviation

**p*<.05 or less

[1] Sample based on a subset of children with at least 2 years of post-randomization follow-up time and were not in foster care episode at the end of the RBV study window (*n*=1,115 or 59% of the 2-year follow-up sample, *n*=1,900). This model also included length of follow-up period as a covariate.

[2] Sample based on a subset of children with at least 2 years of post-randomization follow-up time and had a trial reunification placement by the end of the RBV study window (*n*=904 or 48% of the 2-year follow-up sample, *n*=1,900).

[3] Sample based on a subset of children with at least 2 years of post-randomization follow-up time and exited from foster care to be reunified by the end of the RBV study window (*n*=1,531 or 81% of the 1-year follow-up sample, *n*=1,900).

[4] Sample based on a subset of children with at least 2 years of post-randomization follow-up time and were in an out-of-home placement at some point post-randomization (*n*=1,484 or 78% of the 1-year follow-up sample, *n*=1,900).

[5] Sample based on a subset of children with at least 2 years of post-randomization follow-up time that were reunified and then had a new foster care episode before the end of the RBV study window (*n*=915 or 48% of the 1-year follow-up sample, *n*=1,900).

[6] Sample based on a subset of children with at least 2 years of post-randomization follow-up time with maltreatment report records (*n*=1,806 or 95% of the 2-year follow-up sample, *n*=1,900).

Outcome Analysis Results: Subgroup Analyses

To better understand if outcomes varied depending on family or child characteristics, a series of moderator analyses were conducted to examine Group (Treatment vs. Control) X Subgroup effects; subgroups were described previously, and included: history of inadequate housing; history of parent alcohol and drug abuse; history of parent mental illness; and history of domestic violence in the family. These results are summarized in Table 1-18 below, and graphed in Figures 1-1 to 1-7. Graphs are based on unadjusted means and percentages. Patterns for significant interaction effects for 1-year and 2-year samples were similar (where significant) and thus only results for 1-year samples were graphed.

Table 1-18. Significant Moderation (Group X Stressor) Effects

Moderator	Outcome	Follow-Up Period	Analysis	Test Statistic	p-value
Family history of inadequate housing	Ever reunified	1+ year	ITT	$F(1, 2{,}798) = 6.84$	.01
			TOT	$F(2, 2{,}792) = 3.59$	.03
		2+ year	ITT	$F(1, 1{,}520) = 9.46$	.002
	Ever in relative care	2+ year	TOT	$F(2, 1{,}515) = 4.75$	.01
			ITT	$F(1, 1{,}473) = 4.19$	.04
	Time to first trial reunification	1+ year	ITT	$F(1, 924) = 5.10$	.02
Family history of domestic violence	Time to first trial reunification	1+ year	TOT	$F(2, 169) = 3.76$	.03
Parent history of abuse as a child	Ever in relative care	1+ year	TOT	$F(2, 2{,}693) = 3.06$	.05
	Ever in non-relative care	1+ year	TOT	$F(2, 2{,}700) = 3.92$	.02

Notes. Test statistics presented are from models with covariates.

Figure 1-1. Inadequate Housing Moderation Effects: Reunification Rate (ITT 1 Year Sample)

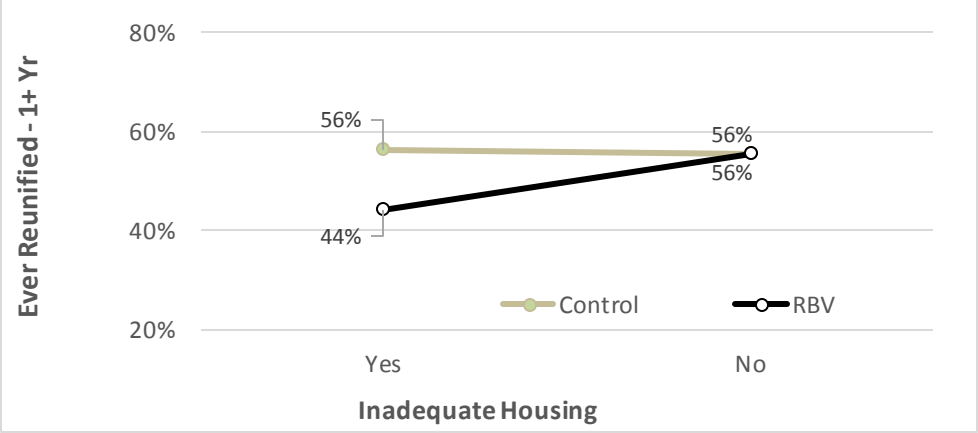


Figure 1-1 shows a similar pattern in terms of reunification likelihood. When housing inadequacy is a family stressor, RBV families were less likely to be reunified (56% v. 44%), while there is no significant difference in reunification rates for families without this stressor.

Figure 1-2. Inadequate Housing Moderation Effects: Reunification Rates (TOT 1 Year Sample)

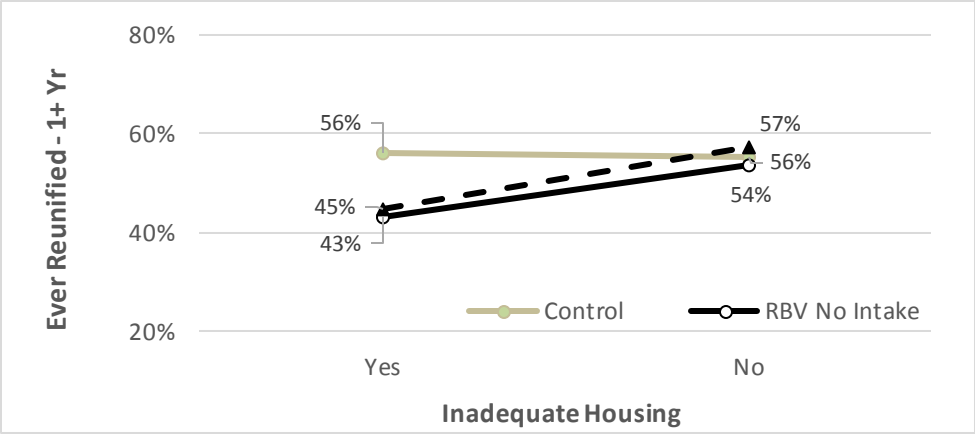
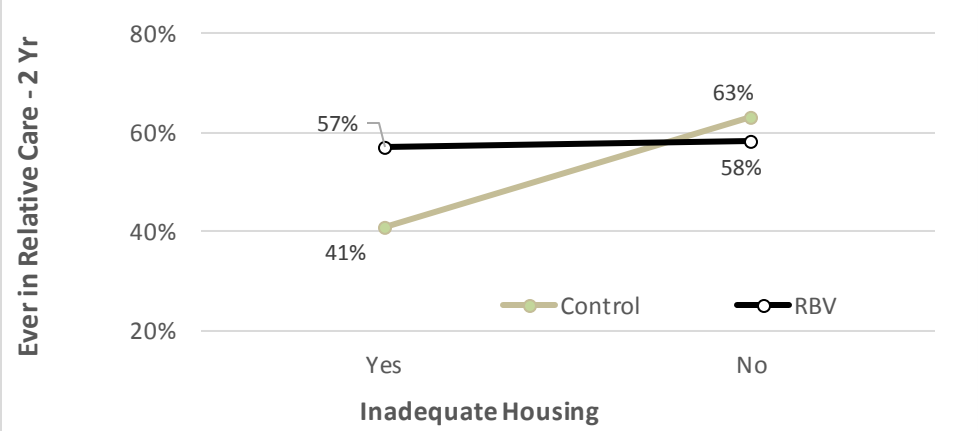


Figure 1-2 indicates that this finding of less positive outcomes for RBV families with housing-related stressors held for both RBV/intake and RBV/not intake group. Thus, whether families actually engaged in RBV services, for families assigned to this group with inadequate housing, changes of reunification were somewhat less than for control group families.

Figure 1-3. Inadequate Housing Moderation Effects: Ever in Relative/Kinship Care (2 Year ITT)



As shown in Figure 1-3, families with housing-related stressors who were in the RBV group were more likely to have a child placed with a relative (57% for RBV vs. 41% for controls). There were no differences between the two groups when housing was not a stressor. Control families were much less likely to have a child placed in a kinship placement if they had inadequate housing, compared to if they did not have housing issues.

Figure 1-4. Inadequate Housing Moderation Effects: Ever in Relative Care (TOT, 1 Year sample)

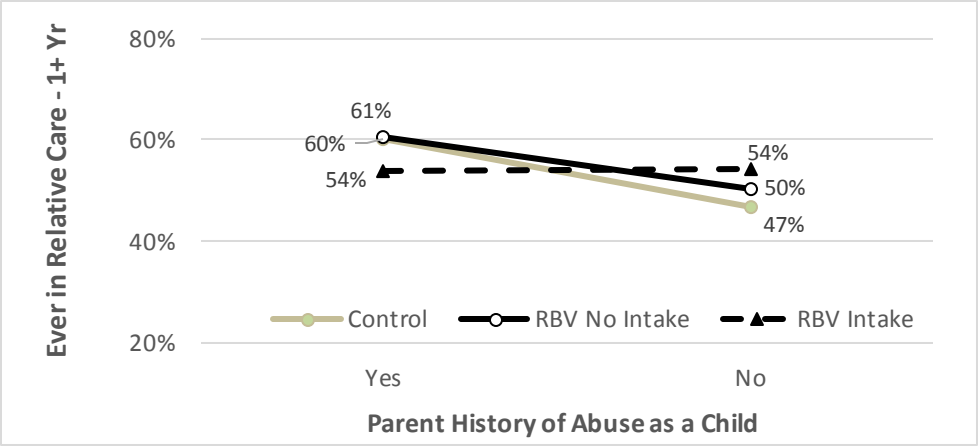


Figure 1-4 shows that RBV/Intake children were somewhat less likely (54%) to have been in relative care if parent had history of abuse than control/RBV no intake with this stressor (60%). Further, while both Controls and RBV/no intake children were somewhat less likely to have a child in relative care if they did not have parents with a history of abuse, while they were more likely to have a child placed with relatives if they did. For RBV children, parental history of abuse did not appear to relate to the likelihood of kinship placement.

Figure 1-5. Parental History of Abuse: Ever in Non-Relative Care (TOT)

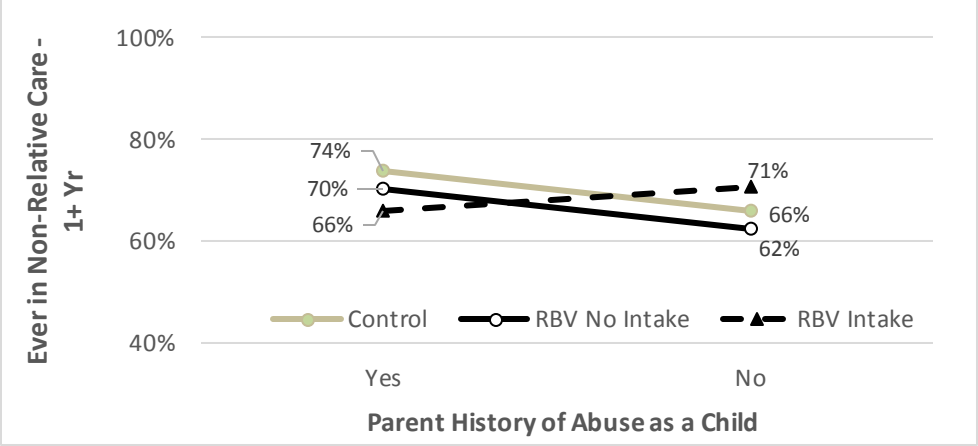
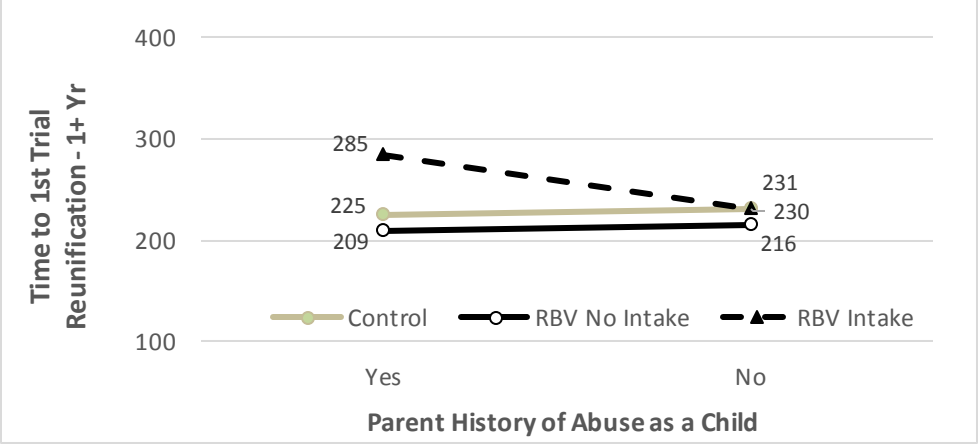


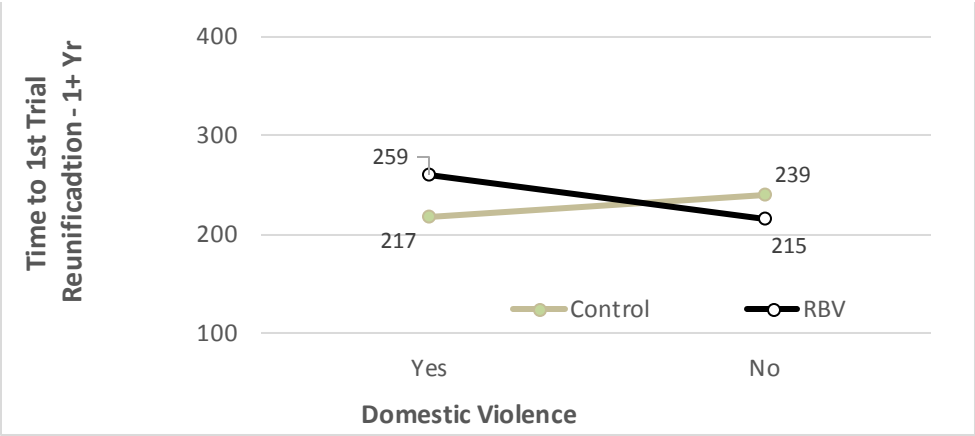
Figure 1-5 shows a similar pattern of results for whether children were ever in non-relative foster care. Controls were more likely than RBV intake to have a non-relative placement if there had been a history of abuse. This pattern was reversed for families without this childhood history; RBV children were more likely to have a non-relative placement, compared to controls and non-intaked RBV children.

Figure 1-6. Parent History of Abuse: Time to 1st Trial Reunification



As shown in Figure 1-6, when parents had a history of childhood abuse, RBV intake families took longer, relative to controls and non-intaked RBV families, to reach reunification. This pattern was similar to families with a history of domestic violence (Figure 1-7) for the intent to treat groups, with RBV children taking longer to reach a first reunification, compared to controls, when there was domestic violence in the home.

Figure 1-7. History of Domestic Violence: Time to 1st Trial Reunification (ITT)



Results: Parent Interview Study

Parent Interview Study Baseline Equivalence

Because the parent interview samples were not random samples of participants, we conducted baseline equivalency analyses (t-tests for continuous variables and Chi-Squared analyses for categorical variables) to compare the treatment and control groups at baseline on demographic characteristics as well as on baseline parent interview measure scores (Table 1-19 below).

As can be seen, there were a few significant differences between treatment and control participants at the time of the baseline interviews. In terms of demographic characteristics, RBV families were somewhat more likely to be in lower income bracket, compared to

comparison families. Comparison families were also somewhat more likely to be categorized as "unknown" in terms of the child's race/ethnicity. Not surprisingly, RBV families were more likely to be participating in parenting-related services. RBV families also reported higher levels of social support and more "readiness to change" using a measure specifically developed for assessing this construct with child-welfare involved parents, even at the baseline interview. This may be because RBV parents had largely already connected with the RBV program by the time the baseline interviews were conducted, and may have been anticipating greater success based on their initial intake to the program. Variables that indicated baseline differences between groups were used as controls in subsequent outcome analyses.

Table 1-19. Baseline Equivalency on Outcome Variables for Key Parent Interview Sample (n=195).[5]

	Treatment % or mean (total n=*85*)	Control % or mean (total n=*110*)	Test Statistic	p-value	Alpha (reliability)
DHS Services Offered					
1. % offered parenting services	69% (59)	62% (68)	X^2 = 1.22	.27	NA
2. % participating in parenting services	48% (41)*	31% (34)	X^2 = 6.08	.01	NA
3. % providing input into visitation plan	44% (37)	46% (50)	X^2 = 0.07	.79	NA
4. Level of involvement in visitation plan (scale 1-4)	2.00 (85)	2.00 (110)	*t* = 0.00	1.0	NA
Parent Interview Scale/Measure					
1. Protective Factors Scale (PFS)(total)	4.43 (85)	4.31 (110)	*t* = -1.84	.07	.78
2. PFS—Family Functioning subscale	3.92 (85)	3.99 (110)	*t* = 0.62	.54	.86
3. PFS—Social support subscale	4.47 (85)*	4.18 (110)	*t* = -2.16	.03	.75
4. PFS—Concrete Support subscale	4.36 (85)*	3.96 (110)	*t* = -2.71	< .01	.70
5. PFS—Nurturing subscale	4.55 (85)	4.43 (110)	*t* = -1.15	.25	.47
6. PFS—Parenting subscale	4.81 (85)	4.77 (110)	*t* = -0.86	.39	.67
7. Parenting Stress Index (PSI) (total)	1.56 (85)	1.61 (110)	*t* = 0.72	.47	.83
8. PSI—General Distress subscale	1.97 (85)	1.94 (110)	*t* = -0.33	.74	.72
9. PSI—Parenting Stress subscale	1.63 (85)	1.71 (110)	*t* = 0.78	.44	.62
10. PSI—Parent-Child Dysfunctional Interaction subscale	1.19 (84)	1.31 (109)	*t* = 1.90	.06	.67
11. PSI—Parent Perception of Child subscale	1.37 (84)	1.42 (110)	*t* = .68	.50	.56
12. PSI—Parent-Child Dysfunction + Parent Perception of Child[6]	1.27 (83)	1.36 (109)	*t* = 1.49	.14	.75
13. Readiness to Change Parenting	3.23 (85)*	2.96 (110)	*t* = -2.58	.01	.76

[5] Sample sizes for individual variables may differ due to missing data.

[6] Reliability for the Parent-Child Dysfunctional Interaction scale and the Parent Perception of Child scales was improved substantially when these two scales were combined. Therefore, we used only the combined scale for outcome analysis.

	Treatment % or mean (total n=*85*)	Control % or mean (total n=*110*)	Test Statistic	p-value	Alpha (reliability)
Behavior (REDI) (total)					
14. Substance Abuse Screening (SSI-SA)	1.69 (83)	1.82 (110)	*t* = .63	.53	.79
15. Depression Screening (PHQ9)	1.29 (75)	0.99 (106)	*t* = -1.59	.12	.90

Results: Parent Interview Outcomes

To examine outcomes measured in the parent interviews, we examined outcomes at follow up using Analyses of Covariance and using group (ANCOVAs, RBV vs. Control) as a factor, and controlling for baseline REDI and the baseline outcome score on each dependent variable. When statistically significant, an interaction term (baseline*group) was included in the model to help adjust for violations of homogeneity of variance.

A second set of analyses was conducted including a dichotomized indicator of family income (baseline difference; < $15K vs. $15K+) as a control; however, these results were the same and income was not generally related to outcomes so results of the original set of analyses are presented in Table 1-20. F-statistics represent the difference between treatment and control group at follow-up, controlling for baseline status on that measure and REDI scores.

As can be seen, RBV parents were significantly higher at follow up in two areas measured by the Protective Factors Survey: Perceived Social Support and Nurturing Approach. Social support may have increased for these parents based on their positive relationship with coaches, which was reported by parents as being a key element of the success of the program. Positive outcomes on the measure of Nurturing Parenting supports the other positive outcomes shown for RBV participants as measured by the program assessment-related tools (AAPI and NSCS, see below).

The measures of parent-related stress assessed with the Parenting Stress Index did not show significant differences between program and control participants at follow-up, although means were generally in the right direction (e.g., lower parenting-related stress in the RBV participant group).

Table 1-20. Impact Analysis for Parent Interview Scale/Measures

	Treatment	Control				
	Baseline % or mean (total *n*)	Follow Up % or mean (total *n*)	Baseline % or mean (total *n*)	Follow Up % or mean (total *n*)	*Test Statistic*	*p-value*
1. Protective Factors Scale (PFS)(total)	4.43 (85)	4.54 (85)	4.31 (110)	4.40 (110)	*F*(1,191) = 2.30	.13
2. PFS—Family Functioning subscale	3.92 (85)	4.10 (85)	3.99 (110)	4.07 (110)	*F*(1,191) = 0.34	.56

	Treatment	Control				
	Baseline % or mean (total *n*)	Follow Up % or mean (total *n*)	Baseline % or mean (total *n*)	Follow Up % or mean (total *n*)	*Test Statistic*	*p-value*
3. PFS—Social support subscale	4.47 (85)	4.61* (85)	4.18 (110)	4.25 (110)	$F(1,191) = 4.57$	.03
4. PFS—Concrete Support subscale	4.36 (85)	4.49 (85)	3.96 (110)	4.30 (110)	$F(1,191) = 0.63$	.43
5. PFS—Nurturing subscale	4.55 (85)	4.64* (85)	4.43 (110)	4.47 (110)	$F(1,191) = 3.88$	.05
6. PFS—Parenting subscale	4.81 (85)	4.83 (85)	4.77 (110)	4.78 (110)	$F(1,191) = 1.24$	.27
7. Parenting Stress Index (PSI) (total)	1.56 (85)	1.48 (85)	1.61 (110)	1.58 (110)	$F(1,191) = 1.44$	.23
8. PSI—General Distress subscale	1.97 (85)	1.78 (85)	1.94 (110)	1.89 (110)	$F(1,191) = 1.39$	.24
9. PSI—Parenting Stress subscale	1.63 (85)	1.52 (85)	1.71 (110)	1.61 (110)	$F(1,191) = 0.30$	.59
10. PSI—Parent-Child Dysfunction + Parent Perception of Child	1.27 (83)	1.28 (83)	1.36 (109)	1.38 (108)	$F(1,187) = 1.23$	.27

Results: AAPI and NSCS Parenting Assessments

To examine other parent-related outcomes we used the results of the AAPI and NSCS assessments. As described previously, for RBV participants, these were collected at the time of enrollment and exit from the program through the RBV provider. Comparison participants completed them over the telephone or via an online system at baseline and approximately 9 months later. Because these samples were not random samples of participants, we conducted baseline equivalency analyses (t-tests for continuous variables and Chi-Squared for categorical variables) to compare the two groups at baseline on demographic characteristics as well as baseline AAPI and NSCS scores (see Table 1-21 below).

As can be seen, there was a significant difference in terms of family income, with RBV families more likely to be in the lowest income category. In terms of baseline parenting assessments, RBV parents had significantly more positive attitudes in several areas, compared to controls, but were significantly lower in terms of their ability to manage children's behavior. RBV parents also reported significantly higher self-care skills. Outcome analyses controlled for these baseline characteristics.

Table 1-21. Baseline Equivalence for AAPI-NSCS Outcome Sample (n=295)[7].

	Treatment % or mean (total *n*)	Control % or mean (total *n*)	Test Statistic	p-value	Alpha (reliability)
Gender – female	76.1% (188)	82.1% (106)	*t* = 1.44	.23	NA
Race/ethnicity:	(188)	(107)			
White	82.4%	73.8%			
African American	1.6%	0%	Cramer's *V*	.07	NA
Hispanic	8.0%	9.3%	= 0.17		
Native American	4.8%	6.5%			
Other/Unknown	3.2%	10.3%			
Average age at interview	30.2 (187)	31.9 (107)	*t* = 1.79	.08	NA
% No partner (single, separated, divorced, widowed)	64.9% (188)	72.0% (107)	X^2 = 1.55	.21	NA
% Did not graduate HS	38.1% (181)	37.7% (106)	X^2 = 0.01	.95	NA
% Unemployed or retired	71.0% (183)	78.5% (107)	X^2 = 0.85	.36	NA
Number of children	2.7 (188)	2.9 (107)	*t* = 0.57	.57	NA
Family Income	(164)	(142)			
< 15K	80.5%	71.3%			
15-25K	9.1%	19.8%*	Cramer's *V*	.04	NA
26-40 K	5.5%	6.9%	= 0.20		
40-60K	3.7%	0%			
Over 60K	1.2%	2.0%			
AAPI Scales					
16. AAPI Inappropriate Expectations	2.66 (188)	2.92* (106)	*t* = -3.02	< .01	.73
17. AAPI Lack of Empathy	1.89 (188)	2.04* (104)	*t* = -1.96	.05	.76
18. AAPI Belief in Corporal Punishment	1.79 (188)	1.91* (104)	*t* = -1.97	.05	.81
19. AAPI Role Reversal	2.01 (188)	2.07 (105)	*t* = 0.01	.99	.74
20. AAPI for Lack of Support Children's Power	1.78 (188)	1.72 (107)	*t* = 1.87	.06	.50
NSCS Risk factors					
21. % Abused as a child	59.9% (187)	65.4% (104)	X^2 = 0.91	.64	NA
22. % A&D problem (self)	55.1% (187)	52.4% (103)	X^2 = 0.19	.66	NA
23. % Abused by partner or spouse	41.3% (184)	40.8% (103)	X^2 = 0.01	.93	NA
24. % Abused partner/spouse	21.3% (183)	29.4% (102)	X^2 = 2.34	.13	NA
25. Family violence (avg)	2.10 (187)	2.14 (105)	*t* = -0.36	.72	NA
26. Quality relationship with partner/spouse (higher score =higher quality)	3.45 (181)	3.35 (106)	*t* = -0.63	.53	NA
NSCS Scales – Parent's Nurturing Skills					
27. Managing child's behavior	3.26 (186)	3.51* (106)	*t*=3.64	<.01	.84
28. Self-care	2.74 (187)	2.90* (107)	*t*=1.98	.05	.81
29. Nurturing parenting skills	3.71 (187)	3.74 (107)	*t*=0.65	.52	.81

[7] Sample sizes for individual variables may differ due to missing data.

