Children Affected by Methamphetamine Program: Implementation Progress and Performance Measurement Report

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National Center on Substance Abuse and Child Welfare

Substance Abuse and Mental Health Services Administration
SAMHSA
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Purpose and Organization of Report

This is the last of a series of reports that keep the Substance Abuse and Mental Health Services Administration (SAMHSA) apprised of Children Affected by Methamphetamine (CAM) grantee program implementation progress and performance on key indicators. This report incorporates lessons learned based on an integration of qualitative and quantitative findings. These lessons and a summary of project design and implementation are followed by grantee performance organized by program priorities. Priorities include improving the safety, permanency and well-being of children affected by methamphetamine and their families including recovery for their parents. The final section includes a summary of grantees' project sustainability plans and lessons learned.

Appendices to this report include site-level summaries that capture the story of each grantee. These site summaries describe grantees' initial plans, how those plans have changed during implementation, what they have accomplished and what was unique about their efforts. Additional appendices provide additional site level performance data and methodological information.

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Executive Summary

Grants to Expand Services to Children Affected by Methamphetamine in Families Participating in Family Treatment Drug Court (CAM) was a Substance Abuse and Mental Health Services Administration (SAMHSA) administered grant program focused on expanding or enhancing services to children (0-17) and their families who are affected by methamphetamine use. SAMHSA provided funding over a four-year period to 12 Family Treatment Drug Courts (FTDCs). This report summarizes cumulative findings regarding program implementation progress and grantee performance. Information for this report is drawn from data uploaded by grantees based on their performance through September 2014,[1] as well as Bi-Annual Performance Reports (BAPRs).

Lessons Learned

After four years of program implementation, several important lessons have emerged from reviews of site visit reports, grantees' bi-annual progress reports, technical assistance reports and the analyses of the performance indicators:

- Improving or adding children's services had a profound impact on the FTDC, especially its relationships with other family serving agencies;
- FTDCs and their partners must assert substantial effort, including the establishment of trust and mutual investment, to add or improve children's services;
- FTDCs must recognize improved child and family functioning as core elements in parents' recovery before they make substantial investments in children's services;
- Grantees did not always anticipate all of the costs of implementing evidence-based practices;
- Adding an engagement or outreach worker position was often key to success even if it was not part of grantees' original project design;
- FTDCs should give careful consideration to matching the target population with appropriate services;
- Sustainability planning should start as early as possible to allow negotiations with stakeholders as ongoing relationships were key to accessing funding opportunities that may arise at any time;
- FTDCs should facilitate regular exchanges between the program and evaluation or data teams to ensure data accuracy and consider implications for program improvement;
- Grantees did not follow a common path or formula in their sustainability planning;
- Grantees employed a wide range of strategies and funding sources to sustain project components;
- Leadership was pivotal in determining what would be sustained and how; and,
- External technical assistance was critical to keep the grantees' attention on sustainability planning

[1] **Dunklin County, MO is not required to upload performance indicator data.**

Grantee Program Designs and Implementation

Families in the child welfare system affected by parental substance use disorders face many challenges. Effective intervention for these families requires intensive, coordinated services from many agencies including the courts, mental health and substance abuse treatment agencies, child welfare, education, vocational rehabilitation and housing. CAM grantee program designs reflected the complexity of these efforts and included a range of evidence-based programs to improve parenting, restore parent-child relationships, address trauma-related problems, link families with appropriate services and meet the therapeutic and behavioral needs of children prenatally exposed to drugs and traumatized by abuse or neglect.

CAM grantees' projects reflected local social and political dynamics, agency priorities and resources. As a result, their efforts were diverse in design and implementation and generalizations about what works best are difficult to assert. For example, the range and type of services selected by grantees impacted the number of clients who participated in services and the duration of those services. The following table provides a snapshot of common strategies implemented by CAM grantees.

Table ES1: Common Programmatic Strategies Implemented by CAM Grantees

Program Strategy	Number of Grantees
Parenting Education	12
Developmental and Behavioral Interventions	12
Engagement and Outreach	10
Therapeutic-Based Parent-Child Interventions	8
Trauma-Focused Children Interventions	5
Trauma-Focused Adult Interventions	4

As noted in the table above, all grantees implemented at least one relationship-based parenting program and developmental and behavior based interventions to improve family functioning and outcomes. Furthermore, definitions of success at the individual and project level were different across grantees and important questions arose about how best to balance important process indicators such as program enrollment or completion with those more closely assessing safety, permanency, well-being and recovery outcomes. The performance monitoring approach reflected in this report seeks to reflect this balance.

Most CAM grantees were meeting or exceeding performance expectations and made steady progress without major problems. When grantees experienced challenges, they were effectively working with collaborative partners and their Performance Management Liaison (PML[2]) to address those issues. According to a review of PML reports, the grantees' greatest achievements were in the areas of

[2] **Every CAM site is assigned a PML from the National Center on Substance Abuse and Child Welfare who provides technical assistance, training, and evaluation support throughout the grant period. PMLs are NCSACW's expert technical assistance providers assigned to support CAM grantees.**

budgeting and sustainability, improved collaboration among partner agencies and working with related agencies.

Number and Characteristics of Families Served

Grantees provided services to a total of 2,479 families.[3] The families were comprised of 3,244 adults and 5,131 children (4927 index and 204 non-index children).[4] The mean age of the children was 5.3 years, there were slightly more girls than boys and the majority of the children were Hispanic. The majority of the adults in CAM programs were female (70.7%) with a mean age for the adults of 31.6 years. Half of the adults participating in the program were White (51.5%).

The average number of families served per grantee was 207 with great variability by site ranging for a low 59 families to 869 families.[5] This broad range reflects the diversity of the 12 grantee program models, the varying size of the geographic regions they served and the differences in selected target populations.

The characteristics of participants also reflected the complex needs of the population that CAM grantees served. For example, approximately half of the adult participants had never been married and over three-quarters of the adults were not working.

Child Safety

Grantees assessed safety outcomes for children and youth in terms of occurrence of maltreatment and substance exposed newborns. The children participating in CAM were kept safe. Very few CAM children were a victim of a substantiated or indicated maltreatment within six months of entering in the CAM program (2.3%).

Permanency in Care-Giving Relationships

The child/youth indicators related to permanency assessed whether they remained in their home, the length of stay in foster care if they were out of their home, the proportion who re-entered foster care, the proportion who were reunified, the length of time to reunification and whether the children and youth exited CAM services with adoption or legal guardianship if they were not reunified with their parents. Grantee performance on each of these indicators showed positive outcomes for children enrolled in CAM programs.

Nearly half of the children were in-home at the time of CAM enrollment and nearly all (91.5%) of the children who were in-home at the time of CAM enrollment remained in their home with their parent/caregiver throughout their family's participation in CAM services. For more than half of the children who were not at home at the start of CAM services, the median length of stay in out-of-home care was less than 12 months. The majority (84.9%) of children exiting out-of-home care were discharged to reunification. Only 5.0% of children receiving CAM services re-entered foster care within 12 months after being returned home. Nearly two-thirds of the children in their programs reunified

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[3] Numbers served include Dunklin County. No demographic information is available for children. Demographic information for adults includes total number of families and adults, gender, age, race/ethnicity, marital status and methamphetamine as a contributing factor only.

[4] Index children are those who are the primary focus of the CAM intervention and non-index children may have participated in a CAM service, but were not the primary or intended beneficiary.

[5] Numbers served through September 30, 2014.

within 12 months. Very few children were discharged to finalized adoption or legal guardianship within 24 months.

Parent Recovery

The adult indicators related to recovery included substance use, access to treatment, treatment outcomes, employment and criminal behavior. All grantees showed positive outcomes for adults enrolled in CAM programs. Approximately half of the adults participating in CAM services were admitted to substance abuse treatment the same day as CAM program entry. For the adults reporting a primary substance problem at treatment admission, over half reported methamphetamine as their primary substance. Approximately two-thirds of adults discharged from substance abuse treatment reported a reduction in methamphetamine use while over half reported a reduction in marijuana and alcohol use. Nearly half of parents' treatment episodes (whose discharge status was known) resulted in a positive treatment discharge status of completing treatment or transferring to another program.[6]

For the adults discharged from treatment who reported employment information, over a third increased or maintained their employment from treatment admission to discharge.[7] For the adults discharged from treatment who reported arrest information at treatment admission and discharge, the majority reported no arrests at both treatment admission and discharge. Nearly all of the adults who reported arrests in the past 30 days at admission reported fewer or no arrests in the past 30 days at discharge.

Child, Parent and Family Well-being

Well-being performance indicators include whether children and adults needed and received supportive services and changes in family functioning. Again, these indicators also show generally favorable results for CAM grantees.

Supportive services needs assessments were conducted for the majority of children enrolled in CAM, ranging from 97.6% assessed for developmental service needs to over 99% assessed for primary pediatric care needs. Furthermore, the majority of children participating in CAM services and identified as needing a given supportive service received it. However, there was a wide range in service delivery. For example, more than 99% of children and youth for whom substance abuse prevention services were needed, received those services; whereas fewer than 5% of children and youth with an identified substance abuse treatment need received those services.

Supportive services needs assessments were conducted for the majority of adults served by CAM grantees as well ranging from 94.4% for family planning to over 99% for primary medical care. Overall, the majority of CAM adults identified as needing supportive services received them. As with children's supportive services, however, there was a wide range in service delivery. More than 90% of the adults for whom parenting, family planning services and trauma were an identified need, received those services. However, just over one-third of those adults for whom domestic violence and child care was an identified need received those services.

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[6]Transferred to another treatment program/facility for further treatment and known to report and completed treatment are considered a positive treatment outcome per Federal TEDS treatment discharge reporting.

[7] Approximately half (54.2%) were unemployed at both treatment admission and discharge.

Finally, there was significant improvement from intake to closure across 10 domains of family functioning,[8] including the environment,[9] parental capabilities, family interactions, family safety, child well-being, social/community life, self-sufficiency, family health, caregiver/child ambivalence and readiness for reunification. The largest improvements between intake and closure were for family safety followed by parental capabilities and self-sufficiency.

Select Key Findings with Contextual Comparisons

There are five important measures[10] for assessing the success of family drug courts, below are select key findings where contextual information for these measures are available.[11] These findings indicate that CAM sites perform better on occurrence of a substantiated or indicated maltreatment within six months of entering in the CAM program and re-entry into foster care.

Across each of the grantees, CAM children were much less likely to experience an occurrence/recurrence of a substantiated or indicated maltreatment within six months of entering the CAM program. For context, the percentage of the county's children who experienced an occurrence/recurrence of a substantiated or indicated maltreatment are presented in the following table, however these are county performance measures, not children in a comparison group.