All outcome analyses were conducted on follow up assessment scores using ANCOVA, with group (RBV vs. control) as a factor, a dichotomized indicator of family income (baseline difference; < $15K vs. $15K+), and the baseline assessment score. When statistically significant, an interaction term (baseline score *group) was included in the model to help adjust for violations of homogeneity of variance). The graphs presented below are based on unadjusted means but the significance of the effect was based on the adjusted models. In the case of nurturing skills (which was highly negatively skewed), the model with robust errors did not show a significant effect for group, so that graph is not presented below. The models with covariates did not have the same sample size due to the inclusion of income, which had some missing data (n=262, RBV=164, Control = 97).

Results comparing baseline and follow up scores for RBV vs. Control participants are shown in Figures 1A and 1B. The figures represent data from a subsample of RBV participants and control participants (n=292, 188 RBV, 104 Control). Results suggest that RBV participants showed significantly more improvement over time (compared to controls) on: (1) having appropriate expectations for children; (2) avoiding corporal punishment; (3) empathy; (4) appropriate parent-child roles; and (5) supporting children's power and independence. RBV participants also showed significantly more improvement on: (1) behavioral management skills; and (2) self-care. The largest improvements were in the areas of self-care, understanding age-appropriate expectations, and behavioral management skills. Control parents generally stayed the same or worsened slightly worse in all these areas over time. These results do suggest that RBV participants improved their parenting attitudes and skills over time, relative to controls.

Several constructs had a significant interaction term included in the model (baseline*group) suggesting that the relationship between T1 and T2 outcomes differed depending upon whether you were RBV or control. Graphs suggest that the improvements experienced by RBV parents were driven by parents who scored lower at baseline and improved to a greater degree, and this pattern was not as strong among controls. The models that included an interaction term were corporal punishment, behavior management, self-care, and nurturing skills.

Figure 1-8: Changes in Parenting Attitudes for RBV Participants vs. Controls

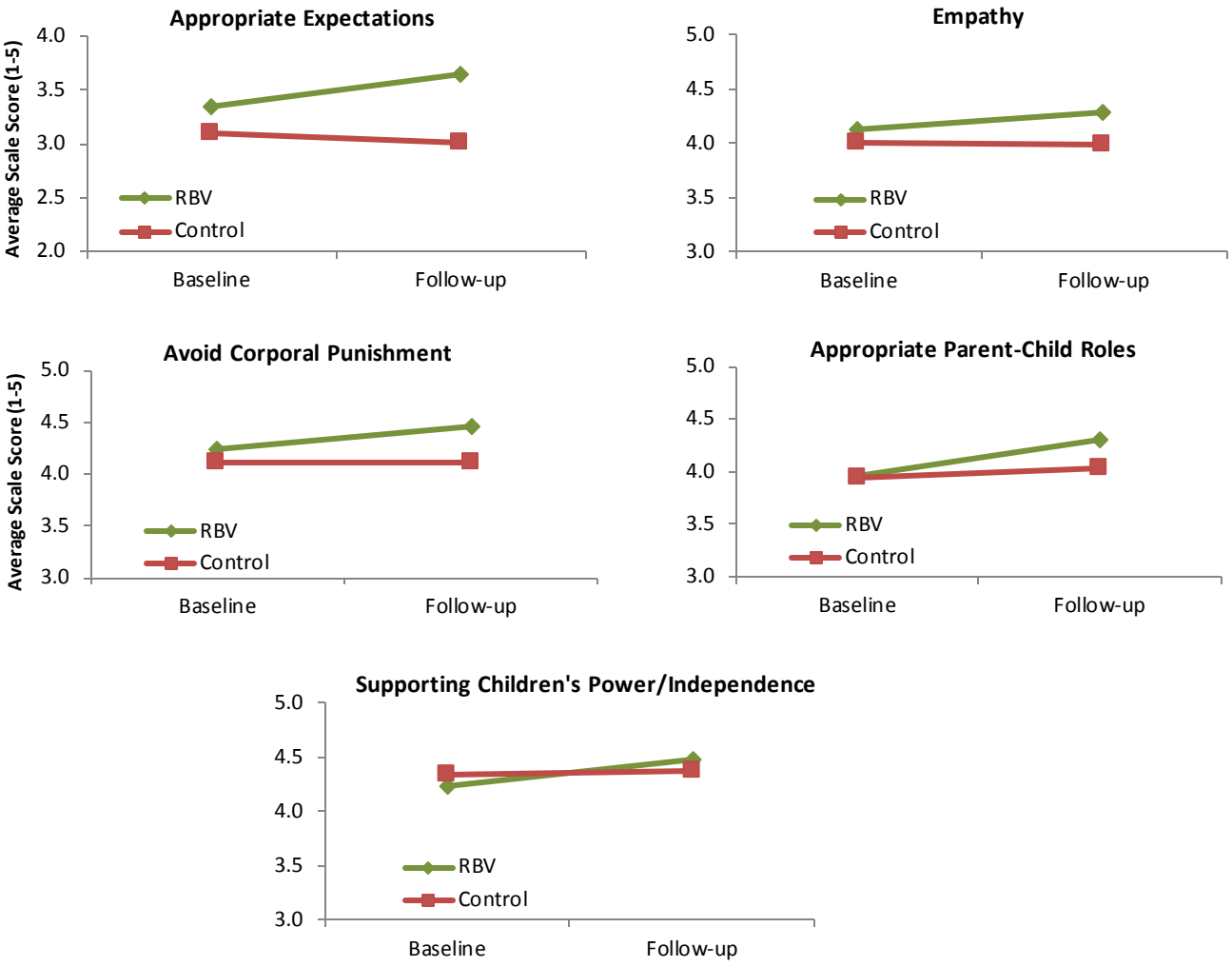
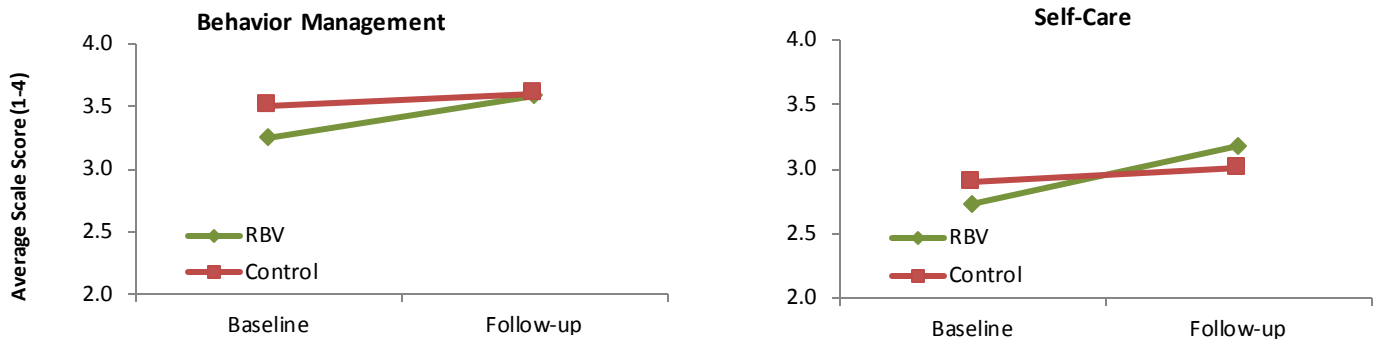


Figure 1-9: Changes in Parenting Skills for RBV Participants vs. Controls



Relationship of Fidelity & Dosage to Outcomes

To begin to explore the relationship between RBV fidelity indicators and child welfare outcomes, we calculated correlation coefficients (Pearson's R) between selected fidelity indicators (see Table 1-22) and the set of key child welfare outcomes. As can be seen, several indicators were significantly associated with outcomes. Generally, increased dosage (more sessions, more time in visits) tended to be associated with children spending more time in care but also with a greater chance of reunification. Similarly, families who received more sessions and spent more time in services also tended to have children in non-relative foster care. Families who were rated as being more engaged in visits also had children who spent more time in care but were more likely to be reunified. Similarly, families who made better progress were more likely to have children remain in care longer, but much more likely to be reunified. Finally, completing the Family Nurturing Plan was associated with taking longer to be referred, being less likely to have been placed with kin, more days in care, but greater likelihood of reunification.

Table 1-22. Correlations Between RBV Fidelity Indicators and Child Welfare Outcomes (n=878-497)

	Days from referral to first intake	Relative Care? 1=yes 0=no	Days in Care	Days to First Reunification	Ever Reunified? 1=yes 0=no	Ever re-reported? 1=yes 0=no
# Sessions	-0.07	-0.13**	0.10*	0.18**	0.11**	0.02
Average sessions/month	-0.02	-0.11**	0.01	-0.01	0.15***	-0.02
Average session time	0.12	0.03	-0.02	0.11**	-0.07	0.01
Total Time in visits/sessions	-0.01	-0.13	0.12**	0.21***	0.07	0.02
Engagement Rating	-0.04	-0.04	-0.13**	0.08	0.10*	-0.03
Progress Rating	-0.06	-0.11**	-0.16**	-0.03	0.23***	-0.03
Ever completed FNP?	-0.10*	-0.13**	-0.11*	-0.11**	0.24***	0.08

**p<.05, **p<.01, ***p<.001*

Table 1-23 below shows the family characteristics that were associated with RBV service delivery. As can be seen, several family characteristics were associated with the level of services received. Families who were White (as opposed to non-White) tended to spend somewhat more time in their RBV sessions, and spent a greater total amount of time in services. White families were also rated as making more progress, and were more likely to have completed their FNP. A history of having a child placed out of home was not generally associated with services, and neither was parent age. However, having either an Alcohol/Drug-related stressor or an IPV related stressor at investigation was associated with receiving fewer

sessions, and spending less time in service. Families with an AOD stressor were also less likely to have ever completed an FNP.

Table 1-23. Correlations Between RBV Fidelity Indicators and Parent Characteristics (n=1053-911)

	Race (1=White, 0=non-White)	Prior Foster Care Episode	Parent Age	Alcohol/Drug	IPV	Mental Illness
# Sessions	0.061	-.049	-.076*	-.207**	-.129**	.007
Average sessions/month	.022	.032	-.015	-.052	-.118**	.055
Average session time	.079*	-.091*	-.023	-.052	.093**	.-.034
Total Time in visits/sessions	.076*	-.062	-.072*	-.187**	-.096**	.008
Engagement Rating	-.012	.018	.046	.011	.015	-.049
Progress Rating	.123**	.005	.045	-.038	.011	.016
Ever completed FNP?	.116**	-.073	-.015	-.144**	-.023	.060

**p<.05, **p<.01, ***p<.001*

Finally, to better understand the relationship between the various child welfare outcomes, we examined the inter-correlations between the key outcomes for RBV families with an intake as shown in Table 1-24 below. As can be seen, when children stayed in care longer, they were less likely to be reunified. Further, when children were placed with kin, the chances of reunification were lower, and these children also tended to stay in care for longer. Generally speaking, reunification was negatively associated with days in foster care placement, such that the longer children spent in care, the less likely were they to be reunified (r-.476**). However, given the results of the fidelity correlations, it appears that for RBV children who received more service may be both more likely to remain in care longer, but also more likely to be reunified. Given these rather complex patterns, further exploration of the relationship between fidelity and outcomes is warranted, although beyond the scope of this report.

Table 1-24. Correlations Between Key Child Welfare Outcomes – RBV Intake Families

	Relative Care? 1=yes 0=no	Days in Care	Days to First Reunification	Ever Reunified? 1=yes 0=no
Placed in relative/kinship care	--			
Days in out of home care	.243***	---		
Days to first reunification	.098	.766***	--	

	Relative Care? 1=yes 0=no	Days in Care	Days to First Reunification	Ever Reunified? 1=yes 0=no
Ever reunified	-.125***	-.476***	-.134***	**
Ever re-reported	.007	.055	-.045	.049

**p<.05, **p<.01, ***p<.001*

RBV: Summary, Limitations & Conclusions

Summary of Outcomes

Participants in the RBV program showed improvements in a number of areas of parenting skills, attitudes, and competencies, relative to controls. These improvements were seen in both the standardized assessments used within the NS/NPP curriculum-related measures (AAPI and NSCS) as well as in an additional measure of parenting administered to a smaller set of participants via the parent interviews. In the interview subsample, RBV parents, compared to controls, reported more feeling more social support and greater frequency of nurturing parent behaviors. On the AAPI and NSCS measures, RBV participants had higher scores at follow up, relative to controls, in terms of: (1) having appropriate expectations for children; (2) avoiding corporal punishment; (3) empathy; (4) appropriate parent-child roles; and (5) supporting children's power and independence. RBV participants also showed significantly more improvement on: (1) behavioral management skills; and (2) self-care skills. The largest improvements were in the areas of self-care, understanding age-appropriate expectations, and behavioral management skills. Control parents' scores in these domains generally stayed the same or decreased slightly over time.

Despite these encouraging results in the parenting domain, there were few corresponding benefits in terms of child welfare outcomes. In fact, contrary to expectations, children who participated (at least through intake) in RBV remained in out of home care longer, compared to controls, were no more or less likely to be reunified, and were no more or less likely to be re-reported to the child welfare system or to re-enter foster care. These results generally did not vary for families with different characteristics at entry into the child welfare system, although RBV families with inadequate housing were somewhat less likely to be reunified, compared to controls.

Program fidelity data supports the relationship of RBV services to extended time in out of home placements, as families who received more RBV services tended to have children who remained in care longer periods of time. However, these families were also more likely to be reunified, an effect not seen in the overall RBV sample. It may be that judges and/or caseworkers are more willing to continue to give parents opportunities to address their case plans and safety

concerns if the parent is engaged with, and supported by, the RBV program. This might have the unintended effect of increasing the time spent by children in out-of-home care, but eventually lead to more positive outcomes in terms of family reunification. Further, it appeared that families whose child was placed in relative care tended to receive *fewer* RBV services, and were rated as making less progress during visits. Placement in relative care was also related to longer lengths of stay in out-of-home placements and to lower reunification rates. To the extent that parents are less motivated to engage in services and/or to complete the RBV program because their children are placed with a family member, this could also lead to lower reunification rates and longer lengths of stay in out of home care.

Finally, it should be noted that although results did not find significant differences in outcomes for families with substance abuse, mental health, or domestic violence issues, both substance abuse and IPV were associated with reduced parent involvement in the RBV program. These findings were consistent with initial concerns that engaging these families in the RBV model would be especially challenging.

Process evaluation results suggest that implementing RBV with fidelity to the planned model was quite challenging, especially in terms of both initial engagement of referred parents and in terms of the frequency of sessions and visits. These implementation challenges maybe have had a significant impact on the ability of RBV to impact child welfare outcomes. Providers reported creative adaptations to maintain the "spirit" of the program, especially related to the core structure – lesson, visit, debrief—as well as to the way that they facilitated foster parent involvement were used relatively frequently. In particular, data suggest that initial and sustained involvement in RBV services was challenging for a variety of reasons. First, it appeared that in a number of DHS offices, there was little initial communication with DHS staff about the RBV program and its potential benefits. DHS workers often had concerns and/or misconceptions about the service, which contributed to reluctance to make needed referrals. More effective communication with DHS staff about the RBV program, which families were eligible, and what the service model looked like, may have helped to improve initial referral rates as well as information sharing. Building relationships between DHS and RBV providers played a significant role, either positively or negatively, in the ability of RBV providers to be able to engage families, especially initially.

Further, a number of families who began services did not complete them. In particular, it appears that families with substance abuse and domestic violence issues were more difficult to engage. Although this is not uncommon especially among child welfare-involved families with multiple challenges, additional training and support for RBV staff may have helped to improve program services in this area. There was a clear and documented need for additional, ongoing support both in the NSP curriculum and in other aspects of coaching that, if they could have been provided, might have given coaches additional tools for sustaining families in services. Collaboration between DHS and RBV providers, may have also influenced family engagement over the long term, however, especially in terms of decision making around whether and when to reunify.

The need to individualize service structure to better meet the needs of families was clearly important to being able to engage families at all, at least in some cases. These modifications while reducing fidelity, may have increased quality and engagement. Certainly, the initial goal of providing one RBV session per week was not met for the large majority of families. Additional logistical supports (e.g., transportation for parents and children) as well as enhanced engagement strategies on the part of RBV providers, may have strengthened this component. Given the finding that fidelity was more challenging for families with specific risk factors (especially domestic violence and substance abuse) incorporating supports specifically related to those issues into the RBV framework, perhaps through partnering directly with service providers or using a wrap-around type model to connect families with auxiliary resources, might be important.

These and other family concerns may have reduced the ability of RBV to impact child welfare (as opposed to parenting) outcomes. The model was specifically designed to focus on parenting and improving parenting skills; however, families involved with child welfare often have a number of other needs and issues that they must address in order to be successfully reunified. Issues such as stable and safe housing, mental health, and substance abuse all posed serious safety concerns in a large percentage of RBV and child welfare clients; at the same time, RBV services did not speak to these needs, retaining a rather narrow focus on parenting. Providing RBV services along with more intensive case management or other supports to ensure that these other safety concerns can be addressed, might be a more effective model for impacting child welfare-related outcomes.

In terms of the quality of services provided by RBV coaches, parents (at least those who participated in interviews) clearly felt the services were beneficial, and that they reflected the intended philosophical approach of using a strength-based, family-driven model. Parents also saw the naturalistic and supportive visit environment as helpful. These factors may have been associated with the relatively positive effects that RBV services appeared to have on parenting skills and competencies, albeit without impacts on child welfare outcomes.

Finally, it is important to note that the study did not assess the potential positive impacts of the RBV services on children. While enhanced visitation is designed to support and sustain the parent-child relationship with the goal of improving child well-being, it was not possible to measure child well-being in the current study. Given parents' improved parenting skills, as well as their positive perception of the differences between RBV visits and DHS "visits as usual" it is possible that children were less traumatized by their out of home placements, and may have benefited indirectly from the RBV service. This area warrants additional research.

Limitations

Several significant methodological issues in the current study deserve mention. First, the follow-up period may not have been long enough to gain a full understanding of the effects of

RBV on child welfare outcomes. At the end of the study window, a full 40% of children in the sample remained in foster care; these children were not included in analyses related to length of stay specifically. Thus, the overall means for length of stay are likely to be underestimates of the time spent in care by these children, and longer-term outcomes, especially related to placement duration and reunification status, might change substantially if children were followed for another year (or longer).

Second, the random assignment process, which occurred very early in the life of these child welfare cases, and prior to families being offered RBV services, likely increased the number of RBV families who were never referred and/or never engaged in RBV services. This method was used to avoid potential problems both of offering services to families that they might not actually end up being provided, as well as on having to rely on over-burdened caseworkers to describe and offer services to families who might not end up in the "treatment group". However, it is likely that a substantial number of parents did not follow up on RBV referrals and/or were not receptive to RBV providers' engagement attempts; this could have been reduced if randomization occurred only on the subsample of participants who indicated that they were interested in and willing to participate in RBV. The consequence of this early random assignment was that in the intent to treat models, a significant and substantial proportion of families assigned to the RBV service group did not receive RBV services, reducing the potential power to detect RBV program effects.

That said, models were estimated that analyzed effects for a "treatment on the treated" group. However, even these analyses did not show significant improvements in child welfare outcomes, relative either to control families or to families assigned to the RBV group who did not make it to the point of having a program intake. In fact, in terms of child welfare outcomes, the documented effect within the TOT models was one of increased days in foster care. While one could argue that we chose a very minimal level of treatment to identify this "treatment on the treated" group (specifically, receiving a program intake), preliminary examination of the association between the amount of RBV services received and child welfare outcomes paints a complicated picture. Specifically, families who received more RBV sessions still clearly had children who remained in care for longer, but also tended to be more likely to be reunified. This pattern of results, and reasons that may underlie the findings, warrant further investigation.

Another limitation is that the positive parenting outcomes were associated with non-random subsets of parents, and in particular for both the AAPI/NSCS and parent interview findings, we compared parents who received at least an intake into the RBV program to comparison families who were willing to complete parent interviews. It may be that the parents who participated in RBV services and/or were willing and able to participate in parent interviews were different in unmeasured characteristics, compared to the overall RBV sample, in ways that could be related to outcomes. RBV parents in the parent interview sample were, in fact, significantly higher than controls in the measure of motivation to change, which may account for their improvement over time, perhaps even over and above the potential benefits of the RBV

service. At the same time, however, there were no significant differences in the measured parenting outcomes at baseline for the two groups, which adds confidence to the likelihood that the documented differences at follow-up may be related to participation in the program.

Measurement, especially measures of parenting-related outcomes, was also a challenge in the current study. Specifically, results based on the AAPI and NSCS rely on a combined methodology in which RBV parents completed assessments in the context of being provided with services, while controls completed these measures with potentially greater anonymity. This could have influenced the pattern of outcomes demonstrated on these assessments. Parent report measures were the exclusive source of parenting-related data.

Conclusions

Overall, results suggest that while RBV may be an effective model to improve parenting-related skills and behaviors among parents involved with the child welfare system, the program did not have its intended effect on shortening children's time in out of home care. If the RBV model were to be adapted and implemented in other settings, it would be important to consider ways in which the program might be improved, and specifically, how the somewhat unintended consequence of keeping children in care for longer periods of time could be addressed. Further, the implementation and fidelity data make it clear that more field support for implementation, training, and communication with/between RBV and DHS would be beneficial to model implementation, and likely to model effectiveness. That said, results do support the benefits of enhancing the quality of parent-child visits and specifically, of providing research-based parenting interventions in a visitation context. Exploring methods for providing this type of parenting service in a timely way with reduced costs, and/or which also included strategies for addressing other family issues, could benefit the field.

Parent Mentoring Evaluation

Introduction

Parent Mentor services in child welfare are increasingly popular; however, the conceptual framework for such efforts is under-developed and there is scant evidence of its effectiveness. Accordingly, Oregon implemented a theory-based, well-specified Parent Mentor program along with a comprehensive evaluation that included a focus on implementation, development of a preliminary fidelity framework, significant attention to the process of mentoring, and both short and longer-term outcomes. The evaluation effort furthers our understanding of how Parent Mentoring works, and allows us to connect key mechanisms to the impact on parents and families in a meaningful way.

Program Description

Focus Population: Parents involved with child welfare services that have been identified as in need of substance abuse treatment.

Goal: To prevent foster care placement, expedite reunification and timely permanency, and prevent repeat maltreatment by motivating, facilitating, and supporting recovery.

Brief Overview: Mentors will develop and maintain transformational relationships with parents in order to inspire and support the parent's own, self-directed change process.
Mentors will use a "parent directed, outcome informed" (PDOI) approach to structure their work with parents, borrowed in part from the Client Directed Outcome Informed (CDOI) approach developed by Duncan and colleagues (Sparks, Duncan & Miller, 2007).[8] A PDOI approach involves the following:

1. Mentors will actively solicit the parent's personal theory of change (TOC), or the parent's own beliefs about the problem(s) that led to child welfare involvement, as well as the parent's ideas about how to address these problems.
2. Next, mentors will work with the parent to design a change plan that is responsive to their TOC, and incorporates services and supports that are perceived by the parent to be relevant and potentially helpful.
3. Thereafter, mentors will use brief pre- and post- contact measures borrowed from the CDOI approach to check in with parents on a regular basis and reflect with them on how the mentoring relationship and change plan is working for them in achieving their recovery and child welfare goals, making adjustments to both the plan and the

8 Studies suggest there is a very significant benefit, both in terms of client retention, and in more distal outcomes, to implementing the CDOI approach (Sparks, et al., 2007). CDOI practice has been implemented by numerous private agencies in the United States, and is now making its way into public agency practice, including Behavioral Health, Child Welfare, Substance Abuse, Corrections and Education. For some examples, see the following:

- State of Arizona, Southwest Behavioral Health (Wraparound)
- State of Georgia, Certified Addiction Recovery Empowerment Specialist (CARES) program
- State of Maine, Community Health and Counseling Services (system-wide)

mentoring relationship whenever necessary. These measures, the Outcome Rating Scale (ORS, see Appendix Q) and Relationship Rating Scale (RRS, see Appendix R) are very simple and take approximately 2-3 minutes to complete.