Table ES2: Recurrence of Maltreatment within 6-months of CAM Program Entry

Grantee	Percent of CAM Children	Percent of Children in the Jurisdiction's Child Welfare Services
Butte	0.0%	7.4%
Clarke	1.6%	7.5%
Colorado	1.8%	4.4%
Nebraska	0.0%	Lancaster 12.1% Sarpy 1.6% Douglas 9.3%
Oklahoma	0.0%	6.2%
Pima	0.4%	4.6%
Riverside	4.0%	4.8%
Sacramento	1.3%	6.3%
San Luis Obispo	1.9%	11.3%
Santa Barbara	0.7%	3.4%

[8] Family functioning is assessed utilizing the North Carolina Family Assessment Scale – General + Reunification (NCFAS-G+R, an assessment tool used to inform case management and family treatment options.

[9] Includes the areas of housing stability, safety in the community, environmental risks, housing habitability, personal hygiene, and learning environment.

[10] The five measures are children remaining in the home, occurrence/recurrence of maltreatment, re-entry into out-of-home care, recovery (tine in treatment) and reunification.

[11] See site level summaries in Appendix C.

Grantee	Percent of CAM Children	Percent of Children in the Jurisdiction's Child Welfare Services
Santa Cruz	2.8%	5.9%

Across each of the grantees, CAM children were much less likely to re-enter care than children in standard services. For context the percentage of the county's children who re-entered care are presented in the following table, however these are county performance measures, not children in a comparison group.

Table ES3: Re-entries to Foster Care within 12-Months of Reunification

Grantee	Percent of CAM Children	Percent of Children in the Jurisdiction's Child Welfare Services
Butte	0.0%	13.8%
Clarke	0.0%	10.1%
Colorado	12.5%*	20.3%
Nebraska	0.0%	Lancaster 5.0% Sarpy 5.5% Douglas 5.9%
Oklahoma	0.0%	10.3%
Pima	0.0%	18.4%
Riverside	3.2%	13.2%
Sacramento	9.0%	17.7%
San Luis Obispo	1.8%	12.0%
Santa Barbara	5.4%	11.9%
Santa Cruz	6.8%	14.1%

*This grantee's performance measure was collected at 6-months post reunification

Key Findings from Local Evaluations with Comparison Groups

Evaluations were conducted by three of the FTDCs utilizing comparison groups to examine whether the implementation of parent and child services improved outcomes for families. Some of the select significant improvements due to the implementation of services include:[12]

- When the days in out of home placements for all the children of each FTC-CAM parent were combined and compared to the combined days of FTC Pre-CAM parents, the difference in days *per parent* was statistically significant. FTC-CAM *parents* showed significant reduction in days their children spent out of home (at 2 years). For all of their children combined the averaged total for

[12] **Results from the locally conducted evaluations can be found in the site level summaries for Clark, Oklahoma and Sacramento in Appendix C.**

FTC-CAM parents was 363 days out of home and the averaged total for all of the children combined for FTC Pre-CAM parents was 615 days out of home

- The percentage of FTC Pre-CAM children who experienced any changes in placement while out of home was significantly higher than FTC-CAM children each year up to 3 years after entry
- For those program participants who entered residential treatment, FTC-CAM participants were significantly more likely to have successfully completed within 2 years than FTC Pre-CAM participants
- Findings indicate that after controlling for all other variables, the FDC group (CAM) is associated with a 178% increase in the likelihood of reunification, compared with a matched comparison group
- Children of families that received the CIF (CAM) enhancement in addition to EIFDC services were significantly more likely to stay in their home than those who received EIFDC services alone (95.1% and 88.1%, respectively)
- Among children who were removed, children of parents in DDC who also received the CIF (CAM) enhancement were significantly more likely to be reunified with their families than children of families that only received DDC (97.0% versus 84.0%, respectively)
- Children of parents in DDC who received the CIF (CAM) enhancement spend significantly less time in out of home care compared to children only provided DDC (median of 268 days versus 287 days, respectively)
- Participation in the CIF (CAM) enhancement significantly increased successful completion of treatment for both DDC and EIFDC
- Among parents in DDC and EIFDC, those who also received the CIF (CAM) enhancement were more likely to experience a positive dismissal (dependency terminated) or graduate from their drug court program

Introduction and Overview

Children Affected by Methamphetamine (CAM) was a Substance Abuse and Mental Health Services Administration (SAMHSA) grant program that focused on expanding or enhancing services to children and their families who are affected by methamphetamine use and abuse.

SAMHSA provided funding over a four-year period to 12 Family Treatment Drug Courts (FTDCs) to improve the well-being, permanency, recovery and safety outcomes of children and families who are in, or at-risk of, out-of-home placement as a result of a parent's or caregiver's methamphetamine or other substance use disorder. The sites were:

- Butte County, California Behavioral Health, Adult Services, Treatment Courts, Chico, CA
- Clark County Family Treatment Court, Vancouver, WA
- Colorado Judicial Department, Denver Juvenile Probation, Denver, CO
- County of Santa Cruz Family and Children's Services, Human Services Department, Santa Cruz, CA
- Dunklin County, Missouri, 35th Judicial Circuit, Family Treatment Court, Kennett, MO
- Nebraska Administrative Office of the Courts, Lincoln, Omaha and Papillion NE
- Oklahoma Department of Mental Health and Substance Abuse Services, Tulsa, OK
- Pima County Juvenile Court Center, Tucson, AZ
- Sacramento County Department of Health and Human Services, Child Protective Services Division, Sacramento, CA
- San Luis Obispo County Behavioral Health, Drug and Alcohol Services, San Luis Obispo, CA
- Santa Barbara County Alcohol, Drug, and Mental Health Services, Santa Barbara, CA
- Superior Court of California, Riverside County Collaborative Drug Court Division, Riverside, CA

The primary focus of this grant program was to provide services directly to the children and to provide supportive services for parents, caregivers and families. Grantees were encouraged to include other caregivers or foster parents involved in the care of the children in the enhanced aspect of the family services. All of the parents served under this program were involved in a FTDC and receiving substance abuse treatment services.

The National Center on Substance Abuse and Child Welfare (NCSACW), funded by an interagency agreement between SAMHSA and the Administration for Children and Families (ACF), provided performance monitoring and programmatic technical assistance (TA) to the grantees on a variety of topics including collaboration, program sustainability and substance abuse treatment practices for parents and families. Each grantee was assigned a NCSACW Performance Management Liaison (PML) to work closely with each site.

This report describes program implementation and progress on key CAM performance indicators. It is designed to integrate information from several sources to provide a comprehensive description from a variety of perspectives. The implementation progress information is based on the PML's assessment of the grantee's progress including a review of the grantee's seventh Bi-Annual Progress Report (BAPR),[13] as well as information gleaned from TA communication. Performance measurement is based on data submitted by grantees through September 2014 and includes a descriptive demographic profile of the children and adults served by 11 of the grantees participating in the CAM Initiative[14] and child, adult and family performance indicator data for CAM participants.

Eleven of the 12 grantees participated in performance monitoring of program implementation and outcomes. One grantee, Dunklin County, MO, provided regular reporting to SAMHSA but did not participate in performance monitoring because they requested a relatively small grant award that was insufficient to support both program implementation and reporting on performance monitoring outcome measures. Grantee performance monitoring included 18 indicators for child, adult and family outcomes (described in more detail beginning on page 11 of this report). Indicator data were drawn predominantly from existing records and data systems to minimize information collection burden and maximize comparability with familiar measures commonly used in substance abuse treatment and child welfare. Grantees submitted performance monitoring indicator data on a bi-annual basis using a web-based upload portal.

Following a review of lessons learned, this report turns to a description of grantee program design and implementation status, followed by performance monitoring information organized by program priorities to improve the safety, permanency and well-being of children and their families, as well as recovery for their parents. These sections describe findings across grantee projects and provide a CAM program-level analysis. Following these sections, grantees' sustainability plans and lessons are summarized. Appendices include detailed summaries describing findings by individual grantee projects and are referenced accordingly in the main body of the report.

Lessons Learned

After four years of project implementation, several important lessons emerged from reviews of site visit reports, grantees' bi-annual progress reports, ongoing TA reports and the analyses of the performance indicators. These lessons are described in this section and include:

- Improving or adding children's services had a profound impact on the FTDC, especially its relationships with other family serving agencies;
- FTDCs and their partners must assert substantial effort, including the establishment of trust and mutual investment, to add or improve children's services;
- FTDCs must recognize improved child and family functioning as core elements in parents' recovery before they make substantial investments in children's services;
- Grantees did not always anticipate all of the costs of implementing evidence-based practices;
- Adding an engagement or outreach worker position was often key to success even if it was not part of grantees' original project design;

[13]Covering April 1, 2014 to September 30, 2014.

[14]Dunklin County, MO is not required to upload performance indicator data.

- FTDCs should focus more intense efforts on matching the target population with appropriate services and securing sustainability;
- Sustainability planning should start as early as possible to allow negotiations with stakeholders as ongoing relationships were key to accessing funding opportunities that may arise at any time;
- FTDCs should facilitate regular exchanges between the program and evaluation or data teams to ensure data accuracy and consider implications for program improvement;
- Grantees did not follow a common path or formula in their sustainability planning;
- Grantees employed a wide range of strategies and funding sources for sustaining components;
- Leadership was pivotal in determining what would be sustained and how; and,
- External technical assistance was critical to keep the grantees' attention on sustainability planning

Grantees report that their success with adding or enhancing children's services profoundly changed the ways in which their courts function and, as several coordinators and judges have stated, "we cannot go back to the way it was before." The increased focus on children also required new collaboration with other agencies including child welfare and other child support services such as primary and mental health care.

Grantee reports and PML observations showed that collaborating agencies, in many cases, came to view the parents differently since introducing or enhancing children's services.

> The CAM Grant has changed the whole atmosphere of this court. It is much more professional and is seen as a credible, valuable program by the whole community. People who used to be against the program are now adamant supporters... I think this comes from the judge and his incredible way with the court team and participants and the increased focus on children as a result of this grant.
>
> —CAM Grantee Coordinator

For example, collaboration built through CAM grant activities led to greater trust between child protective caseworkers and the courts in their ability to decrease risk of child maltreatment and improve parenting. These qualitative findings are born out in the quantitative findings described in greater detail later in this report. For example, only three of the reported 50 children[15] born to mothers after CAM enrollment tested positive for substance exposure at birth. Furthermore, rates of maltreatment recurrence within six months of entering services were less than half of that which was seen nationally (2.3% vs. 6.4%). These changes did not come easily. Collaborative relationships and mutual confidence required many of the courts to broaden their mission, vision and values by incorporating those of partner agencies and to recognize the multiple, dynamic needs of the entire family. Grantees also had to establish or revisit referral protocols, interagency communication approaches, data sharing agreements and case management strategies among other aspects of the FTDCs. These policy and practice improvements only came after grantees broke down barriers and openly discussed issues such as areas of responsibility ("turf") and financing. CAM funding brought the partners together by introducing new resources without necessarily requiring sacrifice from partners, but the investment in collaboration and demonstrable improvements in outcomes seemed to sustain