Core Mentoring Activities:

- Engaging in outreach efforts to referred parents via telephone calls, home visits, accompanying parents to visits at treatment centers, contacting referral sources or writing letters.
- A minimum of three face-to-face contacts with the parent during their enrollment in the program. Typically, mentors will have at least one contact with the parent (face-to-face or by telephone) per month, with potentially more frequent, e.g., daily, contact during certain periods.
- "Relationship work": provision of nonjudgmental, empathic support and encouragement throughout. Use of self-disclosure, informality & "straight talk" to build rapport, increase credibility, create trust, and foster an authentic relationship.
- Elicitation of hope by modeling recovery, sharing aspects of one's own experience when helpful, expressing belief in the parent and the expectation of success. Focus on parent strengths and right to self-determination.
- Modeling of a sober lifestyle & assistance in developing the parent's own social support networks in the community, providing information about drug and alcohol-free activities and resources, and accompanying parents to 12 Step or other culturally appropriate recovery groups.
- Elicitation & privileging of parent's own theory of change and culturally congruent approaches to making change. Active support throughout of parent's change plan.
- Assistance accessing concrete and immediate resources based on individual needs. Provision of direct supports such as transportation and accompaniment when necessary.
- Information regarding potentially relevant, culturally-responsive services and assistance accessing additional information, all informed by a mentor's first-hand knowledge of community resources.
- Providing referrals and linkages to identified services providers, using "warm hand-offs" whenever possible (real-time personal introduction to provider).
- Assistance in navigating the child welfare system by providing information regarding system requirements, transportation (court, visitation), modeling of organizational skills, and coaching regarding self-advocacy and interaction with professionals.
- Encouraging honesty and accountability on the part of parents in their relationship with their DHS caseworker. Fostering perspective-taking regarding the child welfare agency's point of view and legal mandates, while simultaneously acknowledging the parent's right to self-determination.

Parent Mentor services will end by mutual agreement between the mentor and the parent

once the parent is successfully engaged in her/his recovery or once the parent ceases to engage in Parent Mentoring services.

Supervision and Support for Mentors

- Mentors will receive intensive weekly supervision and on-going training specific to the mentoring role.
- Mentors will receive training and support to develop leadership and advocacy skills that help them represent the interests and perspectives of parents involved in the child welfare system. In this role as "Parent Leaders," mentors may:
    - Play an advisory and advocacy role in the larger child welfare and social service system by participating on boards, committees, and in focus groups, and by advocating for systems change and the development of improved community infrastructure to support parents in recovery.
    - Receive training to facilitate parent support groups that expand parents' healthy social support systems and encourage group participants to become advocates for their families.

The program will offer a sense of community and support for mentors and parents alike and will be enhanced through classes, support groups for mentors and parents, social and cultural events, and other opportunities to build parent support networks.

Evaluation Questions

The study included a focus on implementation, development of a preliminary fidelity framework, significant attention to the process of mentoring, and both short and longer-term outcomes. Research questions associated with both the process and outcomes study are detailed below.

Process Evaluation

The process evaluation focused on both the development of the program model and the implementation process for parents, mentors, and agencies.

Parents:

- Degree to which services were parent directed
- Satisfaction with PDOI process (RSS, ORS, etc.)
- Satisfaction with services and supports
- Degree to which services increased understanding of treatment and child welfare system requirements

Mentors:

- Satisfaction with PDOI process
- What did Mentors experience as promoting an effective relationship with parents?

- What challenges did Mentors face in working with parents? What strategies were useful in overcoming these challenges?
- What challenges did Mentors face in working with other service providers and allied professionals? What strategies were useful in overcoming these challenges?
- Satisfaction with training
- Satisfaction with supervision and other agency supports

Agency:

- Was the program implemented as planned?
    - Did mentors have the skills and capacities identified in the program model?
    - Did services delivered follow the model?
    - Did mentors provide additional services / engage in additional activities?
    - Did the predicted number of clients receive services?
    - Did mentors receive supports (supervision, opportunities for professional development) as outlined in the model?
- To the degree the program diverged from original plans in terms of staffing, service delivery, and client numbers, what sorts of barriers did sites face and how were they overcome?
- What factors facilitated implementation?
- What did the implementation process look like? Who was involved? What sort of collaboration took place?

Fidelity:

The fidelity component focused on key elements of the parent mentor intervention as detailed in the Fidelity Framework, Appendix S. The goal of this part of the study was to identify these elements and to begin to develop appropriate indicators and we made significant progress on both fronts. An attempt to explore the relationship between the level of fidelity of services provided and either short or long term outcomes- especially at the case level- was deemed premature due to the preliminary nature of the fidelity framework. In addition, like any individualized intervention, parent-directed services are inherently heterogeneous and much work remains regarding how to account for this fact in the development of fidelity scores.

Outcomes Evaluation

The outcomes evaluation was designed to assess the impact of the program on a range of short and longer term indicators focused on both child welfare and substance abuse treatment and recovery.

Short-Term Outcomes:

- Number and proportion of parents who participate in substance abuse treatment;
- Level of engagement with and connection to the recovery community;
- Number and proportion of parents who participate in other recovery-related activities;

- Intensity and variety of formal and informal social support networks including culturally specific services.
- Hope
- Self-efficacy
- Empowerment
- Positive self-regard

Longer Term-Outcomes[9]:

- Number and proportion of program participants that complete substance abuse treatment;
- ("in-home" cases) Number and proportion of children that enter out-of-home placement;
- ("out-of-home" cases) Number and proportion of children that are reunified with their birth families, or that enter into another permanent living arrangement;
- ("out-of-home" cases) Length of time to reunification or another permanent placement;
- Length of time to case closure; and
- Number and proportion of cases with an alleged and founded maltreatment allegation following case closure and/or reunification.

Study Overview

The study employed random assignment. Parents in new child welfare cases were eligible for Parent Mentor services if they were determined by DHS to be in need of substance abuse treatment. All DHS clients identified as eligible for Parent Mentor were randomly assigned to either referral to Parent Mentor services (intent-to-treat design), or to the control group. Data for the outcome study was collected on all participants from the DHS administrative database, OR-Kids. Additional outcome data was collected for intervention parents via program data, and from a subsample of these parents who participated in interviews conducted by the research team. Other outcome indicators for the intervention group were gathered via written surveys as well as interviews with DHS staff and community partners.

The process evaluation focused on implementation as well as generating information used to refine the model. Significant attention was paid to identifying key program elements and the mechanisms that connect those elements to outputs and outcomes. Data collection included interviews and focus groups with mentors and their supervisors, parent interviews and surveys, interviews with child welfare staff and data generated by the Parent Mentor program.

[9] The original design included the number of proportion of program participants that complete substance abuse treatment, however, DHS instituted new data security requirements mid-way through the project which resulted in significant delays in our accessing administrative data. As it turned out, we did not receive the substance abuse treatment data in time for those analyses to be included in this report. If we complete the analyses at a future date, we will forward those results.

The program fidelity component of the study examined indicators of adherence to the model using the following types of data: service delivery data collected by Parent Mentor providers, interviews with mentors and child welfare staff, interviews with parents and parent surveys.

Parent Mentor Evaluation Methodology

Study Sample, Recruitment, and Random Assignment Process

Parent mentoring was implemented in 3 Child Welfare districts and 1 additional county. Original estimates were that over 400 parents would be deemed eligible for services and approximately 200 parents would receive Parent Mentor services annually. Study recruitment began January 1, 2012 and ended at the end of September, 2014. Services concluded in March 2015 in two sites and in June 2015 in the two others. DHS clients who were identified as eligible for services were assigned to either the intervention or the control group. It is clear from interviews with child welfare staff that not all eligible clients were identified; however, all those who were identified were randomly assigned, except for parents associated with ICWA cases- those clients were automatically assigned to the treatment group.

The screening process varied somewhat in each project site; however, all sites followed the same basic procedure. Results from intake/hotline screenings were reviewed by designated child welfare staff and parents identified as in need of substance abuse treatment- and who belongs to a case that has been or is likely to be opened for services- was identified and their information was entered into an on-line, secure database. These clients were then entered automatically into the random assignment module. Clients were randomly assigned to be referred to Parent Mentor services or to services as usual (control group). All clients identified as eligible and submitted to random assignment are included in final outcome analyses (intent-to-treat design). Parents who were assigned to the treatment group were offered a referral to Parent Mentor services by their caseworkers. Caseworkers attempted to make the referral within 60 days of case opening.

Administrative Data Outcomes Sample

Study identification, randomization, and referral began in February, 2012. It took several months before 3 of the sites were steadily recruiting parents; additionally, the 4th site, District 14, did not commence services in any substantive way until summer, 2012. Recruitment continued through September 30, 2014. All clients who were determined eligible for Parent Mentor services were assigned to the intervention (PM) or the control group (services as usual). The eligibility criteria for PM services were as follows:

1. Parent has an active child welfare case in the participating child welfare districts
2. Parent has been identified as in need of substance abuse treatment
3. Parent has no serious disabilities or mental health issues that would interfere with their ability to make informed decisions about participating in the Parent Mentoring Program or in any accompanying evaluation activities
4. Parent is expected to remain in the local community long enough to receive PM

Final Participant/Case Flow Information for the Parent Mentor study is as follows:

1. **Eligibility:** 774 parents were identified as eligible and randomized as part of the evaluation. Randomization occurred at the case level. All parents associated with a single case received the same assignment (Parent Mentoring or services as usual).
2. **Random Assignment**: of the 774 parents randomized, 495 were assigned to Parent Mentoring, and 279 were assigned to services as usual.
3. **Referral to PM services**: Of 495 parents assigned to PM services, 379 were referred by child welfare staff.
4. **Accepted:** of the 379 parents referred to PM services, 285 parents accepted PM services.

District	Study Enrollment as of 9/31/2014	# Randomly Assigned to PM (% of Enrolled)	# Parents Referred (% of Assigned)	# Parent Accepts Services (% of Referred)
D2	475	299/475 (63%)	244/299 (82%)	176/244 (72%)
D4	119	86/119 (72%)	37/86 (43%)	31/37 (84%)
D12	96	64/96 (67%)	55/64 (86%)	45/55 (82%)
D14	84	46/84 (55%)	43/46 (93%)	32/43 (74%)
Totals	774	495/774 (64%)	379/495 (77%)	284/379 (75%)

Attrition occurred at several points in the study. For example, 23% (116) of parents assigned to PM services were not referred to PM providers. One district (D4) had a particularly low referral rate due to staff turnover and competition from a Family Treatment Drug Court program that caused many parents to decline a referral to PM services. In addition news of the Waiver's termination may have prompted caseworkers to prematurely discontinue identification and referrals. The other 3 sites referred parents at a much greater rate in large measure due to the efforts of child welfare supervisors, office support staff, and caseworkers as well as the local parent mentor supervisors who worked hard to ensure referrals continued over the life of the project.

Of the parents who were referred to PM services, 75% (284) agreed to services after talking with a parent mentor. Attrition at this juncture occurred primarily due to mentors' failure to contact parents. As documented in earlier reports, offering PM services to parents at the front end proved challenging as some parents were actively using alcohol and/or drugs and were difficult to find. This issue is described in more detail in "Parent Participation" below.

Three Year Target Numbers for Intent to Treat Design:

Target numbers for the intent-to-treat design that appeared in the original evaluation design were based on estimates of the number of eligible participants developed by DHS. For this report, targets were adjusted to reflect the shortened study period (3 years of recruitment and services rather than 4) and are therefore lower than what was included in the Terms and

Conditions. As stated above, 495 parents were assigned to PM services; this represents 79% of the three year target for the size of the treatment group. Of those parents randomly assigned to the treatment group, 57% went on to accept PM services.

Table 2-1: Progress towards 3 year Target numbers: (1/1/2012 – 12/31/2014)

District	3 Year Target for PM Treatment Group	# Parents Randomly Assigned to PM
D2	438	299/438 (68%)
D4	78	86/78 (>100%)
D12	45	64/45 (>100%)
D14	66	46/66 (70%)
Totals	627	495/627 (79%)

Parent Participation in PMP Services

The following sections details participation patterns for parents involved with the PMP.

The majority of parents (86%) had a single service episode; approximately 14% (n=54) returned to the program either on their own (18) or after a second referral by a caseworker (36).

- 379 individuals were referred to PMP services.
- One parent was screened out by the provider based on the determination that they could not safely participate in services.
- 71% (n=267) of the 378 parents referred accepted services on their first referral.
- 9% (n=33) declined services and 21% (n=78) could not be contacted on their first referral.
- Of the 111 parents who initially declined or mentors were not able to contact on their first referral, 15% (n=17) accepted services during a later PMP episode.
- Including subsequent episodes, three quarters (n=284) of parents accepted PMP services at least once.

Referral Results

As indicated above, more than two thirds of parents who were referred accepted PMP services on their first referral-- this rate remained steady throughout the project. Fewer than 10% of parents offered the services declined; however, some of the 21% who had no contact likely tacitly declined. The proportion with no contact reflects the challenges of working with parents at the front end: parents are often still actively using alcohol and/or drugs, are experiencing homelessness, or are otherwise reluctant to engage with services.

Program Exits

Of the 267 parents who accepted services on their first referral, nearly half (49%, n=130) completed PMP services and/or exited the PMP because their child welfare case closed. The remaining parents had program exits as described below:

- Didn't engage or disengaged: 29% (n=78)
- No longer available for services: 6% (n=17)
    - Moved (n=13)
    - Incarcerated (n=4)
- No longer wanted to participate: 6% (n=15)
- PMP services ended: 4% (n=11)
- Mentor left the position and/or parent was transferred to a different mentor: 4% (n=11)
    - Mentor left and mutual agreement to end services (n=3)
    - Mentor left and parent declined opportunity to work with a new mentor (n=4)
    - Mentor left and no other mentors were available (n=1)
    - Transferred and the new mentor was not able to find them (n=3)

Additionally, two parents died while receiving PMP services. Two more parents' cases were closed because the mentor felt it was not safe to continue to provide services and one parent was closed for an unknown reason.

It is important to note that some of the exits that are not counted as "completions" in fact represent successful cases; some of these parents were too busy participating in other services, in part as a result of working with their mentor, to have time for PMP.

Subsequent Episodes

Parents who were randomized to PMP services continued to be eligible until their DHS case closed or the demonstration project ended. A number of parents who initially declined services, were never contacted, or quit services, along with a handful of those who completed services, later returned to the PMP on their own or as the result of a subsequent referral from child welfare.

- Approximately 14% of parents returned to the program either on their own (n=18) or after a second referral by a caseworker (n=36).
- Of those parents who had a subsequent PMP episode, 46% (25/54) exited due to completed services and/or child welfare case close.

Of the 17 parents with an initial decline or no contact who went on to accept PMP services on a later episode, 12 were re-referred by their case workers and five were parents who returned to the program on their own. Reasons for exits for these particular parents are described below:

- 41% n=(7) completed services and/or child welfare case closed
- 59% (n=10) didn't/disengaged
- 6% (n=1) No longer wanted to participate

Nearly half of the 54 parents with a subsequent episode (including notably more than 40% of the 17 parents who didn't accept when first referred but accepted on a later episode) went on to complete services and/or have their DHS case closed. This suggests the value of allowing parents to return for subsequent episodes, even after an initial lack of engagement.

Transfers

Nearly 20% (n=72) of parents were transferred to a different mentor at least once during their participation in the PMP; two parents were transferred three times (including one who was transferred across districts when they moved) and six parents were transferred twice. Often the transfer happened because the Parent Mentor left the agency for other employment or maternity leave. A few parents requested a mentor with a similar cultural background as the parent. Interestingly, the data suggested that parents who are transferred are no less likely to complete services than their counterparts. Nearly half (49%, n=35) of those transferred completed services and/or had their DHS case closed, including five of the seven parents who transferred more than once.

Outreach and participation for initial episodes

To help us understand the effort associated with outreach, we calculated the number of days from case opening at the PMP agency to the date a parent made a participation decision (accept or decline) or the case was closed due to no contact with the parents[10].

- Cases (n=324) were open for outreach for an average of 49 days. The maximum length of time was 474 days and the minimum was 0 days.
- Those parents who agreed to PMP services (n=223) did so within an average of 38 days; 385 days was the maximum length of time for these parents and the minimum was 0 days.

Cases were open for an average of about six weeks before parents either agreed to the service, declined, or were closed due to the mentor not being able to make contact. Parents who received the PMP service appreciated the mentors' persistence-- the mentor "never gave up on them". This tenacity was also described as a necessary element of the service by caseworkers who didn't have the time, or perhaps the same skills, to do this outreach.

The average length of time parents' received PMP services varied[11].

- Parents who accepted services on their first referral (n=236) spent an average of 212 days in the program.
- Parents who accepted services on their first referral and whose reasons for exit was services completed and/or child welfare case closed (n=121) spent an average of 249 days in the program.

[10] Due in part to being co-located at child welfare, one agency recorded case opening as occurring on the same date program participation decisions were made by parents; these data are not included in our calculations.

[11] One agency kept cases open even when there was no contact for much longer than any of the other three agencies (upwards of 9 months in some instances). As such, this agency's data was not included in this analysis.

- The maximum length of time spent in the program was 972 days; this person exited when they completed services and/or had their DHS case closed.

Parents typically spent seven to eight months in the program. Those who completed PM services spent an average of five weeks more in the program than those who exited for other reasons.

Measures and Data Collection

Monthly Services and Supports Reports/Exit Forms/ Parent Directed Outcome Informed Tools

Mentors were asked to complete a number of tools and instruments as part of the PMP evaluation. Data submission occurred on a quarterly basis beginning in summer of 2012.

- PDOI tools (ORS and RRS): Mentors were instructed to administer the ORS and RRS each time they met with a parent as long as it was not contraindicated, (e.g. parent was not in crisis). In practice, some mentors found the tools helpful to their work while other mentors found them less so. Additionally, some parents were open to filling out "the paperwork" while other parents were more reluctant. As a result, ORS and RRS were not completed at each meeting and not all parents participated.
- Monthly Service and Support Report (MSSR): At the end of each month, the Monthly Services and Supports Report (MSSR) was completed for each parent with an open case, regardless of whether the mentor made contact with the parent during the corresponding month. The MSSR compiled information about recovery related activities and a wide range of additional services. The MSSR also tracked progress in other areas of parents' child welfare case plans (see Appendix T) .
- Exit Report: Mentors completed the Exit Report at the close of each mentoring case. Mentors recorded information about a range of services as well as parents' recovery status (see Appendix U).

Treatment Group Parent Interviews

The process for interviewing parents differs somewhat from what was outlined in the original evaluation plan. Interviewing parents multiple times on a set schedule proved both unworkable and unnecessary. Instead, we conducted a single, comprehensive interview with parents after they had been enrolled in PMP services for a minimum of six months. Follow up interviews were conducted, when time and resources allowed, with a small sub-set of parents who were willing and still enrolled in services. Interview topics included the impact of the peer model; the extent to which their mentoring was parent directed, and how they received this; typical activities with their mentors; and an overall report of how their mentoring relationship was going.

The vast majority of interviews were conducted in person; a handful of interviews took place over the phone. Parents received a $40 gift card for their participation. Interviews were recorded with permission and transcribed for analysis.

We recruited from the pool of parents who consented to be contacted about the interview process. In the final year of the project we targeted our recruitment towards parents of color and fathers, as these groups were under-represented in our interview sample. As is often the case in child welfare research, parents proved difficult to contact. We did, however, interview 50% of our eligible pool. Parents from all four districts were interviewed as described in Table 2-2 below.

Table 2-2: Parents Interviewed, Round 1-Round 3

District	# Interviews Round 1	# Interviews Round 2	# Interviews Round 3	# Eligible for interview Round 1
D2	19	2	1	38
D4	6	0	0	17
D12	5	0	0	9
D14	4	1	0	4
Total	34	3	1	68

Mentor Interviews

Three rounds of mentor interviews were conducted over the course of the study: Round 1 focused on implementation; Round 2 focused on mentoring activities and the mentoring relationship; and Round 3 asked mentors about their own experiences resulting from their mentoring work. Mentors were eligible to be interviewed after being employed at least six months. All interviews were recorded and transcribed. Interviews were semi-structured and allowed for emerging themes introduced by mentors. Ten mentors were interviewed in Round 1, thirteen mentors in Round 2, and five mentors in Round 3 (total # of interview=28). Over the course of the project 19 individual mentors participated in interviews.

Mentor Focus Groups

While interviews were our primary method of data collection with mentors, we did hold a number of facilitated small group discussions, or focus groups. Topics were varied but included outreach and engagement, how mentoring works, and the impact of the program on both mentors and parents. Focus groups sometimes replaced a round of mentor interviews (e.g. a "Round 1" focus group rather than individual interviews was conducted with D14 mentors to discuss implementation). In other cases, a focus group was convened for additional data collection purposes beyond the 3 rounds of mentor interviews. These convenings covered a range of topics including peerness, motivation, and engagement.

Parent Mentor Agency Supervisors/Management Interviews

We conducted interviews and focus groups with all of the supervisors and management from each of the Parent Mentor agencies. Topics included challenges to, and facilitators of, implementation; supervision and professional development; and impact of the program on both mentors and parents. For the first several years, supervisors convened via telephone for a

total of 5 focus groups. PSU evaluators hosted two additional supervisor focus groups in 2015, both of which focused on the development of a supervision/organizational context for the PMP. Most of the focus groups were recorded; these were transcribed and then analyzed. During two focus groups, recordings were not possible so researcher took detailed notes that were later analyzed.

Interviews with DHS Child Welfare Staff

DHS child welfare staff were interviewed at two different points in time. The first round of interviews with DHS staff focused on the Identification, Randomization and Referral (IRR) process rather than PMP services themselves. The second round of interviews asked caseworkers about the impact of PMP services on parents, casework practice and the broader child welfare system. All interviews were recorded with permission, transcribed, and analyzed. A total of 38 individual DHS staff participated in the 18 first round interviews and 21 second round interviews.

Interviews with Community Partners

The original evaluation design included additional interviews with local community partners. Evaluators originally proposed judges, attorneys, and treatment providers as possible interview subjects. In the final evaluation, the decision was made to not conduct community partner interviews given that only a few would have had significant experience with the PMP and the interviews were therefore unlikely to yield new information.

Treatment Group Parent Surveys

The original Parent Survey proposal included in the evaluation plan submitted to the Children's Bureau included a series of surveys administered at various points during a parent's involvement with the PMP. We decided against that approach for a variety of reasons: coordination of such an effort was too significant a burden for both the mentors as well as the research staff especially given the low likelihood of achieving a significant return rate; the longitudinal design assumed that parents' contact with mentors was both relatively stable and homogeneous across parents- however, this was not the case, which means the data would not be comparable in the way we assumed. Instead, we developed a single version of a one-page written survey that was distributed to all parents with open PMP cases by the mentors during an in-person contact. Surveys were distributed every two months and parents could complete and return the survey at any point during the 2 month window. Parents with open cases that span subsequent survey distributions were eligible (in fact encouraged) to complete additional copies of the survey. The first round of surveys was distributed in April; the project included a total of five rounds.

Control Group Parent Interviews

We were never able to achieve consent to contact from a significant proportion of control group parents- child welfare staff were either unaware of the need to do so, or didn't have the time. Given the likelihood that the parents recruited for inclusion in our interview pool would

be far from representative of the control group overall, we decided to abandon this resource-intensive effort.

Reviews of ORKids Case Files

The original evaluation plan included a review of ORKids case file/narrative data to capture information not available via administrative databases including: progress on case plans; participation in recovery related activities; and the extent to which issues of concern were addressed/resolved. Due to data security issues that arose in the 4th year of the project, PSU no longer has access to those files. Fortunately some of this information was captured by the Monthly Services and Supports and Exit reports completed by mentors; additional information was gathered via interviews.

Quantitative Analysis of SACWIS Administrative Data

Administrative child welfare records were extracted from OR-Kids, Oregon's SACWIS. DHS staff received reports from the PSU Evaluation Team with lists of eligible cases that were randomly assigned to either the Control or Parent Mentor Program (PMP) group. Any children involved in these cases were flagged in the OR-Kids system, and the flags were used to extract records for these children. History in the child welfare system was assessed using foster care episodes, in-home services, family stressors, and maltreatment report data recorded since 2000. Foster care placements associated with PMP involvement were defined as occurring 60 days prior to randomization date through June 2015.

We examined differences in groups based on two stratification schemes for children with two different follow-up periods. The intent-to-treat (ITT) stratification included all children as they were randomized (PMP, *n*=784 vs. Control, *n*=489). The treatment-on-the-treated (TOT) stratification broke the PMP group into two smaller groups: those who accepted PMP services (Accept, *n*=498) and those who did not (No Accept, *n*=286). The two follow-up periods were: at least one year of post-randomization follow-up time (randomized by June 2014, *n*=1,179) and at least two years of post-randomization follow-up time (randomized by June 2013, *n*=690). Thus, each analysis was conducted four times for each of the following samples:

1. ITT 1-year follow-up (PMP, *n*=718 Control, *n*=461)
2. ITT 2-year follow-up (PMP, *n*=411; Control, *n*=279)
3. TOT 1-year follow-up (PMP Accept, *n*=474; PMP No Accept, *n*=244; Control, *n*=461)
4. TOT 2-year follow-up (PMP Accept, *n*=284; PMP No Accept, *n*=127; Control, *n*=279)

Results

Implementation Evaluation

Below, we offer lessons learned related to implementation. We talk in detail about the identification, randomization and referral process that happened at the child welfare branches. That is followed by information about the "start up" of the program in the different communities, including efforts to train and support implementation of the model, as well as activities related to getting the program off the ground more generally. Data sources include interviews with mentors, focus groups with PMP supervisors, interviews with child welfare branch and district staff as well as the Waiver Manager, observations conducted by evaluation staff, participant and program data submitted by PMP providers.

DHS Branch Offices-

The first round of interviews with child welfare staff centered on implementing the identification, randomization and referral process (IRR) in the branches. Branch staff were responsible for identifying parents who met the eligibility criteria for the program. Unlike RBV, PSU did not send child welfare branch offices a list of potentially eligible parents that they were then responsible for screening. This meant they had to both initiate the process (lists sent by PSU served as reminders in RBV sites) and account for the universe of potentially eligible parents. PSU developed a database housed on a Google Drive where branch staff entered parents' I.D. numbers- the computer then automatically assigned individual parents to either PMP services or to the control group. The database also tracked parents belonging to a single case (and assigned them to the same group), as well as duplicate entries. Parents who were assigned to PMP services were then supposed to be contacted by DHS and asked if they agreed to be referred to services.