[15] **Of the 50 births, there was only information on substance exposure for 5 children.**

these relationships. In general, grantees identified the following key factors as instrumental to successful collaborative development:

- Having an oversight body that makes collaboration a priority and addresses it on a regular basis at partnership meetings;
- Having policy leaders who work with the partnership as champions for policy change;
- Having a consistent, dedicated and committed leadership to support the project over time;
- Having a strong and influential cross-systems collaboration beyond the scope of CAM;
- Regularly reviewing major barriers to collaboration;
- Identifying, acknowledging and engaging value-laden issues;
- Using results to improve outcomes;
- Regularly reviewing outcomes and resources to address challenges;
- Regularly soliciting feedback from parents participating in the programs;
- Engaging in sustainability discussions with partners; and,
- Asking partners what is needed to improve outcomes.

Grantees reported that services for children need to be integrated with other FTDC services rather than just adding it onto existing services. For example, improving family well-being requires better parenting and therapeutic services for children and parents. In turn, parenting classes and family therapy require that the court recognize these services as critical to the parent's recovery. As a result, children's and family services became a core part of the courts' staffing and case management protocol.

Grantees Met Families' Needs

- Comprehensive screening and supportive services for children and parents
- Parent training
- Trauma-informed treatment and services
- Coordinated care

Grantees indicated that they did not anticipate some of the costs associated with implementing high quality, evidence-based services. For example, one of the most commonly used curriculums, *Celebrating Families!* includes treatment groups for parents and children. Some cohorts required more groups than the grantees had planned for because of the age range of the children (where there are significant age differences among the children, separate treatment groups are required) and to address the needs of parents who cannot participate together because of discord between them. Each additional group was associated with unanticipated incremental costs for more therapists, space and transportation.

Even when grantees did not plan for an engagement or outreach position (e.g., peer mentor or court appointed special advocate) in their original plan, most (10 of 12) projects incorporated outreach workers. The role of these team members was to keep the parents and children engaged in services through close monitoring of parental adherence to court requirements, family dynamics and

children's progress. In many cases, these workers offered support and encouragement that included logistical problem solving around issues such as transportation. Participants seemed to view these staff members as allies who were able to appreciate how difficult it is to become a better parent and address their substance use issues simultaneously.

Grantees also addressed questions about the appropriate scale of their programs. Specifically, during their final site visits, PMLs helped FTDCs consider whether their current target population will continue to be their priority and how they might continue to support client connections with quality programs in the community. They learned that clearly defining their target population and focusing more intense efforts on matching the needs of their target population with appropriate services had a significant impact on the size and character of their programs. For example, sites that offered intensive programming like Parent-Child Interaction Therapy (PCIT) ensured that their referral processes adequately assessed whether a family's identified needs required such a high-level, specialized intervention or could be met through an appropriate alternative service.

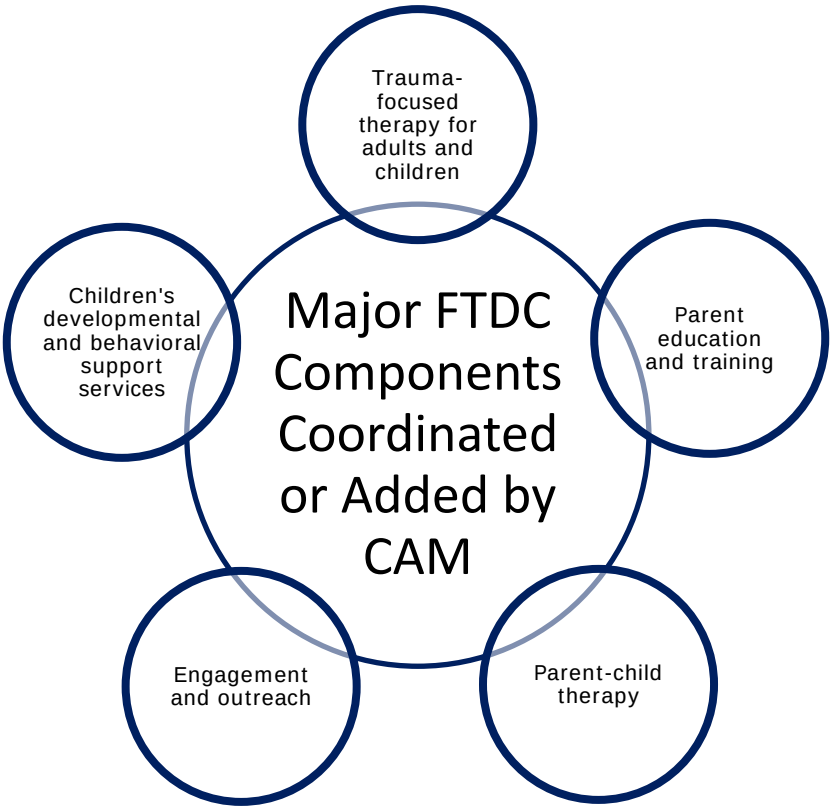
Grantees also realized that inadequate or low quality services were a constraint on growth and that they must assess treatment access and treatment quality and monitor the programs' engagement and retention performance along with the ultimate outcome of recovery. This kind of performance monitoring depended on regular access to and interpretation of accurate evaluation or program performance data. Some grantees experienced more success in performance monitoring and improvement as a result of closer, more regular contact with their evaluation team.