Identification, Randomization and Referral guidelines are outlined below:
Eligibility

- New cases-not already opened for services.
- Parent presents with alcohol/drugs issue and this is documented in ORKids.
- Parent is available to participate in services- the case is/will be opened for on-going services and the parent is local or willing to participate while in prison or residential treatment.
- If one parent from a case is identified as eligible and randomized, any subsequent parent/caregiver (that is a legal party to the case) who presents with alcohol/drug issues, is to be assigned to the same group as the first parent, at any stage of the case.

Timelines:

- Parents must be identified and randomized during the PS assessment or within 2 weeks of the case being transferred to a permanency/on-going unit.
- Data regarding eligible parents will be entered into PSU Database every week (preferably within 1 day of being identified).

- A referral form will be sent to the PMP provider as soon as possible- the parent may need to sign a release for that provider- and no later than 60 days after the parent is assigned to the PMP group.

The IRR guidelines were based on the stipulations outlined in the Terms and Conditions. However, within these guidelines, DHS was allowed to "customize" the work to be compatible with business as usual at their branch. The hope was that this would make it easier to sell the project and speed the process of implementation. This strategy produced mixed results, especially in the first 6 months of the project as described below. Overall, however, most branches routinely identified the vast majority of eligible parents, used the database to do the randomization, and referred a high percentage of parents to services.

Identification- Early on, there were considerable challenges in getting branch staff to consistently identify eligible parents. Even though Program Mangers and some Supervisors appreciated being given the latitude to "figure out how to make it work in (our) site," this freedom actually hindered implementation in some branches. Staff professed to not know what to do or found it very stressful to be responsible for designing something they felt they didn't understand very well. In addition, communication with CPS Supervisors and caseworkers was inadequate. Due to a combination of bad luck and poor planning on our part, CPS staff were the least likely to have been a part of conversations and presentations regarding the process and therefore often got the information both "late" and second hand. Not surprisingly, they also reported a lack of clarity regarding the guidelines; staff described markedly different interpretations of the requirement that cases be "open for services" and a great deal of confusion about the timelines related to the process. The intensity of CPS work and the focus on keeping children safe, the fact that units were significantly understaffed, and a lack of familiarity with PMP services and the IRR process all served as additional barriers to caseworkers identifying parents. The fact that eligible parents would be subject to randomization and therefore were not guaranteed the service struck some workers as unfair and dissuaded a few of them from participating, at least initially.

Over time, however, as the result of increased communication (taking the form of both information and encouragement) from PSU, local providers and the Waiver Manager, and considerable and diligent efforts on the part of individual child welfare staff, the practice of identifying parents became routine in nearly all of the branches. In addition, interest in and commitment to the project grew significantly. That being said, challenges continued.
The IRR process relied largely on individual staff taking it upon themselves to remind coworkers about the process and monitor what's happening. In some sites, these practices were routinized and happened consistently-- thanks to the discipline and ability to remember of individual staff. When key staff left their position, given that these practices were developed locally, there were only informal means of teaching new people to continue the work.

In addition, the process did not capture all eligible parents. Staff were open about this in the interviews- one Supervisor was quite clear that she could not guarantee that all parents were

being identified "in the trenches." And the fact that there was no process for documenting that cases had been screened meant there was no easy way for Supervisors or Program Managers (or the evaluators!) to assess the degree to which this happened other than staff self-report.

Randomization- Randomization is a simple process and branch staff have little leeway (we thought there was none, but someone confessed to having figured out how to "game" the system although not to actually doing so). The process takes little time if parents' Case and Person IDs are easy to access. In addition, PSU provided one-on-one and, where feasible, in-person training to the staff responsible for entering data into the database. PSU also created a manual that includes step by step instructions along with multiple screen shots to assist understanding. Ironically, given that the database is used solely for the PMP project, this part of the process was the easiest to integrate into business as usual at DHS branches.
During interviews, staff reported that the database was easy to use (though they appreciated the availability of on-going Technical Assistance) and had few concerns or complaints about the process. The database served the additional purpose of catching duplicate clients and ensuring that all parents belonging to a single case were referred to the same group (either PMP services or the control). At one point the evaluation team "found" a handful of parents who had been referred to PMP services but who did not appear in the database. It is unclear whether or not caseworkers making these referrals intentionally bypassed the randomization process or were simply unaware of this requirement.

Referrals- Other than the requirement that it happen within 60 days, details regarding the process for referring parents to PMP services were left to the branches. The assumption was that they would use their existing process for service referrals once a parent had been identified and assigned to PM services-the one exception being that the project's referral form (created by PSU with input from both DHS and the PMP providers) had to be used. We hoped that by allowing branches to design this part of the process, it would be more likely to be adopted and sustainable within each branch. This freedom didn't seem to engender the same stress as that associated with the identification process- our guess is this is because the referral process already existed and it was simple to utilize it for the PM project in most branches.

Staff reports indicate there was some variability between branches in both the ways in which parents were offered the referral and the ways in which the referral form was sent to providers. In some branches, the caseworker had this responsibility, in other branches it belonged to administrative or other non-case carrying staff. However, in all but one branch, the process proceeded in a manner mostly consistent with the guidelines. The percentage of parents assigned to PMP services who were actually referred is close to 80%; this would seem to indicate that the vast majority of parents were contacted and referred if they consented. At the single branch where the process did not go as planned, staff were concerned about how to manage the process of offering both the PMP and Family Treatment Drug Court (FTDC) services, especially as both are offered at the front end of a case.

Communication- Communication, especially between PSU and the Waiver Manager and their partners among the DHS field staff, was the Achilles heel of the project in its early months. A Webinar offered to DHS staff prior to implementation was poorly attended and presentations at statewide Program Manager and District Manager meetings didn't necessarily trickle down to staff actually doing the work. Although PSU did numerous trainings, attended multiple meetings and sent countless e-mails, we largely failed to connect with CPS Supervisors- arguably the linchpin of implementation at the branch level. We also struggled to appropriately target our information efforts. At the same time, communication breakdowns occurred within the districts. In one district, a lack of clarity regarding the division of labor between central office, district office staff and branch staff, as well as turnover, hindered progress early on. Workload and turnover also contributed to communication challenges within districts and the branches.

Over time, however, the fact that only 4 districts participated in the PMP project allowed PSU and the Waiver Manager to do a great deal of formal and informal communicating with different DHS branches, often, but not only, in response to problems. Face-to-face communication helped to build relationships between the partners. Fortunately, PSU can easily be "in person" at two of the districts and did site visits to the other two. Unlike the providers, however, there were no regularly scheduled opportunities for conversation between PSU, the Waiver Manger and DHS branch staff. (Providers had monthly calls with the Wavier Manager and the Lead Evaluator, had quarterly Netlinks during the first year and a half of the project, and they gathered in-person once a year for a Summit). Quarterly IRR reports sent to DHS District Managers on occasion prompted phone calls to PSU and/or the Waiver Manager. In addition, PSU and the Waiver Manager agreed on a "no wrong door" policy whereby staff could call either one to get questions answered (even if PSU had to consult with the Waiver Manager behind the scenes, or vice versa). Interviews with DHS yielded numerous suggestions regarding the timing, format and targeting of communication regarding the PMP project and some of these were implemented, most notably e-blasts sent via email containing very brief updates regarding the PMP.

Parent Mentoring Providers

The first round of interviews with mentors as well as the first 3 or 4 focus groups with PMP supervisors focused on implementing the PMP and sustaining the program over time. Mentors and supervisors alike shared many important insights about the processes, structures and other supports key to a successful PMP.

Staffing- All of the providers were able to hire individuals who met the criteria outlined in the RFPs. However, in smaller communities, it proved challenging to identify people who have personal experience with child welfare, have the requisite number of years in recovery, are knowledgeable about local resources and are otherwise appropriate for the positions. A few mentors have a great deal of knowledge of the child welfare system due to previous work experience with agencies that partner closely with DHS, but did not have personal experience with the system. It is also the case that many of the staff have previous experience providing

peer-to-peer services, working in the treatment/ recovery community, or with other non-profits. Providers had mixed success in recruiting mentors who reflected the local populations. One of the sites had only female mentors for the duration of the program; another site had a male mentor for only part of the time. Three of the four sites had persons of color on their staff; however, it proved very difficult to find Spanish speaking bi-cultural mentors- only one such staff member worked as part of the project.

Supervision and Coaching- To a one, mentors felt strongly that supervision was key to the work. Three of the sites held weekly group and/or individual supervision and supervisors were seen as very accessible. Mentors at these sites relied heavily on supervisors for help in understanding "how" to do the mentoring work, especially early on, as well as support related to the stress and vicarious trauma that can result. They also used supervisors to staff challenging cases. Mentors in the remaining site wanted more supervision than was provided.

Interestingly, the content of supervision at all but one of the sites went beyond the fulfillment of job duties to include a focus on the mentor's recovery and wellness, more generally. One of the agencies states clearly that mentors' priorities are "recovery, family, and the work- in that order." Supervision at this site included an explicit check in about mentors' recovery and home life. Another supervisor spoke about the importance of mentors being "in balance" so they could model that for the parents they worked with.

Supervisors faced challenges in their ability to support the implementation of PDOI Parent Mentoring. Supervisors received the same training as was provided to mentors and on the same schedule. This is not to say that none of the supervisors were able to serve as resources for mentors when they had questions about the model; some put considerable effort into learning about PDOI and consulted the manual, the book "What's Right with You," and the CDOI website. However, given the important role supervision played in implementation efforts, it is clear that a more deliberate approach to educating and supporting supervisors would have been useful.

Training- The training provided by DHS at the start of the PMP and infrequently for the remainder of the project represented an introduction to the model and some education regarding related topics. These efforts received mixed reviews from participants though the trainers themselves were mostly perceived as skilled, organized, etc. The primary concern with the early training was that it was insufficient and that additional "refresher" trainings after mentors had some time in the field would have been useful. One of the challenges facing the trainers was the significant variation in the level of knowledge and experience the mentors brought to the work; inevitably some of the mentors saw trainings as too simplistic, while others would have appreciated more time on the basics. Both mentors and their supervisors voiced believed that time spent on peer to peer sharing and learning was as important if not more so than the more formal offerings; eventually, these sorts of activities were granted significant time on the training agenda.

In addition to these offerings, all of the mentors participated in trainings provided by their agency as well as others offered in the community. Mentors were very clear that the training provided by DHS related to the model, while essential, didn't come close to covering what mentors needed in order to work effectively with parents. Mentors identified a long list of topics relevant to their work that included trauma informed practice, working with IPV and mental health issues, communication skills and time management. They also spoke of the need to stay abreast of new information, especially in the addictions arena, such as trends in substance abuse and new treatments. Smaller, more rural communities that lack some of the offerings available in the larger metropolitan areas made good use of trainings available on-line and via other formats. That being said, funding that would facilitate access to additional opportunities would no doubt be appreciated.

One of the providers' in-house training was particularly well developed and included a wide range of content as well as a detailed pedagogy. A supervisor at another agency spoke about trying to access "any and every" training she could for her staff. Both of these supervisors were motivated to equip mentors for their work as well as to promote their professional development more broadly. One of the mentors seemed to speak to this when she described feeling particularly respected in the community, in part because of all the trainings she'd received.

Peer to Peer Learning and Support- Most of the mentors saw peer-to-peer learning as even more useful than formal educational opportunities. Mentors reported problem solving and receiving input from other mentors during team meetings and group supervision- supervisors chimed in only when needed. Co-workers were not only a key source of advice and information, they also provided a great deal of camaraderie and emotional support.

As mentioned above, a number of mentors requested more opportunities for peer to peer discussions at the DHS sponsored trainings. Sharing stories and lessons learned with mentors from across the project may be especially important for staff at the smaller sites- one employed two mentors, one of whom also served as the supervisor; another small site had three mentors, all of whom worked part-time. As one of the mentors at a small site commented, "they (mentors at the largest site) do more work with clients in a week than I do in a year." Then too, even more experienced mentors spoke strongly of the value of learning from their peers.

Administrative Skills and Support- The "paperwork" associated with the project (i.e. the research related documentation and data collection along with the PDOI tools used by mentors) represented a considerable burden to mentors. The majority of the mentors became quite comfortable with the forms over the course of the project and a few professed a great deal of pride in their ability to manage it along with the hands-on work they do with parents. For others, however, this part of the work remained particularly challenging. Mentors pointed out that some of them had few computer or other "office" skills when they were hired and the organization and time management required by the job was also new to many. Literacy and comfort with written documents more generally were challenges for some of the mentors.

Some of the programs provided opportunities for mentors to receive computer training and supported mentors' efforts to develop their organizational skills. In addition, all of the sites reported that managing paperwork was a frequent topic at team meetings and supervision. Most of the programs developed systems to assist mentors in completing and staying up to date with these requirements.

Structure of the mentoring positions- The structure of employment of the mentors varied across sites. Mentors at the largest providers worked full-time and received benefits including paid time off and health insurance. (It should be noted that some of the part-time mentors had been able to secure benefits through their other positions.) Many mentors spoke strongly about the importance of adequate pay and benefits to their ability to bring the necessary energy and commitment to their work. Along these lines, mentors and supervisors talked about the negative impact illness, exhaustion and financial worries can have on mentors' recovery. This sort of employment was also presented as a precursor to the professional development that is a "second, parallel track" of the PMP model. At the two smallest sites, the mentoring positions were part-time; all of these mentors reported having other jobs. One advantage of this design was the significant familiarity with other services and the content knowledge mentors could bring to their work. For example, a mentor who was also employed as a parent trainer was able to provide useful parenting tips to her clients. Then again, mentors working part-time faced some challenges related to being able to meet with parents in a timely fashion- however, they worked hard to be clear in communicating their availability to parents.

Doing Parent-Directed, Outcome-Informed PMP

What follows are key findings from a round of interviews with mentors that dealt specifically with challenges and successes in implementing key components of Parent Directed, Outcome Informed (PDOI) Parent Mentoring services.

Successes: Mentors provided a variety of supports and assisted with systems navigation while employing a largely parent-directed approach by drawing on a combination of quality supervision, peer-to-peer support and education, formal trainings and their own life experiences.

- A great deal of emotional support was provided to parents- mentors offer encouragement, focus on the positive, allow parents to vent, serve as a calming presence, "just listen", and ensure that parents have at least one person who is "on their side."
- Building on both their own experience and various trainings, mentors are knowledgeable about the child welfare system, local substance abuse treatment and recovery options and a host of other community resources and routinely provide relevant information and advocacy to parents.
- Mentors provide transportation to parents, either in a private car or on the bus, and accompany them to child welfare and treatment related meetings as well as court hearings. Parents were also able to access a wide variety of other instrumental supports with assistance from the mentors.

- Mentors are careful to match their approach and communication style to the needs of specific parents. Training related to these interpersonal skills was provided both by local providers and DHS. Mentors also spoke strongly of the value of supervision in figuring out how to deal with challenging parents and of receiving support around when to give up and let go. In addition, mentors draw on their own experiences, as clients and as community members, in deciding what strategies to deploy in their interactions with parents.
- Mentors became quite comfortable with the PDOI approach- utilizing the ORS and RRS, and doing parent directed work more generally. They credit both formal trainings and the education and support provided by peers and supervisors for helping build these skills.

Challenges: Difficulties focused primarily on the ORS, RRS and MCP- many mentors felt it is possible to get feedback from parents and set goals/make plans without using these tools and frequently did so.

- Some mentors felt they didn't receive enough training related to the PDOI tools; others felt instructions were too vague and/or confusing.
- There was some concern that parents are unwilling or unable to provide accurate feedback when completing the ORS and RRS: they are afraid to tell mentors they're unhappy with the services, or because of their addictions, some parents are unable to see clearly what is going on in their lives. Many mentors felt inaccurate feedback wasn't useful; however, others viewed it as a starting point for a conversation about parents' lives and the mentoring relationship.
- The tools were often viewed as so much "paperwork" and a distraction from the more interpersonal work mentors do with parents. Some mentors worried that the tools communicate a bureaucratic or formal approach that is at odds with the sort of relationship they try to build with parents. Many mentors felt it is possible to get feedback from parents and do goal setting without using the PDOI tools.
- The written format of the ORS, RRS and MCP may be unduly challenging or off putting for some parents.

Fidelity

Our exploration of the extent to which mentors provided services to parents as outlined in the fidelity framework (Appendix S) draws on both quantitative and qualitative data. The text below is organized into two sections: first, we review data sources used to assess fidelity; and second, we discuss results of this assessment along six domains of fidelity: (1) parent-directed, (2) goal-focused, (3) systems navigation- child welfare (4) advocacy, (5) supporting recovery, and (6) building support networks.

Data Sources

Monthly Services and Supports Reports (MSSR):

MSSRs are the primary source of quantitative fidelity-related data; these were completed monthly by mentors for all parents currently on their caseload and include information regarding a range of activities mentors might engage in with parents. Mentors submitted a total of 206 MSSRs reporting on services provided to parents from October 1, 2013 to June 30, 2015. Parents were included in the analysis if a Parent Mentor reported meeting with him/her (either in person or over the phone) at any point during the period (n=192)[12]. Calculations proceeded as follows: First, each service, activity or support requested and/or received was coded as a "1" for each parent during each month. Second, the monthly codes were collapsed into a *summative* indicator of whether or not (1 or 0, respectively) each parent participated in/requested/received a particular activity, service or support. Third, frequencies and proportions were calculated for each indicator and are reported below.

Parent Surveys:

Parent surveys provide additional insights for a subsample of parents regarding the degree to which parents perceive services to be parent-directed, along with other fidelity-related indicators. The survey consisted of 34 Likert scale questions and one open-ended question. Questions were developed to gauge mentee satisfaction with the program, fidelity to the program model, and the value of having a peer Parent Mentor. Additionally, Self Determination Theory (SDT) was used as a framework in question development to gather insight in to the level of motivation experienced, internalized, and demonstrated by parents through their work with their Parent Mentors. All questions were worded positively and instructions requested that parents select an answer from 'Strongly Agree' to Strongly Disagree' with 'Neutral' as an option. Parents had the option to complete the survey at multiple time points; results were calculated based on the last survey submitted by 110 individual parents. Frequencies for relevant items are presented below. A copy of the survey is included in Appendix V.

Qualitative Interviews:

Interviews conducted with mentors and their supervisors, parents, and child welfare staff, offer additional insight into the extent to which these activities occur, although they do not include a systematic measure of frequency. Instead, interviews provide significant in-depth information about how and why activities occur and the contextual factors that influence mentors' behavior.

Researchers conducted three rounds of mostly in-person interviews with mentors over the course of the project (n=19 mentors, 28 interviews total). A total of 38 interviews with 34 different parents were completed, the vast majority of which happened in person. Forty seven child welfare staff participated in phone interviews over the course of the project. Finally, a total of 7 focus groups with mentors' supervisors were conducted. The focus of the interviews/focus groups evolved over the course of the project- early interviews centered on

[12] Mentors did not have face-to-face or phone contact with 28 of the 100 parents on their caseloads.

implementation, while later interviews covered the work of mentoring and the impact on parents. Interviews and focus groups were recorded, transcribed, and then analyzed through a process involving review and dialogue among dyads made up of research team members. Researchers used a constant comparative methodology that allowed a coding scheme to emerge from the data. Themes and categories related to fidelity and the key indicators were identified and reviewed for their relevance to this discussion.

Domain 1: Parent Directed

Table 2-3.

MSSR Indicators	Frequency	Percent
Parents requested services and supports	146	76
Of those with requested services and supports, parents' requests acted on (*n*=146)	136	93
Parents invited to use Parent Directed Tools/ORS	146	76
Of those invited to use ORS, Parent Directed Tools Discussed with Parents/ORS (*n*=146)	91	62
Parents invited to use Parent Directed Tools/RRS	148	77
Of those invited to use RRS, Parent Directed Tools Discussed with Parents/RRS (*n*=148)	75	51

Table 2-4.

Parent Survey Indicators	Strongly Agree	Agree	Strongly Disagree or Disagree
I have a say in what my mentor and I work on together	76%	21%	2%
My mentor wants me to decide what we work on together	67%	25%	3%
My mentor wants to know when our relationship isn't working well for me	67%	23%	3%
My mentor encourages me to make my own choices about recovery	71%	23%	0%
My mentor helps me find the services and/or resources that I need	69%	22%	5%

The data offer significant support for the idea that PMP services were parent directed.

MSSRs indicate that over three quarters of the parents with whom mentors had face-to-face or phone contact requested services or supports. If parents requested services or supports, mentors almost always attempted to provide them. One of the items of the parent survey asked about this from the parents' perspective: 91% of parents agreed or strongly agreed with the statement "*My mentor helps me find the services and/or resources that I need*."

A more direct assessment of the degree to which the PMP was parent directed is provided by other survey data. Two items addressed parents' experience of directing the work with their mentor: 97% of parents agreed or strongly agreed with the statement "*I have a say in what my mentor and I work on together*" and 92% with the statement "*My mentor wants me to decide*

what we work on together." An additional item concerns mentors' openness to feedback: 90% of parents agreed or strongly agreed with the statement "*My mentor wants to know when our relationship isn't working well for me*."

The Outcome Rating Scale (ORS) and Relationship Rating Scale (RRS) were included in the original program design in an attempt to make concrete the process of soliciting parents' needs and feedback on the relationship with their mentor- two activities seen as central to operationalizing "Parent Directed" mentoring. Despite considerable initial resistance from some of the mentors (more on this below), nearly all of the mentors offered the tools to at least some of their parents. According to MSSR data, mentors invited three quarters of parents to use the ORS and RRS, and discussed scores with between half and two thirds of those invited to use the tools. In addition, the percentage of mentors using the tools increased over the course of the project.

While there was some confusion at start-up related both to the use of the tools and expectations regarding the specifics of parent-directed mentoring, the mentors felt strongly about the value of this approach to parents who often have little say in their work with other providers. Interview data suggest that even in the absence of PDOI tools, mentors employ a range of strategies to encourage parents to direct the mentoring work by consistently soliciting the parents' needs and wants, and attempting to engage parents in thinking about their goals (this is discussed in greater detail in the results section of the report). Moreover, as the data above indicate, mentors are very responsive to requests by parents and work hard to access the services and supports they say they need.

It is important to note that the most serious objections to the tools had to do with the format and processes involved with administering them. During interviews some mentors described only infrequently inviting parents to fill out the ORS and RRS. They offered many reasons for this: parents already do too much paperwork for child welfare and other providers; using the tools makes mentoring feel bureaucratic or formal; tools can get in the way of efforts to build the relationship with parents; and mentors don't feel adequately trained, or forget to offer the tools. There was also concern that parents aren't willing to provide "honest" ratings so the tools "are a waste of time."

Domain 2: Goal Focused

Table 2-5.

MSSR Indicators	Frequency	Percent
Parent created/updated a My Change Plan	106	55
Of those who created/updated, Parent worked on at least one of the MCP activities (*n*=106)	101	94

Table 2-6.

Parent Survey Indicators	Strongly Agree	Agree	Strongly Disagree or Disagree
My mentor and I talk about the progress I'm	69%	24%	3%

Parent Survey Indicators	Strongly Agree	Agree	Strongly Disagree or Disagree
making towards my goals			
My mentor and I talk about my goals	70%	21%	3%
Working with my mentor helped me realize I can achieve goals that I set for myself	85%	13%	0%
I feel proud when I make progress on my goals	67%	24%	4%

The second fidelity domain reflects the model's focus on supporting parents' change efforts. A third tool, the My Change Plan (MCP, Appendix W), is a semi-structured form used to solicit parents' goals and provide a mechanism for generating timelines and tracking progress. The MSSR data suggest that MCPs were used with only about half of the parents. Indeed, during interviews most mentors reported using the MCP with only a small percentage of parents- and often finding it quite useful- but described actively talking with parents regarding their goals even when not utilizing the MCP. Barriers to the use of the MCP echoed comments about the ORS and RRS: too much paperwork, feels bureaucratic, and a lack of training. Additional concerns such as the idea that the MCP duplicates treatment plans, and assumes more linear forward progress than many parents can achieve, were also shared. However, for many mentors, parent directedness takes the form of consistently soliciting the parents' goals and engaging parents in doing both short and long term planning; in other words, developing an MCP without using the tool. Mentors also spoke about the degree to which parent directed work can conflict with being goal focused when parents are unmotivated or otherwise unwilling to engage. In these situations, mentors, while using a variety of strategies to encourage parents, were willing to take *no* for an answer without judging parents, and communicated to parents that they would be available to work with them when and if they changed their mind.

Survey data offer additional support for the goal-focused nature of the mentoring work. Four items reference attention to goals, and between 91-98% of parents agreed or strongly agreed with these statements (see Table 2-6).

Domain 3: Systems Navigation, Child Welfare

Table 2-7.

MSSR Indicators	Frequency	Percent
Navigating CW systems	170	89

Systems navigation is commonly considered a core feature of mentoring programs and this was true for the PMP. Assisting parents navigate child welfare was reported in more than three quarters of mentoring cases; the MSSRs capture only a narrow range of the types of assistance mentors provide to parents regarding their interactions with child welfare, so it's likely that these data understate the amount of this type of work. For instance, in interviews mentors detailed translating official documents and other instances of agency jargon, explaining "how" the system works (going beyond formal practices and policies to include tips such as "it's not always a bad thing if your caseworker hasn't called you in 2 weeks"), and strategies for communicating effectively with caseworkers and other providers; only the first of these

appears as a distinct option on the MSSR. In addition, it is important to note that advocacy within the child welfare system is not included in this indicator and instead represents a separate "advocacy with child welfare" element that is a component of the "advocacy" domain.

Domain 4: Advocacy

Table 2-8.

MSSR Indicators	Frequency	Percent
Advocacy with CW	151	79
Advocacy with Recovery	82	43
Advocacy with other systems	110	57
Advocacy with any system	156	81

Table 2-9.

Parent Survey Indicators	Strongly Agree	Agree	Strongly Disagree or Disagree
Through my work with my mentor, I learned how to advocate for myself and my children	63%	27%	3%
I do a good job advocating for myself and my children	70%	24%	0%

Advocacy with child welfare, recovery and other systems is another common activity as is clear from the tables above. Advocacy with child welfare occurred in more than half of mentoring cases, advocacy with other systems occurred in nearly half of cases, and close to a third reported advocacy with recovery. This is corroborated by interview data; mentors talked at length about parents' need for assistance in accessing a wide variety of services, as well as in trying to work productively with child welfare. Mentors described speaking with caseworkers and other providers on behalf of parents, sharing updates regarding parents' progress, educating caseworkers about the recovery process, and helping them to better understand some of the barriers parents face. Mentors also served as a cultural translator between caseworkers and parents. On occasion, mentors prodded other providers to follow through on their work associated with the parent's case. Survey results also suggest the importance of advocacy work: 90% of parents agreed or strongly agreed with the statement "*Through my work with my mentor, I learned how to advocate for myself and my children"* and 94% with the statement "*I do a good job advocating for myself and my children."*

Domain 5: Supporting Recovery

Table 2-10.

MSSR Indicators	Frequency	Percent
Navigating Recovery	164	85
Advocacy with Recovery	82	43
Navigating and/or Advocacy with Recovery	167	87

Table 2-11.

Parent Survey Indicators	Strongly Agree	Agree	Strongly Disagree or Disagree
I feel encouraged by the progress I am making in my recovery	80%	17%	0%
My mentor encourages me to make my own choices about recovery	71%	23%	0%

The MRRS data make clear that supporting recovery is a core mentoring activity occurring only slightly less often than navigating child welfare; and as with navigating child welfare, interviews indicate that mentors are engaging in a host of relevant activities not captured by the MSSR. The high level of activity in this area is a particularly positive finding given that parents who are willing to engage in other services often resist dealing with addiction issues. Mentors described a wide range of recovery-related activities in interviews; provide detailed information about local treatment agencies and 12-Step groups, help parents with transportation, introduce them to the local recovery community, planning and problem solving related to potential triggers, and coaching on life skills related to maintaining a clean and sober lifestyle. Two survey items relate to parents' recovery activity; 97% and 94% of parents agreed or strongly agreed with them respectively as indicated below.

Domain 6: Building Support Networks

Table 2-12.

MSSR Indicators	Frequency	Percent
Accessing Informal Supports	52	27
Accessing Culturally Specific or Faith Based Services	75	39

Accessing informal supports and culturally-specific or faith-based services is happening with fewer cases than desired, and while the data collection tools may be missing some relevant activities, it's also likely that mentors need training and support in this area. It is also possible that parents ask for help with working with paid providers associated with their child welfare case plans rather than with building networks of informal supports. That being said, many mentors spoke during interviews about the need to support parents in developing informal networks. These mentors stressed that recovery needs to be sustained long after professional services, including their own, are removed. Several described helping parents inventory their informal supports, introducing parents to a recovery community (such as 12 step meetings), or helping familiarize parents with local parent-led parenting groups that might launch their development of their own informal support network. One survey item related to the provision of culturally specific services: 89% of parents agreed or strongly agreed with the statement *"My mentor works with me to find services that fit my culture and life experiences."*

Parent Satisfaction Surveys

In the spring of 2014, the evaluation team developed a parent survey to assess parents' experiences with the PMP. The survey consisted of 34 Likert scale items and one open-ended

question. Questions were designed to gauge mentee satisfaction with the program, fidelity to the program model, and the value of having a peer Parent Mentor. Additionally, Self Determination Theory (SDT) was used as a framework in question development to gather insight into the level of motivation experienced, internalized, and demonstrated by parents through their work with their Parent Mentors. Specifically, the three psychological needs of belonging, structure, and autonomy, identified by SDT theory, helped guide question development. All questions were worded positively and parents were instructed to select a response ranging from 'Strongly Agree' to Strongly Disagree' with 'Neutral' as an option. The survey is included in Appendix V.

Surveys were distributed to 219 of the284 parents who agreed to services (77% of the population) and 110 of these parents responded, a 50% response rate, (39% of the total population). As described below, most parents had the opportunity to complete the survey more than once, and many did. Slightly more than half of parents (55.5%) completed the survey more than once; four parents completed it five times, five parents completed it four times, 14 completed it three times, 38 completing it twice, and 49 (44.5%) parents completed the survey just once.
A variety of analyses were conducted using the data. The findings included below represent responses from the last (most recent) survey submitted by each parent- in other words, results represent the responses of 110 unique parents, not the total number of surveys submitted during the project.

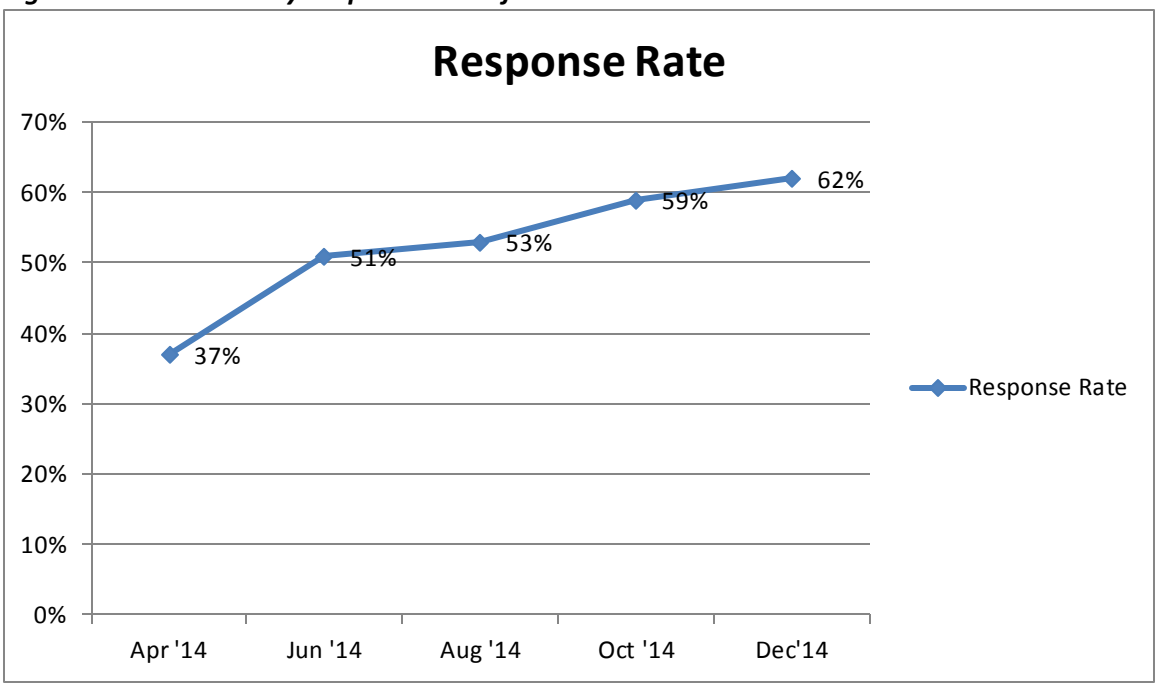
Method for conducting surveys

Two rounds of survey distributions were conducted. The first round consisted of five intervals of survey distributions that occurred every two months; and the second round consisted of a single distribution.

The first round of distributions began in April 2014 ended in December 2014. Surveys were delivered to mentors every two months over the ten month period for a total of five separate distributions. Mentors were asked to invite any parent they had contact with during the two month window to complete the survey. Any surveys not handed out at the end of the two months were returned to PSU. Parents who completed the surveys could either return it to PSU in a postage-paid envelope or give it to their mentor who then mailed the surveys to PSU. Mentors were asked by parents to mail the majority of the surveys. Parents were given $5 when they accepted the survey in appreciation for their time. Parents could complete the survey once during each of the two-month windows. The response rate for the first round of survey distributions was as follows: April 37% (32/86), June 51% (35/69), August 53% (36/68), October 49% (40/68), December 62% (39/63). Many of the surveys were returned to PSU because the cases were closed or the mentor was unable to reach the client to offer the survey. Mentors were also asked not to give surveys to parents if they thought it would be detrimental, e.g., if the parent was in crisis.

Figure 2-1 illustrates the steady increase in response rate with each interval of the first round. This was likely due, in part, to better communication between the providers and the evaluation team and mentors increased comfort with describing and distributing surveys to parents.

Figure 2-1 Parent Survey Response Rates for Round One



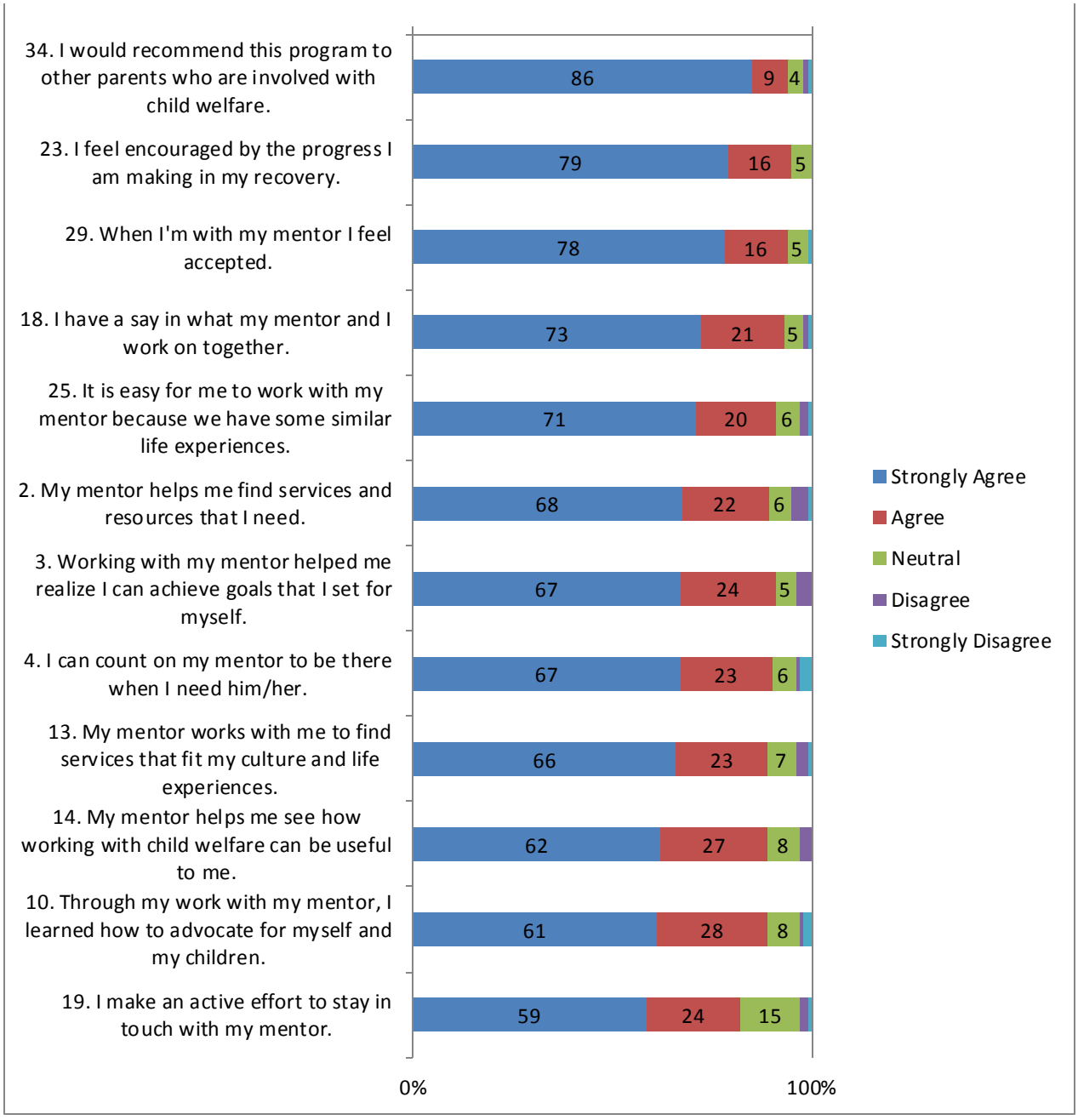
In June 2015, a final distribution took place. Surveys were sent out to all parents who had participated in the Parent Mentor Program at any point in the previous 18 months but had not yet responded to a survey request. At this point, most cases were closed or closing very soon. Because many of these parents were no longer in contact with mentors, providers were asked to mail surveys to the parents' last known address. Once the survey was complete, parents could return it to PSU in the postage-paid envelope that was included or they could complete the survey online using a secure survey program, Qualtrics. In order to increase response rate, the incentive for this last round was increased to $20. Parents who returned paper copies of the survey were asked to send up-to-date contact information so that gift cards could be mailed to a current address. Parents who completed the survey online could provide their mailing address online as well. Twenty five completed surveys were received out of 121 surveys distributed. Two parents responded using Qualtrics and the rest returned paper forms. As shown in Figure 2-1 , the last distribution received a 21% response rate, which was higher than anticipated, considering many of these parents had disengaged from the program, mentors were no longer in touch, and addresses were old.

Survey Results

Completed surveys were entered into SPSS and frequencies were run for the last survey completed by each parent. Complete results are included in Appendix X. Twelve items were

selected to include in Figure 2-2. The items included represent the fidelity indicators: parent-directedness (item 18), goal focused (item 3), instrumental supports (item 13), advocacy (item 10), and systems navigation (item 2) as well as Self Determination Theory constructs (items 23, 29, 18, 2, 3, 4, 13, 14, 10, 19), peerness (item 25), and parent satisfaction (item 34).

Figure 2-2 Selected Parent Survey Items



The vast majority of the responses were positive. All but five items received 90% or more Agree or Strongly Agree responses and none received lower than 83% of these responses. Of the six

highest scoring items (96% or greater Strongly agree or Agree), three are representative of the parent's level of engagement in services: #16 *I feel proud when I make progress on my goals*, 99% Strongly Agree or Agree; #21*I show up for my child welfare meetings and court hearings*, 97% Strongly Agree or Agree; and #32 *I work hard to stay on top of what's happening with my child welfare case,* 96%. Over 90% of respondents chose Strongly Agree or Agree for item 2, *My mentor helps me find the services and/or resources that I need*; this item also received the most Disagree or Strongly Disagree (5%) responses. Item 19, *I make an active effort to stay in touch with my mentor*, had one of the lowest rates of Strongly Agree or Agree (83%) responses and the highest rate of the Neutral response (15%).

As can be seen in Figure 2-2, 95% of parents would recommend this program to other parents involved with Child Welfare (item 34). 91% agreed that having similar life experiences made it easier for them to work with their mentors (item 25).

Parents were also asked one open-ended question, *Is there anything else you would like to tell us about the program?* We received 94 responses to this question from 46 individuals. In their responses, parents described the many ways mentors helped them. Parents also shared that mentors made them feel important and understood. One parent explained that her mentor was the only person in her life to provide her with support.

Echoing one of the survey results cited above, one parent pointed out the significance of the mentor being a peer:

> *"My mentor makes me feel at ease. I can relate to her because I know she has been through it all herself. She boosts my confidence not only in dealing with child welfare but in knowing that I still have a bright future ahead of me no matter what my past is. Thank you."*

Another parent's suggestion illustrated her willingness to accept positive support from a mentor when she might not be willing to accept it from others:

> *"I think parent mentors should be assigned as soon as the case is open instead of waiting until after it goes to court. DHS workers are intimidating and manipulative and if parents had someone who could give them positive options so they could make the right choices more people would succeed."*

By far, the majority of responses were "thank yous" for support. A few parents went on to attribute some of their success specifically to this support:

> *"She was ALWAYS there for me and NEVER judged me or told me what to do. I felt she was more of a friend than anything. If it wasn't for her I might not have been as successful as I AM! I have 9 months sober and my DHS case is being closed! I owe much of my success to [my mentor]!"*

A couple of responses illustrated the strong relationship that can develop between the mentors and their mentees. For example, one parent shared:

> *"I really enjoyed having her around, wish it was longer time. Now I'm kind of disappointed she's gone. I don't hear from her or see her. She was starting to feel like family."*

Parents also offered some ideas for program improvement. Most common were suggestions that mentors have lighter caseloads so that parents can get more of their time.

> *"...the parent mentors here are very understaffed...they have too many cases per mentor and some clients tend to fall thru the cracks."*

Lastly, two parents wrote about their disappointment; both seemed to be dissatisfied with the more casual aspect of the service.

> *"I went through two mentors in my time involved with DHS. I did not feel like the first one cared to get to know me or to do anything but gossip. So I requested a new one. The next person was better but she didn't work with me on my goals at all. All she did was take me to meetings. I personally felt like it was a waste of time. I could take myself to meetings or have other people who were not getting paid do it. My uncle (who was my son's foster parent) called them "paid friends". That was a good description."*

> *"Got along with my mentor as a friend. We did set some goals but overall the program was not very necessary. I could see it helping someone that does not go into inpatient, getting them out of the house, to meetings, etc... But otherwise, people (even drug addicts) are capable of making friends."*

Short Term Outcomes

The study explored the impact of the PMP on a range of short term outcomes including those having to do with substance abuse treatment and other recovery related activities; connections to culturally specific services, informal supports and support networks; and the degree to which parents experience positive changes in their level of hope, self-efficacy, empowerment and self-regard. Below we detail findings related to these outcomes drawing on a range of data sources including Exit Forms, Parent Surveys and interviews with parents, mentors and child welfare staff.

Substance Abuse Treatment and Recovery-Related Activities

Exit Forms included a large number of items related to substance abuse, treatment and recovery. These results indicate a high degree of participation in treatment and recovery related activities by parents.

Parent participated in	Anytime during PMP enrollment	At last meeting with PMP mentor
Outpatient or Inpatient Substance Abuse Treatment	74%	45%
Any recovery- related activity (including tx)	83%	63%
Any recovery activity excluding inpatient tx	80%	60%
Recovery Activities (e.g. faith based/ gender based/12step groups, on-line supports, recovery dances)	60%	44%
Interactions with Sponsor	23%	20%
Engagement with informal supports including traditional healing activities and other positive social supports	53%	45%

Mentors also reported the length of time parents had been substance free as of the mentors' last meeting with parents.

- <30 days 11%
- 30-90 days 14%
- >90 days 42%
- Still using 9%
- Dk 25%

Mentors were invited to provide additional details regarding treatment and recovery-related activities on these forms. Comments included: *Client started attending AA- she loves the program and is still very active in it. Getting connected with women in recovery. Getting involved in recovery community including finding a sponsor. Getting involved in recovery events for fun. Client very active in his recovery and now takes 12 Step meetings into tx and detox centers! Client very connected with recovery community. Helped this parent realize that helping people and talking to other recovering addicts and developing a support group helps.* (Interview data related to recovery is presented in detail below so is not included here.)

Informal Supports/Culturally Congruent Services

Exit data indicated that mentors helped approximately 40% (n=72) of parents develop new, positive interests and activities or to reconnect to old ones. A wide variety of informal supports and community-based activities was reported. These included the following:

- Church and other faith based activities, including a four day silent retreat. *Helped client find a church she felt comfortable with*.
- Parenting support including classes and groups, and family focused community events, such as family game night, supporting involvement in the children's school, and reconnecting with family more generally. *Supported the development of natural parenting supports in the recovery community.*
- A variety of stress reduction strategies including going for walks, the gym, dancing, meditation, and "meeting for coffee instead of doing drugs". One mentor reported

helping a mother *"get back involved with music that she lost touch with during her addiction."* Other activities include gardening, fishing and swimming.

- Education and employment related activities such as enrolling in school and connecting with handy-man work and other service opportunities. *Helped client fill out job applications on line.*
- Gender or culturally specific services including women's only support groups, fathers' parenting groups, playgroups or other supports offered by local Native American organizations or other services offered by the parents' Tribal groups. *Helped client connect with cultural help from the reservation.*

Positive change in Parents' level of Hope, Self-Efficacy and Empowerment, and Self-Regard

Hope, expectation that change is possible for someone like me

A number of the Parent Survey items related to hope and the potential for positive changes and outcomes; responses were overwhelmingly positive.

Parent Survey Item	Strongly Agree	Agree	Strongly Disagree or Disagree
I feel encouraged by the progress I am making in my recovery	80%	17%	0%
My mentor gives me hope about my situation	79%	17%	1%
I feel hopeful about how my DHS case will turn out	70%	15%	0%
My mentor helps me see how working with child welfare can be useful to me	63%	27%	3%

Interviews with caseworkers and parents are consistent with those results; for example, they noted the impact of mentoring on parents' expectations regarding the future and their ability to succeed.

> "..*Having someone with the shared experience and with a positive outcome… (parents) can be more optimistic about themselves and can perhaps not be as hard on themselves." (caseworker)*
>
> *"I thought I was too broken to be fixed before I met (M). She boost my confidence to where I am not shattered, I am just a little chipped on the edges." (parent)*
>
> *"The difference was my parent mentor pulling me out of it and saying 'wake up. You are getting into this fog… and before you know it your kid is going to be gone… But we can turn this around and it doesn't have to be'." (parent)*

Self-efficacy/ Empowerment

Responses to the 3 survey items that asked about parents' self-efficacy were also very positive.

Parent Survey Item	Strongly Agree	Agree	Strongly Disagree or Disagree
Working with my mentor helped me realize I can make life better for myself	79%	15%	2%
Working with my mentor helped me realize I can achieve goals that I set for myself	67%	24%	4%
I can make choices that are good for me and my children	71%	24%	0%

During interviews, caseworkers described in some detail some of the ways in which mentoring increases parents' confidence and can empower them to take on additional challenges.

> *I have certainly seen this parent started to get to her appointments because of the mentor. … It gave her some confidence in reaching out to other support networks and being a little more independent from my help, which was really, really big. (caseworker)*

> *(Parents) struggle with (transportation) things that aren't a big deal to us, that when they have (mentor) who can help them get to that appointment the first two or three times, and then I can reinforce this client 'look, you did it, that was fantastic' and they start to build that confidence that they can do things… and can reach out to people… who can help them. … having that response, especially in a system where they don't get that a lot, and when most of them are addicts they don't get it a lot in the community…. (caseworker)*

> *Court or a Citizens Review Board … is a very intimidating time for most parents. There is a lot of fear… When there is this (mentor) that (parents) see as real and on their level, it helps to give them the support that they need to… be confident when they are sitting in that CRB and to be able to say, 'this is what I've done'. (caseworker)*

Other survey items asked about whether parents experience the PMP as parent-directed and responses indicate that they did by a wide margin.

Parent Survey Items	Strongly Agree	Agree	Strongly Disagree or Disagree
I have a say in what my mentor and I work on together	76%	21%	2%
My mentor wants me to decide what we work on together	67%	25%	3%
My mentor encourages me to make my own choices about recovery	71%	23%	0%

Interview data also suggests that parents felt empowered in their work with the mentors:

> *I like that she asks me what I'm needing to do, not mandating and saying 'we are doing this." I like the control. (parent)*

somebody telling you what to do—yeah it feels good when you accomplish that, but when you set the goal for yourself it feels so much better. For me personally, I feel so much more accomplished, and you are ready to set another goal a little bit higher goal, and I did it! It is like a rush, an adrenaline rush. Yeah, I did it. (parent)

Just listening to your ideas and your goals instead of telling you what they think you should do with your life. That helps a lot. I know a lot of people that have enough people telling them, I think this is what you should do with your life, or this is what you are going to do if you want this. We have enough of that, so just having somebody who, "what do you want to do? How do you want to get to your main goal? I think that is more helpful than having another person telling me what to do and how to live. (parent)

Additional survey results suggest that the PMP supports the development of specific skills such as advocacy and problem solving, and engagement in their child welfare case more generally.

Parent Survey Items	Strongly Agree	Agree	Strongly Disagree or Disagree
Through my work with my mentor, I learned how to advocate for myself and my children	63%	27%	3%
I do a good job advocating for myself and my children	70%	24%	0%
My mentor helps me problem solve	67%	27%	3%
I work hard to stay on top of what's happening with my child welfare case	77%	19%	0%

Positive self-regard/respect

The 4 items on the survey related to parents' self-regard received very positive responses.

Parent Survey Items	Strongly Agree	Agree	Strongly Disagree or Disagree
I feel proud when I make progress on my goals	85%	13%	0%
When I'm with my mentor I feel important	69%	22%	4%
My mentor respects me	81%	16%	1%
When I'm with my mentor I feel accepted	80%	16%	1%

Interviews with parents and mentors contained numerous descriptions of the positive impact mentoring had on parents' sense of themselves and their abilities.