The next section provides a description of project designs and implementation. Appendix C has more detailed site-level summaries of grantee project implementation, lessons learned, accomplishments and performance.

Grantee Project Design and Implementation

Effective intervention for families in the child welfare system affected by parental substance requires intensive, coordinated services from many agencies including the courts, mental health and substance abuse treatment, child welfare, education, vocational rehabilitation and housing. CAM grantees focused resources on ensuring that children are central to these collaborative efforts in the FTDC setting.

Figure 1A: Major FTDC Components



Grantees designed their programs to address the unique community context of their FTDC; therefore they were very diverse with respect to the types of evidence-based strategies they employed. SAMHSA did not require particular interventions, only that interventions and program designs were selected to meet program goals. Most children and their parents served by CAM grantees showed signs of having been traumatized. Therefore, grantees implemented evidence-based trauma-focused interventions including Helping Women Recover, Seeking Safety, Helping Men Recover and TheraPlay. All grantees included a parenting program such as *Celebrating Families!*, Nurturing Parenting and SafeCare. Most grantees (10) also used therapeutic strategies to heal the relationship between children and their parents. Evidence-based therapeutic approaches included Parent-Child Interaction Therapy and Promoting First Relationships among others. Given the complex needs of these families, grantees also worked to strengthen service referral and engagement systems. This component included a range of approaches including Peer Mentors, Recovery Mentors, Outreach Workers, Recovery Resource Specialists and Court-Appointed Special Advocates. Finally, several grantees focused efforts on the developmental and behavioral needs frequently present among children prenatally exposed to drugs or who have been traumatized by neglect or abuse. These interventions included child developmental and behavioral assessments such as the Ages and Stages Questionnaires (ASQ) and Child Behavior Checklist for Children (CBCL), as well as referrals or actual

provision of services or interventions to address areas of delays and concerns. Some Grantees also partnered with developmental clinics to conduct neuro-developmental and psycho-social assessments and treatment. Table 1 summarizes the number of grantees that implemented each of the strategies just described.

Table 1: CAM Grantee Program Design Components

Program Strategy	Number of Grantees
Parenting Education	12
Developmental and Behavioral Interventions	12
Engagement and Outreach	10
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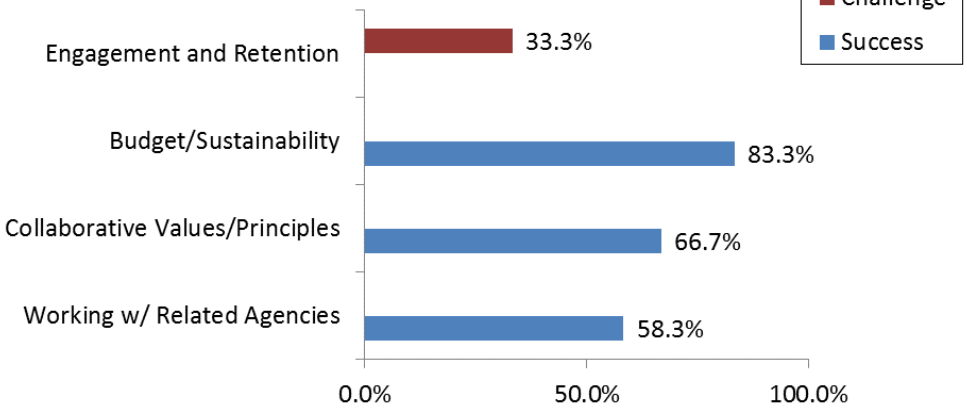
Trauma-Focused Children Interventions	5
Trauma-Focused Adult Interventions	4

The remainder of this section provides a summary of grantees including:

- Greatest successes and challenges
- Community and implementation context
- Collaboration with partners
- Identification, enrollment and services to clients
- Evaluation data collection and reporting
- Cumulative progress

Greatest Successes and Challenges

Figure 1: Percentage of Grantees Greatest Successes and Challenges



Utilizing a 10 Element Collaborative Framework,[16] developed by Children and Family Futures, Inc., and based on site visit observation and interviews with stakeholders, PMLs assessed each grantee's greatest successes and challenges during the last six months (see Table B2 in Appendix B for site level details). Ten of the 12 grantees (83.3%) experienced successes in budgeting or sustainability planning in the last six months (see Figure 1). The majority of grantees experienced successes in similar collaborative values and principles (66.7%) and working with related agencies (58.3%). Four grantees[17] (41.7%) experienced challenges in client engagement and retention issues during the last six months.

According to PMLs, all of the grantees made progress on achieving their primary project goals, with six grantees[18] making significant progress in the last six months of their project (see Table B3 in Appendix B for site level details). Three of the grantees (25.0%) experienced changes to their program during the past six months. These included changes in expanded scope of services (n=2),[19] project staffing (n=1), and expanded scope of target population (n=1).

Significant Community or Implementation Context Issues

Six grantees experienced some significant community or larger contextual issues during the last six months (see Table B9 in Appendix B for site level details). The larger contextual issues included budget cuts or layoffs (n=1), a change in legislative or policy changes (n=1), new grant or related initiative changes (n=1), the county lifting hiring freeze and hiring over 100 new social workers (n=1), a federal injunction requiring massive reconstruction of child welfare system (n=1) and a State/County/Other

[16] The 10 elements encompass collaborative values and principles, client screening and assessment, client engagement and retention, services to children, information sharing and data systems, joint accountability and shared outcomes, budget and sustainability, staff training and development, working with related agencies, and building community supports.