I didn't have that before. I was beat down, broken. I was just tired, sick and tired. I didn't *have the drive or the will to fight it. (Mentor) kind of gave that back to me, by showing me there are good people in the world. There are people willing to help me and that I'm not a bad person. I'm not all the things my ex told me I was. I'm not this horrible person, I'm not. (parent)*

(mentor) helped me and talk to me and made me see, I'm strong. It is in my head.. my conversations with her, I remember that, okay, everybody is different, everybody goes through the same thing, be strong. …. I remember that, because they were eye openers. (parent)

That is another thing that I like about (mentor). She didn't give up. When she saw that I had potential and I think she actually said that to me once, that she saw that potential. That boosted my ego and confidence and everything. Then I started doing the classes…. (parent)

I think if somebody sticks with them even through their failures and does not give up on them even though there is so many reasons why they should have, I think the more they believe in you, the more you start believing in yourself. … I think that knowing there is somebody there that is thinking about you, checks with you about how you are doing, that genuinely does care, I think that makes a big difference. (mentor)

When I first went into treatment… our counselor asked me to say three good things about myself and I couldn't name one. I started bawling… There isn't anything good about me. Now I can name a lot of things and it is because I hear it from other people. (parent)

(mentor) would give me ideas of what to do to boost my confidence. (parent)

With her, just being there, helped me realize that I am worth it. That is one thing she almost, not every time, but chronically, would tell me, Always tell yourself that you are worth it. That helped me a lot. (parent)

PM and Recovery

The focus population for the PMP was child welfare involved parents who presented with substance abuse issues; as such both the program model and the training included components specifically focused on addiction and recovery. Data collection efforts also tracked treatment and recovery related activities; this included interviews with parent, mentor and child welfare staff. What follows is a description of the intersection of the PMP and recovery derived from these data including the types of assistance provided by mentors and the difference this made for parents.

Recovery presents a significant challenge for many parents involved with child welfare.

One parent described it as follows, "*For example, me, I am learning how to do everything in a sober way, because what used to give me -- for example, right now we are talking. The only way I would (talk) is if I had alcohol in me. My addiction was alcohol. It was scary going to court, going to talk to people."*

Mentors offer a wide range of supports to parents, drawing on their personal experience as well as other professional resources. This includes helping parents' access treatment and recovery related services. For example, they shared information about recovery-related events with parents and encouraged them to participate.

One parent said, *"(Mentor) will tell me about things that are going on, like events and stuff. You know, the NA retreat is coming up on blah, blah, blah. 'You should be there'."*

Other parents described their mentors being a bit more forceful, "*When we got to the treatment center, I didn't want to walk through the door. She was, 'I don't know why you are scared now, you weren't scared when you were getting high, so get your butt up these stairs, come on, let's go.' She kind of gave me that extra push, go. 'We didn't come this far for nothing', so that helped. I wanted to run and she didn't let me – 'come on, come on'."*

Another parent shared, *"(Mentor) told me, 'I know you are sitting around doing nothing, so we are going to an AA meeting'."*

Mentors were able to provide "insider" information regarding recovery related activities-information that DHS often didn't have. This sort of information helped parents find services that "fit" and increased the likelihood of their participating.

One parent described her mentor as helping her "*getting a better idea of where meetings were. I needed to know where child-friendly meetings were."* Another shared *"(mentor) told me about where there is a meeting that I didn't even know... over here on 34th, just right up the road.*"

A caseworker commented, "*Mentors are better able to help parents understand that, yes, there may be a bunch of junkies (at the NA meeting), but you will also encounter people like you."*

Another mentor shared her insights regarding the character of different treatment agencies with parents: *"(A county treatment program) is hard, good, you can go there even if you don't have insurance. (a different program) is a little bit easier, takes less time to get through it, (a third program) -- a lot more touchy-feely, lovey."*

Another parent described a conversation with her mentor, *"She will ask me, 'Do you not like these meetings?' I don't like to go. I don't like to share at the meetings. She will say, 'Why don't you like it?' I don't like the people, it triggers me, it makes me think about when I was using. She said, 'You don't like the people? You don't go to the meetings for the people. You have to remember, they are just like you, trying to get better, too.' That is so true. Since she said that to me, I'll go to the meeting, and I will sit up front like she told me to and not pay attention to everybody else around me. I'll just focus on the meeting."*

Mentors also provided badly needed transportation and accompanied parents to recovery related activities.

> One parent described, *"The other ways that (mentor) helped would be to come and get me and physically drive met to a meeting, we would go to meetings together."*
>
> Another said, *"(Mentor) knew where meetings were. He knew how to get there or where I needed to go to get there, even if he needed to come pick me up for a ride. It was a good resource. It was like my beginning step to entering a sober life."*

At times, mentors made it possible for parents to comply with recovery-related mandates or service requirements.

> One parent from a rural community reported, *"If my color comes up, I have to come in and UA within 2 hours. I don't know how many times I was freaking out because I didn't have a ride into town. I would call (mentor), and she would be, 'I'm on my way'. Oh, thank god. If you are not here within 2 hours, it is considered a dirty UA. I can't get dirty UA's and get my kids back."*
>
> Another shared, *"In order for me to get back into treatment, I had to do 4 meetings. (Mentor) made sure I went to every one. She would take me to my UAs that I had for Family Treatment Court. She would take me to Family Treatment Court. God, there wasn't anything that she wouldn't do."*

When mentors accompanied parents' to12 Step meetings and similar activities, this reduced parents' anxiety and uncertainty and increased the likelihood that they went.

> As one parent described, ***"****It is helpful because when you are first in recovery and you don't have a lot of support at first, it is nice to have somebody there that you can vent to, or somebody who will take us to meetings and stuff like that, somebody that we feel she is on our side."*
>
> A different parent shared, *"(Mentor) would take me to meetings and stuff. It got me familiar with meetings, which is really important. DHS workers don't take you to meetings."*

Mentors also worked to connect parents with the recovery community. Parents and caseworkers agreed on the importance of securing these resources so parents had on-going support after their child welfare case closed.

> A mentor described the importance of this work with parents in the following way, *"Get (parents) out in the community so they can build their network stronger. My sponsor told me one time, a network with 4 people is going to leave so many holes you will fall through it. You want to have a lot of networks. I am visual person so she showed me a net and there are too many holes if you don't have enough strings in it."*

Another mentor said-- parents are *"just trying to find somewhere that they fit in. Basically that is why we all ended up getting loaded or drinking in the first place because we didn't feel like we belonged somewhere. I feel like that sense of community is imperative."*

A third said, *"What I try to do with that is put them in a position to where they have support because I only get to work with them for so long. One of my main goals in working with fathers is helping them find those supports when service providers can't answer the phone."*

A caseworker described it as follows, *"A community can share the load of client's stress. Client feels vulnerable if they just have one person to go to. People have cultural and community needs-- the mentors bridge the person back to their community, a supportive community."*

Another mentor said, *"I introduce them to really amazing women in recovery, too, who I think will identify with them, who have some really good experience and good recovery. I know a woman who just knocks your socks off, and I'll introduce them. A lot of times that becomes their sponsor."*

Yet another mentor said, *"A lot of the dads that I work with are okay with going to 12-step meetings…. It depends on the dad. The ones that get excited about going to the 12-step groups, I encourage to get peoples' phone numbers and try to build that support group."*

Mentors promoted and supported recovery in a variety of ways beyond connecting parents with services and activities. Many parents spoke about the importance of mentors modeling recovery.

One parent shared the following, *"We got to start doing things clean, and that is what those mentors do. They start showing you how to do it…they start rubbing off on you."*

Other comments include--*"[M]'s mentoring, it showed me I could be a clean and sober adult and still be happy."*

Another parent talked about the value of mentors showing parents "*that recovery is fun."*

Because of his mentor, a parent *"found out there are things that I love that I can do clean and sober."*

Mentors have "been there" and are knowledgeable about the process of recovery. Drawing on this experience, they offered lots of advice and targeted encouragement to parents.

A mentor described helping a parent develop a safety plan**: "***everybody else is gone Monday through Friday, but you can still go to meetings. There are all different kinds of meetings. You can still go to church, whatever it is. She actually likes meetings."*

One parent described the advice about AA meetings offered by her mentor: *(Mentor said) "Just listen, don't show them, just listen. After a while, the internal change will happen. You have to take the time and give it the chance. You can't just go there closed-channeled, and not want to hear nobody... Just sit there for a while, and after a while you are going to see yourself relate to some of the people, some of the stories -- maybe not everything but something."*

Mentors encouraged sobriety by speaking honestly and forcefully about addiction with parents.

One parent recounted a conversation with her mentor, *"It was the way she said it, the sincerity in it. She took the time to look me in my eyes and not look away and just sort of talk and move fast. She sat there and she talked to me and she told me why. 'If you use on a daily basis. It doesn't matter if you don't get sick. It doesn't matter if you don't have to, you just want to. That is what an addict does'."*

Another parent shared, *"(mentor) told me that -- the minute you use, you are going to get right back there so fast that it isn't even going to be funny, because you are an addict. You are not a social user. You are not going to be able to recreationally drink on the weekends. All that is out the window. You are not going to be able to do it.' Because I don't know how to quit. You know what I mean?"*

Another parent said, *"(Mentor) wants me to do different thinking habits. OK, hookah is legal, but it is almost the same thing as smoking weed. She wants me to get out of old habits like that… We were talking and she said, 'If you don't want to be tempted, you should really change the way that you are thinking, the things that you have around you, the places you go, the people you talk to', which is really true. We have been working a lot on that."*

Mentors helped parents understand addiction and recovery and offered coaching and encouragement including advice regarding how to prevent and respond to relapse.

A parent stated that his mentor *"got me to understand that I have to do this (recovery) all for me."* Another mentor offered an alternate view of addiction that was useful to the parent, *"(Mentor) made me realize it was my choices, not me and that I can be a better person."*

When asked, one caseworker said the most important things mentors do for clients includes "*helping parent to understand addiction and recovery."*

A mentor offered the following advice to a parent, *"(Mentor) said, 'What are you going to do on your first pass? You are able to go out on your own'. I was, 'I don't know. I*

don't have no friends anymore. Everybody uses and I can't be around them. That's not going to get me nowhere'. She is, 'exactly. Enjoy some time by yourself. You don't have to go nowhere with nobody. Go to the library, read a book'."

Another mentor used a relapse as an opportunity to think about how to avoid another one. The parent described the conversation as follows--*, (mentor) asked me, 'what made you relapse?' Well, I went out and then I got mad at the dude. She said, No, a relapse starts way before. So just play the tape back. Then she was, 'think about all the little things you were doing first'."*

Mentors offer an important and useful perspective on relapse: As one mentor put it, *"Yeah, we got to confront it, but also, it happens. It is not the end of the world, we can get through it*." In fact, mentors were able to offer significant concrete relapse prevention and response, often in the nick of time.

One parent shared, *"sometimes there are bad days and sometimes there are good days. If I really feel like it is going to be one of those 'I need to use days', (mentor) will come get me. We will hang out."*

Another parents' story went like this-- *I called (mentor) up and told her how I was feeling, and … She talked me through it. She said, 'this is just a little bitty hump. All you have to do is get over this one day'. That made me feel so good. I got to believing for a little while that I was a pebble away from relapse. She kept on telling me that sometimes some people have to do it one breath at a time. That helped me out a lot."*

Parents also saw mentors as a resource for getting back on track after a relapse.

One parent described being able to *"let down my guard enough to actually talk in group, talk to him, and really open up and be able to feel comfortable enough to call him and say, Hey, I have a problem. I had a drink. I need to go to an AA meeting right now."*

Another parent shared a more dramatic story. *"I relapsed in January, and … I was too scared to go back to the treatment center. I called (mentor) and she was, 'Where are you at? I'm coming to you right now'… She called the treatment center and said, 'I got [parent] with me right now and she needs to get back in there, what can we do?' They were, 'you have one hour to be here or she can't come back because it will be 24 hours by then'. She got me on the bus, walking me down the hill from Emanuel Hospital to the treatment center."* This parent was clear that, *"If (mentor) wouldn't have came to me, I never would have went back to treatment."*

The mentors' ability to respond quickly was very useful to parents.

A parent described reaching out to her mentor when a friend threatened her recovery: *"(the friend) was sitting in front of me getting high... (Parent called her mentor) and (mentor) came to Corvallis, got me and all my stuff, and took me to where I had a clean, safe place to live."*

Lastly, parents described how important mentors were to their recovery efforts.

> *When I first met her, I wasn't even in recovery yet. She gave me some good advice that kind of led me to wanting to go, OK, I can do this, she did it. And then she supported me while I was in there. Then I relapsed and she was there for me and supported me through that. That was a hard time, me not being able to see my kids. She helped me do that… Me and [mentor] have been through a lot together. She was there for my one year -- when I got my one year key tag. She gave me her one year key tag. She cried with me and everything and she spoke for me there. It was amazing. Yeah, [mentor], she has been a big part of my recovery."*
>
> *I honestly think if it was not for [mentor], I would probably still be using. I probably would have left the treatment center.*
>
> *Well, I think I'm back in the house because… I don't know, if he… If I didn't get that initial, "it is going to be alright, guy", you know what I mean, I think I would have went out there and I might have stayed with old friends at a drug house or with somebody using or something. But I didn't. You know, I stopped and thought about the situation and you know and I made the right choice. With (mentor's) help, I did make the right choice.*

Long Term Outcomes

Approach to Administrative Data Analysis

Administrative child welfare records were extracted from OR-Kids, Oregon's SACWIS. DHS staff received reports from the PSU Evaluation Team with lists of eligible cases that were randomly assigned to either the Control or Parent Mentor Program (PMP) group. Any children involved in these cases were flagged in the OR-Kids system, and the flags were used to extract records for these children. History in the child welfare system was assessed using foster care episodes, in-home services, family stressors, and maltreatment report data recorded since 2000. Foster care placements associated with PMP involvement were defined as occurring 60 days prior to randomization date through June 2015.

We examined differences in groups based on two stratification schemes for children with two different follow-up periods. The intent-to-treat (ITT) stratification included all children as they were randomized (PMP, *n*=784 vs. Control, *n*=489). The treatment-on-the-treated (TOT) stratification broke the PMP group into two smaller groups: those who accepted PMP services (Accept, *n*=498) and those who did not (No Accept, *n*=286). The two follow-up periods were: at least one year of post-randomization follow-up time (randomized by June 2014, *n*=1,179) and at least two years of post-randomization follow-up time (randomized by June 2013, *n*=690). Thus, each analysis was conducted four times for each of the following samples:

1. ITT 1-year follow-up (PMP, *n*=718 Control, *n*=461)

2. ITT 2-year follow-up (PMP, *n*=411; Control, *n*=279)
3. TOT 1-year follow-up (PMP Accept, *n*=474; PMP No Accept, *n*=244; Control, *n*=461)
4. TOT 2-year follow-up (PMP Accept, *n*=284; PMP No Accept, *n*=127; Control, *n*=279)

Child Welfare Administrative Data Samples Baseline Equivalence

Given the randomized control design, we did not expect to see any baseline differences between the groups. To test this assumption, the first step in the analysis process was to examine whether the PMP group was statistically equivalent to the Control group on a number of history and demographic factors in three samples: (1) full sample of parents/children as randomized; (2) parents/children with at least one year of post-randomization follow-up time; and (3) parents/children with at least two years of post-randomization follow-up time. Table 2-13 presents the sample characteristics for the full intent-to-treat sample and *p*-values for the statistical tests conducted to determine whether the Control and PMP groups were significantly different in each of the three samples. Table 2-14 presents the same information for the full treatment-on-the-treated sample.

Table 2-13. Parent Mentor vs. Control Group Child Welfare Baseline Equivalence Tests: Intent to Treat

Characteristic		Full Sample		Significant group difference? *p*-value		
		Control	PMP			
		% or mean (*n*)	% or mean (*n*)	Full sample	1+ Year follow-up	2+ Year follow-up
Child demographics						
Child age		6.4 (489)	5.9 (784)	.08	.06	.18
Female child		50% (242)	49% (386)	.97	.93	.81
Child race	White	61%* (299)	56% (436)	<.01	<.01	<.01
	African American	9% (46)	11% (86)			
	Hispanic/Latino	21% (101)	18% (137)			
	American Indian/Alaskan Native	2% (9)	9%* (69)			
	Native Hawaiian/Pacific Islander	1%* (4)	0% (0)			
	Asian	1% (3)	1% (7)			
	Unknown	6% (27)	6% (49)			
Pre-randomization child welfare involvement						
Follow-up time (# of days from randomization to end of study window)		784.3* (489)	756.1 (784)	.08	.30	<.01
At least one founded maltreatment report		78% (383)	84%* (660)	.01	.02	.03

Characteristic		Full Sample		Significant group difference? *p*-value		
		Control	PMP			
At least one founded report by type	Threat of harm	47% (232)	48% (379)	.76	.29	.06
	Mental injury	1% (7)	2% (16)	.43	.39	.87
	Neglect	55% (267)	61%* (477)	.03	.05	.21
	Physical abuse	6% (31)	5% (42)	.46	.51	.08
	Sexual abuse	1% (5)	2% (15)	.21	.10	.09
At least one foster care episode		52% (253)	60%* (470)	<.01	.02	.49
At least one in-home service		25% (124)	31%* (246)	.02	.01	.01

Notes. * denotes a significantly higher proportion than expected by chance, or significantly higher average. Shading indicates statistically significant differences between the Control and PMP intent-to-treat samples. Chi-squared analysis was used to test differences for dichotomous variables, Cramer's *V* was used for polytomous categorical variables, and *t*-tests were used to test mean differences.

Table 2-14. Parent Mentor vs. Control Group Child Welfare Baseline Equivalence Tests: Treatment on the Treated

Characteristic		Control	PMP No Accept	PMP Accept	Significant group difference? *p*-value		
		% or mean (*n*)	% or mean (*n*)	% or mean (*n*)	Full sample	1+ Year follow-up	2+ Year follow-up
Child Demographics							
Child age		6.4_a (489)	6.4_a (286)	5.6_b (498)	.03	.03	.01
Female child		50% (242)	50% (142)	49% (244)	.98	1.00	.89
Child race	White	$61\%_a$ (299)	$57\%_b$ (164)	$55\%_b$ (272)	<.01	<.01	.08
	African American	$9\%_a$ (46)	$12\%_a$ (34)	$10\%_a$ (52)			
	Hispanic/Latino	$21\%_a$ (101)	$15\%_b$ (42)	$19\%_b$ (95)			
	American Indian/Alaskan Native	$2\%_a$ (9)	$9\%_b$ (27)	$8\%_b$ (42)			
	Native Hawaiian/Pacific Islander	$1\%_a$ (4)	$0\%_b$ (0)	$0\%_b$ (0)			
	Asian	$1\%_a$ (3)	$>1\%_a$ (1)	$1\%_a$ (6)			
	Unknown	$6\%_a$ (27)	$6\%_a$ (18)	$6\%_a$ (31)			
Pre-randomization child welfare involvement							
Follow-up time (# of days from randomization to end of study		784.3_a (489)	703.4_b (286)	786.3_a (498)	<.01	.09	<.01

Characteristic		Control	PMP No Accept	PMP Accept	Significant group difference? *p*-value		
window)							
At least one founded maltreatment report		78%$_a$ (383)	83%$_b$ (238)	85%$_b$ (422)	.03	.05	.10
At least one founded report by type	Threat of harm	47%$_a$ (232)	40%$_b$ (114)	53%$_c$ (265)	<.01	<.01	.01
	Mental injury	1% (7)	1% (2)	3% (14)	.07	.10	.30
	Neglect	55%$_a$ (267)	64%$_b$ (184)	59%$_a$ (293)	.03	.05	.44
	Physical abuse	6% (31)	5% (15)	5% (27)	.76	.80	.13
	Sexual abuse	1% (5)	2% (6)	2% (9)	.44	.23	.18
At least one foster care episode		52%$_a$ (253)	56%$_a$ (161)	62%$_b$ (309)	.01	.01	.01
At least one in-home service		25%$_a$ (124)	25%$_a$ (72)	35%$_b$ (174)	<.01	<.01	<.01

Notes. Different subscript letters indicate significantly different group means or proportions. Shading indicates statistically significant differences between the Control, PMP No Accept, and PMP Accept samples. Cramer's *V* was used to test categorical variables and ANOVA with Bonferroni post hoc comparisons was were used to test mean differences.

The groups differed significantly on several characteristics:

- Child race
- Child age
- At least one founded maltreatment report- threat of harm and neglect
- At least one foster care episode
- At least one in-home service

To improve the estimates of effects of the PMP, the following child-level variables were included in the final child welfare outcome models: child age, child race, previous founded maltreatment report, previous foster care episode, and previous in-home service. Specific types of maltreatment were not included in the models because they were highly correlated with the overall "previous founded maltreatment" variable. ITT and TOT group differences in the length of follow-up period were also examined. We found that the PM Accept and Control group children had similar follow-up periods, but the PM No Accept group had a significantly shorter follow-up period (by approximately 80 days). All models were tested with length of follow-up period as a covariate but it did not change the substantive findings, and therefore follow-up time was not included as a covariate in the final models for parsimony.

Analysis Plan

After examining baseline equivalence, we followed a multi-step process for analyzing data for cases in each follow-up stratification: at least one year of follow-up time (randomized on or

before June 2014), and at least two years of follow-up time (randomized on or before June 2013).

7. Simple intent-to-treat (ITT) analyses (PMP vs. Control) testing differences in outcomes (*t*-test, chi-squared)
8. Simple treatment-of-the-treated (TOT) analyses (PMP No Accept vs. PMP Accept vs. Control) testing differences in outcomes (ANOVA, Cramer's V)
9. ITT analyses with covariates testing differences in outcomes after adjusting for baseline differences (ANCOVA, logistic regression)
10. TOT analyses with covariates testing differences in outcomes after adjusting for baseline differences (ANCOVA, multinomial regression)
11. Nested ITT analyses with covariates testing differences in outcomes after adjusting for baseline differences and accounting for case-level clustering (Linear Mixed Model, LMM or General Estimating Equations, GEE)
12. Nested TOT analyses with covariates testing differences in outcomes after adjusting for baseline differences and accounting for case-level clustering (LMM, GEE)

To test the assumption that covariates must have homogeneity of slopes in each group (ITT=Control vs. PMP; TOT=Control vs. PMP No Accept vs. PMP Accept), group X covariate interactions were tested for each outcome. Main effects (without interactions in model) for program are reported in Tables X-X. A four-category race variable (White, Black/African American, Hispanic/Latino, and Other) was tested in all models, but due to small sample sizes, a dichotomous race variable was included in all final models, White vs. All Others.

Administrative Data Results - Child Welfare Outcomes

The key outcomes analyzed, and descriptions of how they were calculated are presented in Table 2-15.

Table 2-15: Key Child Welfare Outcomes

Outcome	How it was calculated
Days in foster care	Using foster care placements that occurred on or after randomization, calculate total number of days in foster care (including time spent in trial reunification). If placement started before, randomization, placement start date is changed to randomization date. Excludes children who were still in care at the end of the study window.
Time to first permanency	Using the first foster care episode end date that occurred post-randomization, calculate length of episode in days. If the episode started before randomization date, use randomization date as start date. Excludes children who had not reached permanency at the end of the study window.
Type of first permanent placement	Using the first foster care episode end date that occurred post-randomization, find the associated disposition: 1-Reunification, 2-Living with Other Relative, 3-Guardianship, 4-Adoption, 5-Other (Child Deceased, Aged Out, Transferred to Another Agency, Runaway, or Youth, Under 21 Self Sufficient). If first foster care episode is still open, disposition is coded: 6-Still open.
Post-randomization founded maltreatment report	Using maltreatment report data, create a variable (0/1) that indicates whether there was at least one founded report made after the random assignment date.

Outcome	How it was calculated
Post-randomization placement in foster care (not in foster care at time of randomization)	Using foster care episode data, find the start date of the first post-randomization foster care episode, and the end date of the foster care episode immediately preceding the first post-randomization foster care episode. If there was no post-rand FC AND no preceding FC that ended after randomization, code as a 0 (not in foster care at randomization, did not go into foster care later). If there was a post-rand FC AND no preceding FC that ended after randomization, code as a 1 (not in foster care at randomization, but went into foster care later). Excludes children who were in foster care at time of randomization.
Re-removed after first permanency	Using foster care episode data, create a variable (0/1) that indicates whether there was at least one new foster care episode that started after the end of the first post-randomization foster care episode.

The tables that follow (Tables 2-16 – 2-19) present the unadjusted means and percentages and significance tests from steps 5 and 6 (which included adjustments for covariates and case-level clustering). The ITT analyses for the sample of children with at least one year of post-randomization follow-up time suggest no statistical differences between children with parents involved in the PMP vs. control children (see Table 2-16). Children were in foster care for an average of approximately 1.1 years, and it took them an average of 1.1 years to exit foster care. Four out of every five children who exited foster care within this time frame were returned home. Of the children who exited foster care, one out of every seven were re-placed in foster care. Of the children who were not in foster care at the time their parents were randomized for the program, 20% went into foster care later in the case. Finally, 18% of the children had a founded post-randomization maltreatment report.

Table 2-16. Intent-to-Treat Child Welfare Outcomes: 1+ Years of Follow-up Time

Outcome	Control	PMP	Test Statistic	*p*-value
	% or mean (*n*)	% or mean (*n*)	(*df*) value	
Days in care (closed foster care episodes only)[1]	395.3 (120)	415.0 (215)	$F(1, 194) = 0.04$	.84
Time to first permanency[2]	403.0 (136)	398.0 (233)	$F(1, 220) = 0.12$	.73
Type of first permanent placement-Reunification[2]	86% (116)	79% (184)	$F(1, 272) = 1.49$	.22
Post-randomization founded maltreatment report[3]	17% (79)	19% (137)	$F(1, 658) = 0.23$	.63
Post-randomization placement in foster care (not in foster care at time of randomization)[4]	18% (47)	21% (78)	$F(1, 348) = 0.22$	.64
Re-removed after first permanency[2]	15% (20)	13% (31)	$F(1, 291) = 0.03$	.86

Notes. Final models included child age, child race (White vs. Other), previous foster care episode (yes/no), previous founded maltreatment report (yes/no), and previous in-home services (yes/no) as covariates.