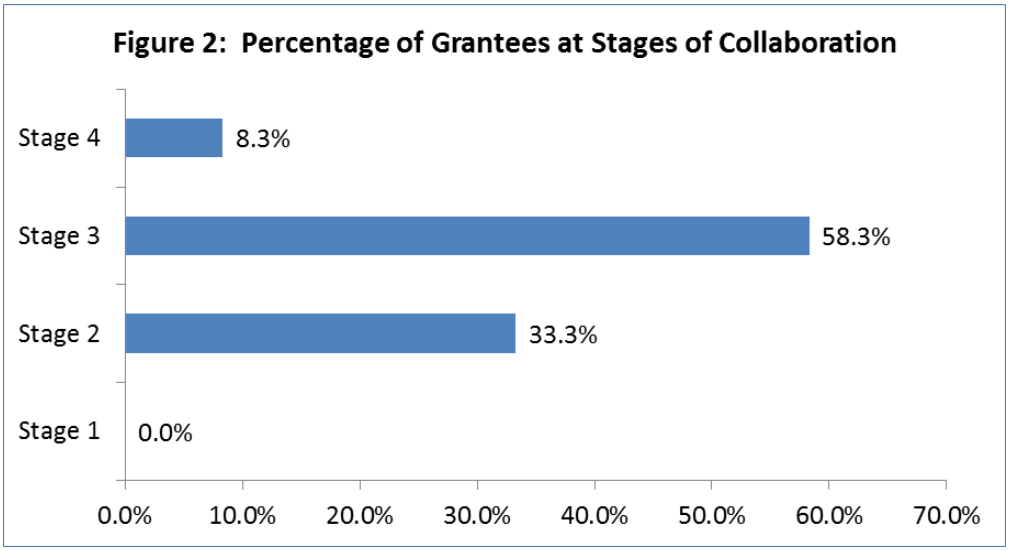
[17] Nebraska, Riverside, Santa Barbara and Santa Cruz.

[18] Clark County, Colorado, Dunklin County, Oklahoma, Riverside and Sacramento.

[19] Oklahoma and Pima.

agency change (n=1). The environmental or community factors included changes in child welfare trends or caseloads (n=2) and changes in substance use or treatment trends (n=1).

Collaboration with Partners



For the 12 grantees, progress in collaborative efforts was categorized by the Four Stages of Collaboration defined by Gardner in 1998.[20] During Stage 1, partners are taking initial steps of exchanging information about each other's systems with the goal of understanding each other's operations and resources. During Stage 2, partners have undertaken some type of joint projects (e.g., out-stationed staff) to better meet the needs of families and to help identify barriers to system-wide reform efforts. In Stage 3 partners are identifying what works to change how they operate evidenced by actions such as redirection of funding toward shared clients, training from a joint cross-systems approach, integrating data systems, implementing interagency agreements and processes for case management of shared clients, and/or developing unified family-centered treatment plans. Collaboratives have moved to Stage 4 when they are making systems-level changes based on interagency and interpersonal trust and experience. Examples of this stage of collaborative practice include actions such as the various partners across systems having assumed responsibility for shared outcomes, implemented integrated information systems, institutionalized CAM practices and services through-out operations, and has an overall focus on the system rather than the project as the target of integrated efforts.

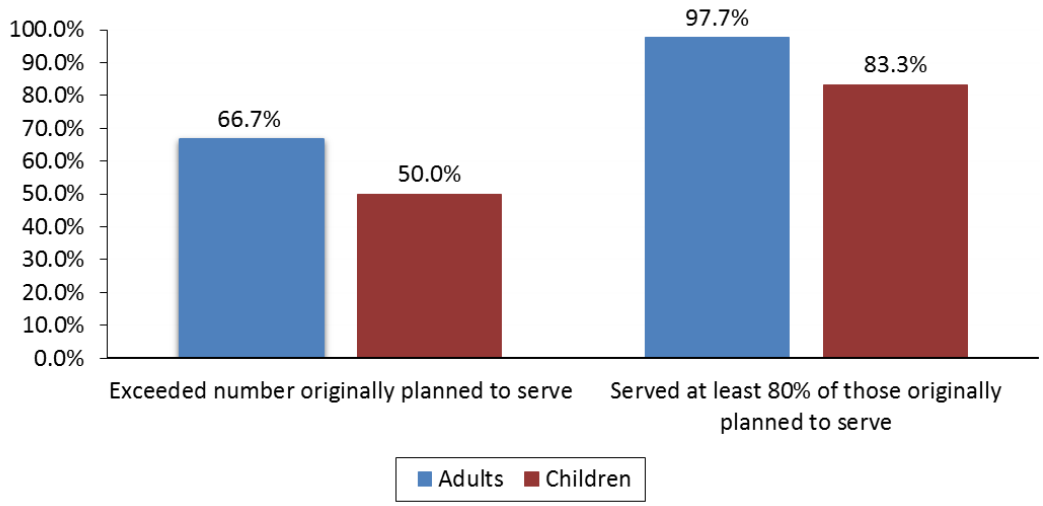
During the last six months of operations six grantees experienced challenges regarding adequate identification, engagement or support of key partners including child welfare (n=2), substance abuse treatment (n=3), adult mental health (n=3), children's mental health (n=3), family drug court/judge (n=2), dependency court/judge (n=2) and probation (n=1) (see Table B4 in Appendix B for site level details). Seven of the 12 grantees (58.3%) were assessed by the technical assistance staff as having reached Stage 3 in their level of collaboration. One of the grantees was assessed as having some aspects of Stage 4 in their level of collaboration. The four remaining of the grantees were assessed at Stage 2 in their level of collaboration (see Figure 2).