[1] Includes a subset of children with at least one year of post-randomization follow-up time who were no longer in foster care at the end of the study window, *n*=335 (or 28% of the total 1-year follow-up sample = 1,179).

[2] Includes a subset of children with at least one year of post-randomization follow-up time who had exited foster care at least once during the study window, *n*=369 (or 31% of the total 1-year follow-up sample = 1,179). Two children had exited foster care but had missing dispositions for the type of first permanent placement-reunification outcome (*n*=367).
[3] Includes a subset of children with at least one year of post-randomization follow-up time, *n*=1,179.
[4] Includes a subset of children with at least one year of post-randomization follow-up time who were not in foster care at time of randomization, *n*=632 (or 54% of the total 1-year follow-up sample = 1,179).

The TOT analyses for the sample of children with at least one year of post-randomization follow-up time also indicated no statistical differences between children with parents involved in the PMP who accepted the program vs. control children (see Table 2-17).

Table 2-17. Treatment-on-the-Treated Child Welfare Outcomes: 1+ Years of Follow-up Time

Outcome	Control	PMP No Accept	PMP Accept	Test Statistic	*p*-value
	% or mean (n)	% or mean (*n*)	% or mean (*n*)	(*df*) value	
Days in care (closed foster care episodes only)[1]	395.5 (120)	384.8 (74)	431.3 (141)	*F*(2, 139)= 1.00	.37
Time to first permanency[2]	403.0 (136)	379.7 (79)	407.4 (154)	*F*(2, 178)= 0.61	.54
Type of first permanent placement-Reunification[2]	86% (116)	80% (62)	79% (122)	*F*(2, 261)= 0.82	.44
Post-randomization founded maltreatment report[3]	17% (79)	15% (37)	21% (100)	*F*(2, 670)= 1.89	.15
Post-randomization placement in foster care (not in foster care at time of randomization)[4]	18% (47)	24% (33)	19% (45)	*F*(2, 311)= 0.42	.66
Re-removed after first permanency[2]	15% (20)	14% (11)	13% (20)	*F*(2, 274)=0.13	.88

Notes. Final models included child age, child race (White vs. Other), previous foster care episode (yes/no), previous founded maltreatment report (yes/no), and previous in-home services (yes/no) as covariates.
[1] Includes a subset of children with at least one year of post-randomization follow-up time who were no longer in foster care at the end of the study window, *n*=335 (or 28% of the total 1-year follow-up sample = 1,179).
[2] Includes a subset of children with at least one year of post-randomization follow-up time who had been reunified at least once during the study window, *n*=369 (or 31% of the total 1-year follow-up sample = 1,179).
[3] Includes a subset of children with at least one year of post-randomization follow-up time, *n*=1,179.
[4] Includes a subset of children with at least one year of post-randomization follow-up time who were not in foster care at time of randomization, *n*=632 (or 54% of the total 1-year follow-up sample = 1,179).

The ITT analyses for the sample of children with at least two years of post-randomization follow-up time produced nearly identical results to those reported for the children with at least one year of follow-up time (see Table 2-18). With a longer follow-up period, children were generally in care for longer periods of time (1.3 years), and there were slightly higher rates of subsequent maltreatment reports and re-placements in foster care, but this occurred uniformly in both the PMP and Control groups.

Table 2-18. Intent-to-Treat Child Welfare Outcomes: 2+ Years of Follow-up Time

Outcome	Control	PMP	Test Statistic	*p*-value
	% or mean (*n*)	% or mean (*n*)	(*df*) value	
Days in care (closed foster care episodes only)[1]	461.3 (86)	477.7 (138)	*F*(1, 126)= 0.15	.70
Time to first permanency[2]	465.4 (100)	448.9 (153)	*F*(1, 147)= 0.34	.56
Type of first permanent placement-Reunification[2]	84% (84)	78% (119)	*F*(1, 175)= 0.67	.42
Post-randomization founded maltreatment report[3]	19% (54)	23% (93)	*F*(1, 356)= 0.19	.66
Post-randomization placement in foster care (not in foster care at time of randomization)[4]	20% (32)	24% (57)	*F*(1, 179)= 0.48	.49
Re-removed after first permanency[2]	17% (17)	18% (27)	*F*(1, 198)= =0.08	.77

Notes. Final models included child age, child race (White vs. Other), previous foster care episode (yes/no), previous founded maltreatment report (yes/no), and previous in-home services (yes/no) as covariates.

[1] Includes a subset of children with at least two years of post-randomization follow-up time who were no longer in foster care at the end of the study window, *n*=224 (or 32% of the total 2-year follow-up sample = 690).

[2] Includes a subset of children with at least two years of post-randomization follow-up time who had exited foster care at least once during the study window, *n*=253 (or 37% of the total 2-year follow-up sample = 690).

[3] Includes a subset of children with at least two years of post-randomization follow-up time who were not in foster care at baseline, *n*=690.

[4] Includes a subset of children with at least two years of post-randomization follow-up time who were not in foster care at baseline, *n*=399 (or 58% of the total 2-year follow-up sample = 690).

The TOT analyses for the sample of children with at least two years of post-randomization follow-up time also indicated no statistically significant differences between the PMP Accept, PMP No Accept, and the Control group children (see Table 2-19).

Table 2-19. Treatment-on-the-Treated Child Welfare Outcomes: 2+ Years of Follow-up Time

Outcome	Control	PMP No Accept	PMP Accept	Test Statistic	*p*-value
	% or mean (*n*)	% or mean (*n*)	% or mean (*n*)	(*df*) value	
Days in care (closed foster care episodes only)[1]	461.3 (86)	438.8 (40)	493.54 (98)	*F*(2, 71)= 0.29	.75
Time to first permanency[2]	465.4 (100)	439.5 (42)	452.5 (111)	*F*(2, 109)= 0.17	.84
Type of first permanent placement-Reunification[2]	84% (84)	76% (31)	79% (88)	*F*(2, 155)= 0.37	.69
Post-randomization founded maltreatment report[3]	19% (54)	18% (23)	25% (70)	*F*(2, 366)= 1.30	.27

Outcome	Control	PMP No Accept	PMP Accept	Test Statistic	*p*-value
Post-randomization placement in foster care (not in foster care at time of randomization)[4]	20% (32)	33% (28)	19% (29)	*F*(2, 174)= 1.44	.24
Re-removed after first permanency[2]	17% (17)	19% (8)	17% (19)	*F*(2, 143) =0.07	.94

Notes. Final models included child age, child race (White vs. Other), previous foster care episode (yes/no), previous founded maltreatment report (yes/no), and previous in-home services (yes/no) as covariates.

[1] Includes a subset of children with at least two years of post-randomization follow-up time who were no longer in foster care at the end of the study window, *n*=224 (or 32% of the total 2-year follow-up sample = 690).

[2] Includes a subset of children with at least two years of post-randomization follow-up time who had exited foster care at least once during the study window, *n*=253 (or 37% of the total 2-year follow-up sample = 690).

[3] Includes a subset of children with at least two years of post-randomization follow-up time who were not in foster care at baseline, *n*=690.

[4] Includes a subset of children with at least two years of post-randomization follow-up time who were not in foster care at baseline, *n*=399 (or 58% of the total 2-year follow-up sample = 690).

Covariates as Potential Moderators

All impact models included four covariates to adjust estimates for the baseline difference: child age, previous in-home services, previous foster care placement, and previous founded maltreatment report. The PM group, and the PM Accept group in particular, had a significantly larger proportion of children with previous in-home services, out-of-home placements, and child maltreatment reports, and the children were younger by an average of 1 year.

To examine homogeneity of slope, all covariates were tested to see if their effect on an outcome interacted with group assignment (ITT and TOT groups). A number of significant (p<=.05) interactions were found for previous in-home services, previous foster care placement, and child age. Child race was also a statistically significant moderator for a number of variables. These interactions suggest that the relationship between these variables and a number of outcomes (days in foster care, time to permanency, likelihood of re-removal, entering foster care post-randomization but not in foster care at time of randomization) differed based on group assignment.

Unfortunately, all of the interaction effects were based on a small number of children (in many cases <20), which limits generalizability. Moreover, the pattern of findings was not consistent in terms of the effects of the PM program, making the overall findings difficult to interpret. For these reasons, we do not present the moderation results; however, it might be important for other programs to consider previous child welfare involvement, child age, and race as moderators of the effect of programs on subsequent placement and permanency outcomes.

Limitations

It should be noted that these results are based on data available for about one-third of the total child sample. Foster care placement was not an eligibility criterion, so it is not surprising that

many children associated with the PM program were not in foster care at any time during the study window. Conversely, a number of children were still in foster care at the end of the study window (i.e., had not yet reached a permanency) and were not included in the calculations of days in foster care. With larger samples and longer follow-up periods, there would be increased power to detect statistically significant differences. Given the lack of baseline equivalence between the groups (and interaction effects found for covariates), it is likely that the significance tests were not fully adjusted for all of the differences (measured and unmeasured) between the groups. We also did not find strong evidence of moderated program effects to confidently make statements about parenting mentoring services working better for certain groups of children and their families.

From Research to Practice: Topical Briefs for Practitioners

To broaden the reach of the findings, the research team prepared a number of topic-oriented briefs for use by practitioners. This information emerged from our research and we believe it brings new perspectives and guidance to professionals working in the fields of child welfare, recovery, and peer mentoring. Titles and a short description of the content are listed below.

Supervision: A Parallel Process for Supporting Parent Mentors

- In this brief, we discuss three key ways in which supervisors can create high quality work environments for parent mentors that mirror the work parent mentors do with parents: (1) develop a trusting relationship, (2) build competencies, and (3) empowerment.

Parents Benefit When Mentors & Caseworkers Collaborate

- When appropriate and with a parent's agreement, parent mentors can communicate and collaborate with caseworkers. In this short brief we describe what this communication and collaboration looks like.

What Mentors Do (with and for Parents)

- The work that mentors do is multi-layered and constantly changing depending on the needs of each parent. This brief categorizes and describes key mentoring activities, and highlights how *peerness* further enhances the usefulness of these activities.

Peer Mentoring: What, How, and So What?

- This brief is concerned with describing what is unique about *peer* mentoring. It is broken into three related sections: (1) What makes mentoring *peer* mentoring? (2) How exactly does peer mentoring work? And (3) what does peer mentoring help accomplish?

How Does Peer Parent Mentoring Work? A Motivational Framework

- While peer support programs are increasingly common in child welfare, theory that might explain how such programs promote engagement is under-developed. In this brief, we propose a framework for understanding how peer mentoring facilitates parents' motivation and results in their making progress on their child welfare case.

Parent Mentors' Impact on Caseworkers and Casework

- The positive benefits from having a parent mentor extend far beyond just parents. This brief describes how caseworkers also significantly benefit from parent mentors. The primary benefit described is that mentors help facilitate better working relationships between parents and caseworkers.

Working with Parent Disaffection: What Would a Parent Mentor Do?

- Parent disaffection is often seen in child welfare cases. This brief describes what parent disaffection looks like and how parent mentors and other caseworkers can respond in motivationally supportive ways to facilitate re-engagement.

Supervision: A Parallel Process for Supporting Parent Mentors

Supervision is commonly understood to be a time when service providers can, either individually or in a group, discuss work with their clients, problem solve, and develop skills. Competency-focused supports are necessary but may not be sufficient for creating the highest quality work environments for parent mentors. Focus groups and interviews with parent mentors and their supervisors revealed the belief that supervision should provide similar supports to parent mentors as parent mentors provide to parents, a notion referred to as "parallel process."

In this research brief, we discuss three key ways in which supervisors can create high quality work environments for parent mentors that mirror the work parent mentors do with parent: (1) develop a trusting relationship, (2) build competencies, and (3) empowerment.

> "…my number one goal for supervising is…to build trust. I want to be viewed as trustworthy. I want to be viewed as safe." –Supervisor

Develop a Trusting Relationship

Show mentors you care about them

- Know their story/trauma history
- Check in after you know mentor has done something difficult
- Make sure that the first part of your supervision time is devoted to how the mentor is doing

Prioritize mentor's wellness

- Provide personal and emotional support in addition to professional support
- Encourage and be flexible about self-care.
- Continually monitor personal well-being

> "I'm calling my supervisor saying, 'OK, I have a client and she needs to go into the psych ward…and she wants me to pick her up and take her somewhere. She is detoxing and suicidal… [supervisor] is just walking me through it. She is telling me that's the right thing to do, that's the wrong thing to do." – Mentor

Recognize positive steps taken

- Honestly validate effort
- Praise

Be available

- A supervisor is always reachable by phone
- In-the-moment coaching

Build Mentoring Competencies

Help mentors establish and adhere to professional boundaries

- Monitor contact hours, attending to cases with high or low numbers

> "If you create the environment where honestly and transparency is safe, and…you stick with the model of asking about each and every client, and not letting the mentor kind of cherry pick who they want to talk about, then you are going to hear it." – Supervisor

- Look for client issues that could trigger mentor's own past trauma

Assist mentors in building their toolkit

- Model what you want them to do with clients.
- Explore new tools to apply to challenging situations
- Allow mentors to come up with their own solutions
- Teach mentors when to use certain tools

Provide workforce development opportunities

- Coach mentors on what is expected in certain settings (e.g., court, community meeting)
- Place value on mentors being a cultural bridge between the client and the caseworker
- Ensure resources and support for ongoing training

Empowerment

> "You don't want the mentor to have a top-down approach with their clients, and we… don't manage with a hammer… [we] try to involve mentors in decision making."
> –Supervisor

Respect life experience as much as professional training

- Defer to mentor experience as much as possible.

Ask mentors for feedback on supervision

- Check in frequently on whether the supervisory relationship is working
- Develop a mechanism for mentors to hold supervisors accountable if they are not getting what they need

Provide opportunities for shared leadership

- Have mentors participate in hiring
- Give mentors a say in how services are delivered
- Incorporate mentors' feedback and ideas into decision making

Parents Benefit When Mentors & Caseworkers Collaborate

Caseworkers and mentors draw on distinct types of expertise and often have very different relationships with parents that when combined can make a powerful impact on parents' experiences with child welfare. Both mentors and caseworkers spoke to the value of their working together on behalf of parents; communication[13] and a willingness to partner were seen as key to making this happen. This collaboration takes a variety of forms; some examples are listed below.

- Exchange contact information and ideas about how to connect with parents who are homeless or otherwise difficult to find.
- Brainstorm ways to engage parents- caseworkers share clinical skills and mentors draw on their lived experience of what works.
- Identify resources- mentors often have information about programs and how to access them that child welfare doesn't have.
- Mentors can listen to caseworkers with/for parents, and make sure parents really understand by translating jargon and taking the time to explain.
- Share feedback from parents about what's working, what's not and what else they need.
- Alert each other when parents are in crisis so as to provide timely and appropriate support.
- Mentors can share information and insights about addiction and recovery with caseworkers/Caseworkers can help mentors identify mental health challenges and other disabilities.

Finally, when parents see mentors and caseworkers working together, it oftentimes makes it easier for them to trust the agency and to actively engage.

"...when you're able to [work as a team] there is this magic that happens with a case. Things start to go really good for the parent."
-Mentor

"The people involved in the case need to be communicating. [Caseworker] is telling me everything that is going on, I'm telling him that we are going to meetings and what the plan is. Then I am able to communicate with my parent, 'This is what you should be doing', and 'How can I help you with that?'"
-Mentor

"...if you feel you've wracked your brain about ways to engage this client, maybe [the mentor] has a better way, and then you can go behind them and do what they're doing or however they're approaching the client." -Caseworker

"I had one client that I thought used drugs... She had severe DD, developmentally delayed, and that can be confused with [being on drugs] -- I didn't know that. I know it now after talking with the caseworker".
-Mentor

"[Mentors say] 'You know, I'd really try looking at this program. I just don't think this (other) one's working for (parent)' or 'he complains because they don't like it when you ...' and I wanna hear this stuff 'cause maybe they can tell me stuff that the client's sharing about how I'm doing my job and then I can do it better to fit their needs..."
-Caseworker

"The caseworker and me and mom, all of us, just us 3, had been in communication this whole time, so we were able to support this parent and she is able to stay clean." -Mentor

[13] The PMP utilized a Release of Information that allowed parents to limit the type of information that could be shared by mentors with parents' caseworkers.

What Mentors Do (with and for Parents)

Below is a list of key mentoring activities gleaned from interviews with parents and mentors. The supports that mentors provide affect how parents think about themselves, their motivation for change, and their actions (e.g., coping with difficulties, engaging in services). The potency of these supports is accelerated by the fact that peer mentors have lived experience; the quote boxes below highlight the ways in which "peerness" enhances mentoring activities.

*Mentors' success helps parents **believe success is possible** "for people like me."*

Create Warm, Trusting Relationships

- Offer kindness, warmth, and caring, help parents feel "worth it"
- Provide encouragement and positive reinforcement
- Believe in parents, argue for hope
- Be available, accessible and responsive

***Relationship** facilitates mentors' ability to solicit parents' goals and interests and their meaningful involvement in planning.*

Promote Empowerment

- Solicit parents' goals and focus on parents' needs
- Offer acceptance rather than judgment – meet parents "where they are at"
- Help parents see choices and imagine possibilities
- Put together a path made of small steps, make the process more manageable and less overwhelming

*Parents are often **more receptive** to information and advice offered by a*

Build Support Networks and Social Capital

- Introduce parents to informal supports in recovery, faith-based, cultural and other communities
- Promote parents' extracurricular interests such as exercise, gardening, fishing
- Connect parents to community based agencies
- Facilitate parents' efforts to gain skills and education

*Mentors have **information** about how systems work based on **personal experience.***

Help Navigate Systems

- Explain how the system works and how to prepare
- Share information about resources and how to access them
- Translate jargon, use language that's easy to understand, take the time to make sure parents really understand.
- Advocate- identify where parents are stuck and when providers are working at cross purposes, coach/model effective communication skills

Provide Transportation

- Provide rides to parents, especially those in rural areas without public transit
- Make sure parents make it to crucial appointments such as court hearings and unscheduled UAs

> *Peers are **better able to anticipate triggers** and have realistic suggestions for managing emotions.*

Accompany Parents

- Provide emotional support, help reduce parents' anxiety and increase their confidence
- Advocate for parents, vouch for their progress, help providers understand parents' experiences
- Coach parents before and during meetings, court hearings and other important appointments
- Listen carefully and take notes when parents are too stressed to hear clearly

Communicate-- Encourage, Problem Solve, Celebrate and Support

- Check in frequently with parents, provide real time monitoring, encouragement and advice
- Celebrate successes and build parents' sense of competence
- Help parents anticipate triggers and develop safety plans
- Hold parents accountable and encourage rigorous honesty

> ***Peers know from experience** what kinds of safety plans work, and what's worth celebrating.*

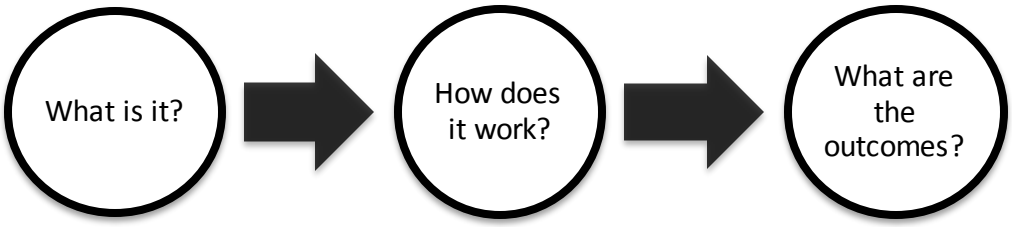
Get Parents "Back on Track"

- Respond to parents' setbacks with "Yeah, you messed up-- now get back on track!"
- Push parents, don't settle for "I give up"
- Help parents understand addiction and the recovery process
- Be available to accompany parents back to treatment, or away from situations that are a risk to their recovery or safety.

> *Parents may be **more willing to disclose to a peer** because they are less afraid of being judged.*

Peer Mentoring: What, How, and So What?

Peer mentoring programs are becoming popular services in a number of systems including physical health, mental health, education, and child welfare. In the Parent Mentoring Project, peer mentors are former child welfare clients who have been successfully in substance recovery for at least two years. This research brief highlights some lessons learned from the PMP Project. We first define peer and then offer explanations, supported by data, about how and why peer mentorship works and benefits parents.



WHAT makes mentoring peer mentoring?

In this project, peerness was grounded in a history of similar experiences: mentors were in recovery at least 2 years and most had previous involvement with child welfare. Other factors that generated a sense of peerness included:

- Gender
- Race/ethnicity
- Primary drug of choice during their addiction
- Religion/spirituality

While the above factors *may* facilitate a peer connection between mentors and parents, this is not guaranteed, and "mismatches" can work. For instance, in the PMP, women successfully mentored dads and some successful pairs included mentors who were of a different race than their parent. What made the biggest difference was whether mentors had "been in their shoes" as measured by a history of substance abuse and a successful recovery, along with experience as a child welfare client.

> *[I thought to myself] why not keep using? And that's the addict's thinking, in their head- [looking for] any way to bandage it or any way to avoid it altogether. That is why when [my mentor and I] saw each other face to face, he knew what was going on. I couldn't dance around him. He knew what was going on. That is the difference between somebody who has been there and knows what to look for, and somebody who hasn't. I'm not saying that all parent mentors should be former users or anything like that. I am saying in my situation, it helped me, because I know ways to dance around situations and [mentor] knows what to look for.* -Parent

> *I don't like this part of my job. I had to tell [my supervisor], I said, that was the most difficult day of my life… I don't like this part of my job. I don't ever want to have to do that again. I don't know if I'm cut out for this, because it retriggered my trauma. I remember when I had to pack up my daughter's things for DHS to come and get her. The difference is, my supervisor said, you did it alone and the mother had you… She said, who better to do it with her than you that can relate. You know what that exact pain feels like, when the caseworker doesn't, to have her [parental rights terminated].*-Mentor

> *(Mentors) can be that person that can talk straight with a parent and have the credibility to back it up. I can talk until I'm blue in the face to a parent about this is what you need to do, these are the steps that you need to take towards recovery, but I don't have any credibility. A parent mentor does.*-Caseworker

HOW does peer mentoring work?

Peers create a safe, accepting, and non-judgmental relationship with parents.
How? Peers have been there, they have a similar history. As a result, they understand the shame that child welfare involvement and substance abuse elicit.

Peerness creates shortcuts in communication and understanding.
How? Peers share common experiences and backgrounds, helping them to anticipate parents' recovery and child welfare needs.

Peer mentors inspire parents.
How? Peers are symbols of hope: they started where parents are and went on to succeed in their recovery, close their child welfare cases, and work in positions that elicit respect by providers and parents alike.

Peer mentors have unique and irreplicable knowledge and perspectives.
How? Peers have experience-based knowledge from having successfully navigated the system(s) themselves *and* the acquired knowledge of training and education; they have both insider and outsider information.

Peer mentors don't give up on parents.
How? Peers draw on their own long and complex paths to recovery. They've been there. They know change is difficult and even planting a seed of hope can make the difference later.

I think maybe because right off the bat, when [the parent mentors] came into that visiting room, and told me that they had both been through the same thing. So I just let my guard down there. - Parent

Sometimes it is just that they speak my client's language and I don't all the time. My parent mentors can look at them and say, I've been where you are, and I know what it feels like. That is just so helpful. - Caseworker

It made me feel that there is a light at the end of the tunnel. She is proof- living proof. - Parent

If you have addiction, you have this view of yourself as a person on the sideline -- oh, that person is an addict… Then you see [mentors] are going to court, they have good relationships with all these people and they worked really hard for what they got -- it is inspirational. - Parent

It comes from having someone who can say, 'Oh, I was in front of this judge two years ago' and can tell them exactly what that judge is like. Or tell them about this treatment program they're going into or can say 'DHS is doing this, and I know it feels awful and I know it doesn't feel like it's for your own good, but if you stick with it, it will help in the long run'. - Caseworker

What you have to take is the fact that… if anything, you've planted a seed. Maybe 10 years down the road that person [will] get clean and sober. - Mentor

There [were] a few times where I didn't think this parent had it in her- it was just that little aha moment of hers happened farther down the road. That's one of the reasons I don't give up on them- you never know when it's going to be. - Mentor

WHAT does peer mentoring help accomplish?

Parents, caseworkers, and mentors all spoke to the unique experiences and relationships that resulted from peer mentoring. What outcomes do we see as a result?

- Parents **engage earlier** because they are not afraid of being misunderstood.
- Parents **see new possibilities**: recovery and successful child welfare case closure are possible.
- Parents **feel good**, and **derive a sense of self-worth** from walking alongside their mentors' recovery.
- Parents **feel worthy**, which feeds their sense of efficacy.
- Parents **feel motivated to make progress** in their recovery and child welfare cases.

How Does Peer Parent Mentoring Work? A Motivational Framework

While peer support programs are increasingly common in child welfare settings, theory that might explain how such programs promote engagement and progress on child welfare requirements is under-developed. We propose a motivational framework for understanding how peer mentoring facilitates parents' motivation and results in their making progress on various aspects of their child welfare case. Our theory draws on Self-Determination Theory, and Basic Psychological Needs Theory (BPNT) in particular.

How do mentors support parent motivation?

Peer parent mentor supports help parents have more **positive self-beliefs**.

> *Someone who is positive, who believes I can do it. I can do anything if I have some support. You can't bank a basketball if someone in the background is saying, Oh, god, you are never going to make a shot. You know what I mean, it doesn't make sense. - Parent*
>
> *That trust made me just more motivated man, he believes in me. If he believes in me, I know I can do it.- Parent*

- ***Warmth and caring*** meets parents' needs for ***connection and belonging***

  It made me feel not alone, like other people go through it too, so I'm not the only person. – Parent

  Some parents talked about feeling like a number in other service systems; in contrast, mentors really got to know parents. One parent described her mentor as understanding "what I'm about, what I'm trying to do and about me as a person, me as a mother…"

  It is nice because let's say I wasn't doing good, and I just needed that phone call. When you are doing bad, the phone feels really heavy. Sometimes it is nice just to hear that somebody cares. - Parent

- ***Structure and guidance*** help parents feel ***successful and competent***

  The biggest thing for all my client is transportation, getting to where they need to go. They struggle so much with the little things like that, things that aren't a big deal to us, that when they get to that appointment the first two or three times, and then my client can call me or a parent mentor can all me and say, Hey, they did this, they were successful, then I can go back and reinforce this client -- Look, you did it, that was fantastic and they start to build that confidence that they can do things and that they can reach out to people who are there, who can help them. I think having that response, that positive response 2 or 3 times, especially in a

system where they don't get that a lot, and when most of them are addicts, they don't get it a lot in the community at large, then I think that is really where I see it.- Caseworker

Sometimes you don't really know, you know what you want to do, but then you don't know. You have to find yourself again, especially after being lost in some world on drugs and stuff. You don't really know [yourself] no more and what you like to do because [using substances] is all you know. When we are setting these goals or whatever, give me some hints. She will give me some ideas. Are you into this and this? Why don't you try this?- Parent

- Being ***parent-directed*** and supporting parents' autonomy helps parents feel like they ***can take charge of their own situation***

For me, personally, that is huge, is being able to make those choices instead of having another person telling us what to do. Instead of somebody telling you want to do -- yeah, it feels good when you accomplish that, but when you set the goal for yourself it feels so much better. For me personally, I feel so much more accomplished. Like, Ah, I did it, and you are ready to set another goal, a little bit higher goal, and I did it! It is like a rush, an adrenaline rush. Yeah, I did it.- Parent

It can build their self esteem and self worth, because they did it. They directed it, they did it their way. All we have to do is kind of guide them.- Mentor

Why are positive self-beliefs important?

Positive self-beliefs help motivate parents toward **actions that support their goals**.

We are just scared at first. Everything gets taken away from you and everything is all about what you have done wrong. You don't feel like you can ever overcome it. -Parent

- Connection and belonging = "I am worthy" therefore ***I will take care of myself***.

(Mentor) made me feel like my life and my kid's lives matter.-Parent

She would tell me all these good things about me. You don't feel like that, but sometimes when you hear it long enough, you start to feel like it. – Parent

I am 39 years old and just got a job at McDonalds. Everyone, Oh, McDonalds, that is for teenagers. But, you know what, my bosses make me feel like I am needed and that feels good, because then I strive to be a better worker.- Parent

- Successful and competent = "I can do it" therefore ***I will try again***.

I did, and the more I do it, the easier it gets. The more time I get, the less I want to ever use, because I have worked my ass off to get this far. I'm not saying I'm anywhere. I'm just saying I

made it 8 months. I have never been able to say that without being in jail or being locked up. I have never done it on my own.- Parent

I have certainly seen this one parent of mine started getting to her appointments because of this mentor. Not only was it really good for me to see, but it also gave her some confidence in reaching out to other support networks and being a little more independent from my help which was really, really big. –Caseworker

I think it motivates them to feel like they are getting stuff done, and they are. -Mentor

If I hadn't went to CPS class, I wouldn't feel that accomplishment there and graduated, I wouldn't have followed through with the anger management. I probably would still be yelling and cursing and all that. With her just being there, helped me realize that I am worth it. That helped me a lot. - Parent

- Take charge = "I have a say" therefore ***I will advocate for my preferences***.

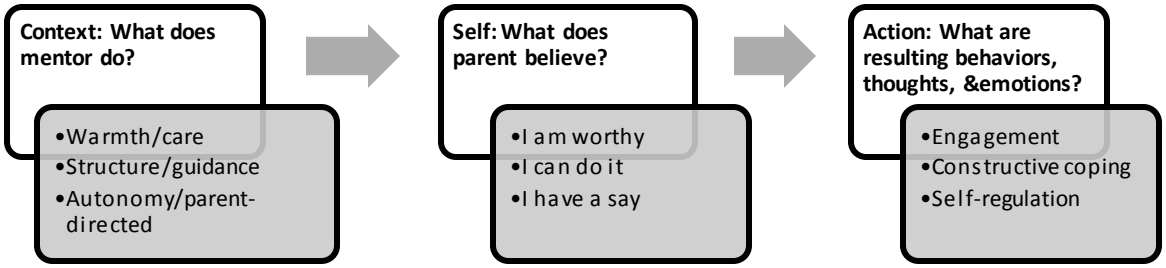
A parent would not go to her daughter's school because she had a fear of teachers, because she didn't do well in school herself. Her daughter was getting bullied. I told her, You can't let your daughter be bullied. You have to speak up. She needs you to speak up. She asked, What are they going to do if I say anything? I said, Well, they might pay attention. You just have to go in there and explain. You have to be calm. You can be assertive, you don't have to be aggressive, and I gave her examples of what to say. The next time her daughter came home crying from school she went to the principal and said, I need to have a talk with the person who is on duty during recesses because my daughter has come home crying every day, she is getting bullied, and I'm not okay with it. It is stopped. That was, huge for her.- Mentor

It gives them a sense of independence that they don't have. A lot of the women are in domestic violence situations. They have never had that independence. They have always been told what to do, always. So it gives them that sense of accomplishment and independence. At first they don't know it and that's why they fight it, until they can see, Oh, I did that, I did that. No one else gave that to me. I did that myself. Then it builds on them, and most of my clients right now are, they are amazing what they are doing with their lives, like running 12-step programs that they started by themselves, and being independent single moms who are putting their kids in dance class, things that they never would have done before.- Mentor

Having goals and then being able to actually achieve a goal is huge. It is huge on so many levels -- confidence. You feel like you are doing something with yourself. You are feeling good about yourself and feeling that you have a choice, and what goals you want to work on.- Parent

Parent-Mentor Motivational Process Model

Motivated action parallels the notion of empowerment as a driver of change. As a result, parents felt more hopeful and were motivated to participate in services; they were also able to cope more constructively with difficulties including effectively managing behaviors and emotions.



A lot of times (parents) get really hopeless and feel that they can't do it and that their life is a failure. The mentors give them hope and some structure and the strength that they can do it. I know hopelessness is something that really triggers parents to give it up and use. -Mentors

I got my noon tag. It really boosts the self-confidence. (Mentor) helped me do that. I thought I was too broken to be fixed before I met (mentor. She boost my confidence to where I am not shattered, I am just a little chipped on the edges. - Parent

I think if somebody sticks with them, even through their failures and does not give up on them, even though is so many reasons why they should have, I think the more they believe in you, the more you start believing in yourself. At the end of the day they are really alone. The caseworker goes home to her family. The judge goes home to theirs. The jailers or whoever go to their family. And you are still stuck there. You are by yourself and they don't think about you. They have so much other stuff going on. I think knowing that there is somebody there that is thinking about you, checks with you how you are doing, that genuinely does care -- I think that makes a big difference. - Caseworker

Parent Mentors' Impact on Caseworkers and Casework

The PMP had impacts beyond the effects on parents and their case plans. The vast majority of caseworkers had a positive experience with the PMP and cited a number of benefits to working with the mentors.

> *"It made it easier. I knew with the mentor I did not have to worry as much about the client."* -Caseworker

- Mentors do **things caseworkers can't or don't have the time to do**:
  - Mentors provide resources and transportation and often become the parent's first point of contact when they have questions.
  - Mentors are an additional positive support for parents throughout the case, especially during crises.
  - Mentors may have more frequent contact with parents, so may be able to anticipate mishaps before they occur or respond in a timely fashion.

> *"... it is also another set of eyes, that if things are going astray, [the mentor] is going to probably recognize it and help intervene, so that we may not end up having to remove the child because it has gone too far."* -Caseworker

- Mentors facilitate parents' **understanding of the system and requirements**:
  - Mentors have the time to explain things to parents using parent-accessible language about how the system works, what they are being asked to do and why.
  - Parents may be more inclined to listen to mentors and to ask questions when they don't understand.

> *"... 'if I would have known that in the beginning, if my DHS worker would have told me that in the beginning', because (mentors) explain it to you in their terms. (Caseworkers) don't explain it to you where you can understand it. That is what Parent Mentors do, because they have been through it. "*- Parent

- Mentors and caseworkers **share ideas and insights**:
  - They brainstorm ways to engage and support parents and how to meet their needs when resources are limited.
  - Their different perspectives regarding parents' needs and behaviors enriches each other's understanding of the case.

"...(Mentors) know what recovery groups or what treatment facility or program would be more appropriate for that client and that helps me because, I know of all the treatment programs but I've never stayed in one -- not every program's the best one for a client so maybe they have more insight on what would be the best setting."- Caseworker

- Partnership promotes caseworkers' **professional development**:
    - Mentors help caseworkers understand addiction and recovery.
    - Mentors share information about what it's like for parents to deal with the child welfare system.

"It has helped me understand the thinking of addiction and how hard it really is. It also provided me with insight about the mentor's experience in DHS as clients and has changed my work for the better. I have become much more understanding and supportive of parents." -Caseworker

- Mentors facilitate **better working relationships** between parents and caseworkers:
    - Mentors openly encourage parents to work with their caseworker, explaining the benefits of working with the agency.
    - Mentors model their own positive working relationships with caseworkers and others on the parent's team.
    - Mentors help parents understand the caseworker's role and intention, and decrease the parent's anxiety and hostility towards caseworkers.

"It helps that (mentors) know the system and humanize the system, helping take the fear away, the fear of us being the authority figures... Helping the caseworkers form that relationship and helping clients open their eyes and know that not everyone at DHS is out to get you."- Caseworker

- Working with mentors has **other advantages** for caseworkers:

"It is really nice to be able to talk to a service provider who kind of gets the nitty gritty and the down and dirty, and who I don't always have to explain every facet of my decisions, because they have been there and understand a lot of it." -Caseworker

"... [the mentor] was an extension of what I would want to do, so I kind of use the mentors as support, too, not just for the parents but for me." -Caseworker

- All of this leads to **better outcomes for families**.

"...the mom did the work, but I truly believe that it was [the mentor] who helped with that transformation. I flat out told her there were things as the caseworker that I just couldn't have done for this mom. I believe [the mentor] was the reason that this family was able to come back together." -Caseworker

Working with Parent Disaffection: What Would a Parent Mentor Do?

What is disaffection?

- Actions (including thoughts, emotions, & behavior) that signal one's needs aren't being met.
- A multifaceted concept including the absence of engagement (e.g., giving up, dejection, discouraged, helpless), alienation (e.g., withdrawal, rejection, shame, worthless), and/or opposition (e.g., fighting, anger, frustration, resistance).
- Malleable, not a personality trait; strongly tied to previous experience, self-beliefs, and the context/situation.

Parent Mentor Program Evaluation Key Finding

In part due to their own experiences with addiction and the child welfare system, Parent Mentors have a unique way of interpreting parent disaffection that allows them to respond in a motivationally supportive way. Motivational support, in turn, helps to re-engage parents in the pursuit of their goals (e.g., recovery, child welfare case planning, service involvement).

How do people respond to disaffection?

Disaffection is typically met with *less* support from social partners, including service providers and other helping professionals, at times when parents actually require *more* support to get their needs met. Why? Parent disaffection contributes to service provider disaffection (e.g., frustration, burnout, hopelessness, apathy, withdraw support, coercion).

How do Parent Mentors respond to disaffection?

Parent Mentors interpret parents' actions in a way that is informed by their own experience, and readily recognize the underlying needs. Coming from a place of recognition, Parent Mentors are able to respond with motivational support.

The next two tables explicate two types of parent disaffection: resistance and withdrawal. The **Disaffection** column illustrates what is going on for the parent and how it might appear to service providers. The **Motivationally Unsupportive** column details how service providers might (perhaps understandably) interpret and respond to parent disaffection, and the **Motivationally Supportive** column describes how Parent Mentors reframe parent disaffection. As a result, the **Re-Engagement** column gives examples of how motivational support helped parents re-engage in their goals. Parent, Parent Mentor, and Caseworker quotes demonstrate the process.

Example: When Parents Resist

Disaffection (thoughts, emotions, behaviors)		Motivationally Unsupportive	Motivationally Supportive	Re-Engagement
What might be going on for the parent?	How might the parent act toward service providers?	How might service providers interpret & respond to parent's actions?	How might a parent mentor interpret & respond to parent's actions?	How does parent respond?
Pressured, coerced Not ready to accept their situation	Resists participation Anger Argumentative	Parent is in denial → demand, confront, remove privileges Parent is too difficult → put in less effort on the case, focus on more "deserving" families	I understand → normalize feelings, provide warmth, connect with support community Parent is not ready yet → continue outreach, provide information & guidance, recognize small steps	"That trust made me just more motivated, man, he believes in me. If he believes in me, I know I can do it." – *Parent* "I had that habit of…when I'm mad …I'll hang up or I'll leave…then [Mentor] said it was, OK. Now I'm able to sit there and say, 'No, this is bothering me because of this' and not get mad. I will have the patience to actually listen." – *Parent* "I always got very defensive, and very angry at the drop of a dime, and [Mentor] helped me learn how to process my emotions and my feelings or whatever, and turn it around into a positive way." – *Parent*
"It is really easy to do something stupid when you are stuck in a spot and don't see a way out." – *Parent*	"I'm the kind of person that the more you push me, the more I'm going to push back." – *Parent*	"I still struggle sometimes…it seemed like anytime I got 5 steps forward, I would end up getting 10 steps back. I think a lot of it was because my caseworker told me flat out once that she didn't think I was going to make it." – *Parent*	"[Mother] would cuss you out in a heartbeat and be ready to fist fight in a minute…My approach to her was, "Oh, honey, you are trying to scare the world away but you don't scare me. Either you want my help or you don't. Which one are you going to do? " – *Mentor* "[Mentor] kept texting her, and one day she said, 'I'm ready to go to jail. I'm ready to turn myself in.' She had been out on the lam for months. I kept telling her, 'When you are ready, I'm there.' So she did, and I drove her to jail." – *Mentor* "I try to encourage [Father] to go to a meeting and share with other people, because there can be other people…who are struggling with the same thing and you can give them hope. Then they start to feel like they are leaders and they are positive members of the community." – *Mentor*	

Example: When Parents Withdraw

Disaffection (thoughts, emotions, behaviors)		Motivationally Unsupportive	Motivationally Supportive	Re-Engagement
What might be going on for the parent?	How might the parent act toward service providers?	How might service providers interpret & respond to parent's actions?	How might a parent mentor interpret & respond to parent's actions?	How does parent respond?
Confusion Helpless Worthless Shame Defeated	No shows for appointments Avoidance Lack of communication Lying	Parent doesn't care → demand, confront, remove privileges I can't connect with this parent → wait for parent to initiate	I understand → normalize feelings, provide warmth, connect with support community I can hear what this parent has to say → learn about parent, non-judgment, help identify goals, explain importance of working together, help see choices	"I lied to [Mentor] at first. I had been clean a month, and an opportunity came up and I said, 'I've been lying to you. I just want you to know I'm on the right track.' That matters to me, because once again I was going back to old behaviors…lying about things that you don't really have to lie about…[Mentor] said, 'OK, that's all I need to hear.' – *Parent* "I have certainly seen this one parent of mine started getting to her appointments because of this mentor. Not only was it really good for me to see, but it also gave her some confidence in reaching out to other support networks and being a little more independent from my help…" – *Caseworker*
"…when you are where I was, when I wasn't ready, I felt like I had no nobody and I was never going to be good enough. I had no idea how to navigate the system. I just thought it was over." – *Parent*	"I was not only avoiding [Mentor], but I was avoiding everybody…that was the breakdown out of me facing this head on, being accountable." – *Parent*	"I knew they wanted me to do some things but I didn't know how to go about doing those things…after court everybody was so busy they just went their separate ways, and I was standing there, freaked out. I didn't know which way to go. I didn't know how to start these services. It was really a lonely place." – *Parent*	"I called and tried to make a last attempt. I just said that, I know you ended up not going back to treatment and that's okay. There are other avenues or going back to that, and if you want to talk to me how you felt about that treatment center or whatever." – *Mentor* "…things were just starting to spin out of control…the Parent Mentor came in and kind of pulled him back and said, 'You can do other things'…he was very helpful in identifying this father's natural strengths and the things he could do differently or better." – *Caseworker* "You just know when someone genuinely cares…She would just sit there and listen to me, and she would always tell me, 'You already know your own answer.' She would let me figure it out, because in my head I always doubted myself." – *Parent*	

Conclusion and Next Steps

This evaluation of Oregon's Parent-Directed Parent Mentoring Program makes a significant contribution to the peer mentoring knowledge base. Findings from the project include a detailed picture of what mentors do, a comprehensive list of important mentoring practices, rich reporting from both parents and caseworkers of the impact of the PMP, and identification of some of the mechanisms by which mentoring facilitates parents' engagement and progress on their case plans. We also identified the organizational and other supports that facilitate implementation and sustain the program over time. Building on the program model and other relevant research, a Fidelity Framework was constructed that captures key program features, and results suggest the PMP was delivered largely in accordance with the original design. Both quantitative and qualitative data indicate that the PMP had a positive impact on a range of short-term outcomes. Unfortunately we were unable to include an analysis of substance abuse treatment administrative data, however, other data sources suggest the PMP is particularly well suited to facilitate parents' recovery-related efforts.

Results from the analyses of the child welfare administrative data are inconclusive at best- the evaluation suffered from many of the pitfalls common to RCTs in applied settings-and next steps should include a rigorous outcomes study. Also important will be further development of the fidelity framework, especially efforts to account for the individualized (parent-directed) nature of the supports that are provided. We are also very excited to build on our preliminary work regarding the application of Self Determination Theory to peer mentoring, and motivation and engagement among child welfare involved parents more generally.

Cost Analysis

The original intent of the cost analysis was to examine the costs of foster-care related services received by participants in the experimental group and to compare these costs with those of the usual services/placements received by the control group, and, if appropriate to conduct cost-benefit analysis comparing the costs of foster care relative to program investments (RBV and PM) or services as usual (control). However, given outcome data that demonstrated either no reliable differences in time spent in care (Parent Mentor) or that program participants spent somewhat more time in out of home care (RBV) made additional cost analysis unproductive. However we did conduct a basic comparison, for both models, of the costs related to foster care services both for children who were randomly assigned to either treatment group (RBV/PM) compared to controls (ITT samples) and for children whose families had some level of participation in program services (TOT samples).

Cost Analysis Methodology

Sample

A list of 4,918 children flagged as Waiver children in OR-Kids was matched for associated monthly cost data for services provided between January 1, 2012 and June 30, 2015. Of the 295,347 matching cost records, 63% were placement services (*n*=185,693) and retained for further analysis. The vast majority of these placements were categorized as *foster care* (*n*=151,712, 82%). The next most frequent service categories were *shelter care* (*n*=25,687, 14%) and foster care residential care BRS placement (*n*=7,369, 4%). The remaining 925 (<1%) services were *residential care non-BRS placement*, *enhanced shelter care*, or *tribal placement*.

Services Included

Services were selected for analysis if: (1) the service started before but continued past the date the child's case was randomized for the Waiver project, or (2) the service started after the case randomization date. Table 3-1 shows the cost study samples for each program, PM and RBV. Overall, 72% of the children appearing on the Waiver list had available cost records, although this ranged from 38% for PM to 91% for RBV.

Calculating Costs

Each service record had an associated cost. If the service started after the case randomization date, we retained the total cost for that service record. If the service started *before but continued after* the case randomization date, we calculated a per-day cost by determining length of service (service begin date - service end date) and divide total cost by number of service days in that month (ranged from 1-31). Then, we replaced the service begin date with randomization date and re-calculate the cost by multiplying per-day cost by the number of post-randomization service days in that month. Costs for all services within the study window time frame for that case were summed for each child. Costs ranged from -$46.81 to $120,611.56 and the distributions were highly positively skewed. Placement service spans (start of first service [or randomization date if service started earlier] to the end date of the last service) ranged from 1 day to 1,224 days (average = 471 days, 1.3 years).

Table 3-1. PM and RBV Cost Sample Sizes

Program	Waiver List	Had Placement Cost Records	On Waiver List but No Cost Records	Cost Records Outside of Study Window or Not Placements
Parent Mentor	1,831*	694 (38%)	886 (48%)	251 (14%)
RBV	3,102*	2,834 (91%)	0	268 (9%)

*Includes 15 children who were associated with both PM and RBV programs.

Cost Analysis Results

Analysis Approach

Two basic analyses were conducted – average costs for treatment vs. control (intent-to-treat analysis) and average costs for treatment served vs. treatment not served vs. control (treatment-on-the-treated analysis). A number of models were tested (*t*-test/ANOVA, Mann-Whitney U/Kruskal-Wallis H, general linear model [GLM] with a robust estimator, and GLM with a gamma distribution and log link function, both with and without extreme values trimmed).

Parent Mentor Cost Results

Intent to Treat. We compared all treatment and control children on their total placement costs incurred between the date their case was randomized through June 30, 2015. Table 3-2 presents the placement cost means, medians, ranges, and significance tests for each group. Results of all tests suggest no significant difference in average or median placement costs children associated with the PM program compared to Control children.

Treatment-on-the-Treated. We also compared PMP children whose parents accepted services, did not accept services, and control children on their total placement costs. Again, results of all tests indicated no significant average or median placement cost differences between the three groups.

Table 3-2: PM Foster Care Placement Cost Comparisons: Intent to Treat and Treatment on the Treated

Intent to Treat (ITT)		Control *n*=254	PMP *n*=440	Test statistic and significance
Placement Cost	Mean	$9,465.93	$9,936.64	Wald $X^2(1)=0.43$, $p=.51$
	Median	$8,072.66	$8,392.30	$U(1) = 0.84$, $p=.40$
	Range	$24.60 - $66,473.02	$49.20 - $93,352.06	

Treatment on the Treated (TOT)		Control *n*=254	PMP No Service *n*=160	PMP Accepted Service *n*=280	Test statistic and significance
Placement Cost	Mean	$9,465.93	$9,471.83	$10,202.24	Wald $X^2(2)=1.06$, $p=.59$
	Median	$8,072.66	$8,038.81	$8,521.97	$H(2) = 0.80$, $p=.67$
	Range	$24.60 - $66,473.02	$287.50 - $47,781.38	$49.20 - $93,352.06	

Notes. The significance test for mean differences was taken from the GLM model with gamma distribution, and for median/distribution differences was taken from the Mann-Whitney (ITT) or Kruskall-Wallis (TOT) model.

RBV Cost Results

Intent to Treat. We compared all RBV and control children on their total placement costs incurred between the date their case was randomized through June 30, 2015. Table 3-3 presents the placement cost means, medians, ranges, and significance tests for each group. Results from the parametric tests suggest no significant difference between the two groups. However, the non-parametric test (comparing whether two samples originated from the same distribution) suggest significantly higher foster care placement costs for RBV children compared to children in the control group. It is likely that the wide distributions, and therefore standard errors, are the reason the non-parametric tests were not statistically significant.

Treatment-on-the-Treated. We also compared RBV children whose parents had an intake to those whose parents did not have an intake and to control children. Again, the parametric tests indicated no significant differences between the groups, but the non-parametric tests (comparing whether three or more samples originated from the same distribution) suggest significantly higher foster care placement costs for children in the RBV intake group.

Table 3-3: RBV Foster Care Placement Cost Comparisons: Intent to Treat and Treatment on the Treated

Intent to Treat (ITT)		**Control *n*=1,438**	**RBV *n*=1,396**		**Test statistic and significance**
Placement Cost	Mean	$8,656.42	$9,142.73		Wald $X^2(1)=2.01$, $p=.16$
	Median	$7,145.68	$7,767.28*		$U = 2.94$, $p=.003$*
	Range	-$46.81 - $120,611.56	-$46.67 - $113,985.97		
Treatment on the Treated (TOT)		**Control *n*=1,438**	**RBV No Intake *n*=626**	**RBV Intake *n*=770**	**Test statistic and significance**
Placement Cost	Mean	$8,656.42	$8,974.75	$9,279.30	Wald $X^2(2)=2.45$, $p=.29$
	Median	$7,145.68[a]	$7,929.44[ab]	$7,666.31[b]	$H = 10.24$, $p=.01$*
	Range	-$46.81 - $120,611.56	$0 - $113,985.97	-$46.67 - $108,240.90	

Discussion

The general pattern of findings suggests that children in the PM and RBV groups, especially if their parents accepted services, had higher foster care placement costs over an average period of 1.3 years (within the Waiver study window, randomization date through June 30, 2015). Placement costs ranged widely and distributions were highly positively skewed (e.g., 90% of the children had costs under $17,000), which implies that costs were driven by a smaller group of children. Indeed, 10% of the children (with costs over $17,000) accounted for 30% of the total placement costs for all children included in the analysis. By definition, RBV children accounted for a larger proportion of the placement costs overall, as program eligibility relied on at least one child being in foster care, whereas most children whose parents were identified for the PM program did not have foster care placement costs.

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