[20] **Gardner, Sidney. 1998. *Beyond Collaboration to Results.* Arizona Prevention Resource Center: Phoenix, Arizona.**

Identifying, Enrolling and Serving Clients

Eight of the 12 grantees (66.7%) met or exceeded their targets for serving children over the last six months[21] – an increase of two grantees since the prior reporting period. Seven grantees (58.3%) met or exceeded their targets for serving adults. Five grantees (41.7%) met or exceeded their targets for serving a families (see Figure 3 and Table B5 in Appendix B for site level details). For those grantees unable to meet their targets, primary reasons included not receiving enough referrals (n=4), difficulties engaging or enrolling after referral (n=1), shift in the target population (n=1), shift in CPS staffing (n=1), lower number of children per family than estimated (n=1) and new staff or team members and changes in child welfare (n=1).[22]

Figure 3: Percentage Grantees Meeting Cumulative Target Enrollment Numbers



The lower percentages meeting or exceeding their targets during this period may be due to grantees enrolling fewer new participants as the grant funding nears its end and grantees' greater focus on sustainability planning. Overall, an examination of the cumulative enrollment numbers across the grant period[23] reveals that (not including no-cost extensions), eight grantees (66.7%) have exceeded the total number of adults they originally planned to serve. Six grantees (50.0%) served more than the number of children originally targeted. Eleven grantees (91.7%) have served at least 80.0% of the number of originally targeted adults and ten grantees (83.3%) served at least 80.0% the number of originally targeted children.

Staffing and Training

Five of the 12 grantees (41.7%) faced programmatic staffing challenges during the past six months (see Table B6 in Appendix B for site level details). This is a decrease of one grantee having such

[21] **April 2014 through September 2014**

[22] **Three sites have multiple reasons**

[23] **October 2010 through August 2014**

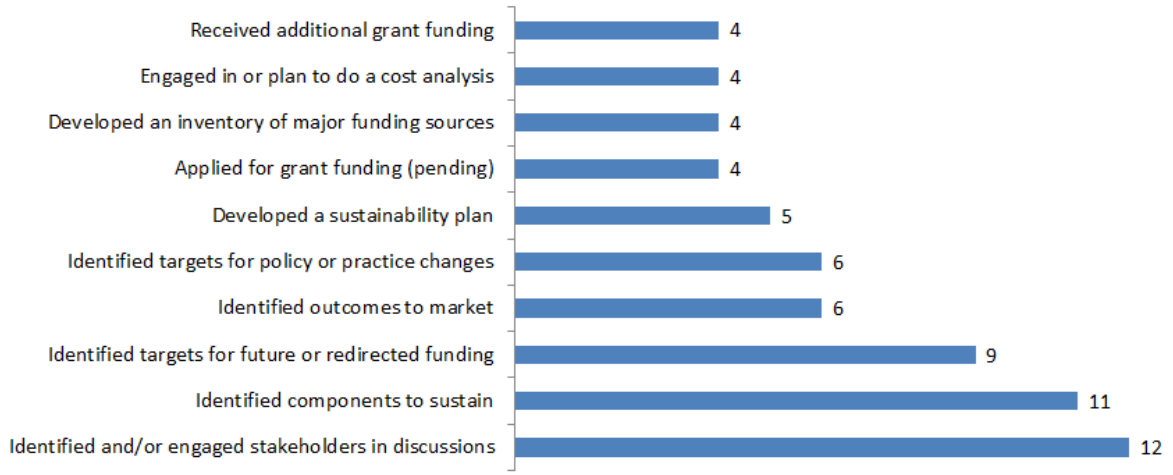
problems compared with the last reporting period. These included staff turnover or retention of key positions (n=3),[24] staff vacancies impacting service delivery (n=2), difficulty hiring qualified staff (n=1), poor performance for some contracted therapists (n=1) and staffing changes imposed by the judge (n=1). Two of the grantees faced evaluation staffing challenges during the past six months with the data analyst leaving the position in one case and the lead evaluator leaving at the other site.

Evaluation Data Collection and Reporting

Three of the grantees experienced difficulties in collecting performance measurement data for their treatment group during the past six months (see Table B7 in Appendix B for site level details). Two grantees experienced difficulty accessing child welfare data and one grantee identified difficulties with quality/consistency of data, analyzing/interpreting data, and they identified problems with previously uploaded data. One grantee experienced difficulties with the quality and consistency of data, analyzing the data and loss of the lead evaluator. The grantee worked with their new evaluator and resolved the data issues. Two grantees reported experiencing difficulties in collecting comparison group data. The reporting provided by local evaluations varied with six of the grantees (50.0%) provided information in the BAPR only. Two grantees provided a separate evaluation report and two grantees provided information in both the BAPR and a separate evaluation report.

Budget and Sustainability Planning

Figure 4: Sustainabilty Tasks



Eleven of the 12 grantees (91.7%) did not report experiencing significant budget problems (see Table B8 in Appendix B for site level details). Eleven of the grantees (91.7%) actively engaged in sustainability discussions while the remaining grantee has engaged in initial discussions regarding sustainability during the last six months. TA and additional grantee attention to sustainability appears to have paid off with more grantees actively engaged in sustainability planning. Grantees had also increased their engagement with sustainability-related tasks (see Figure 4). All of the grantees had identified and/or engaged stakeholders in discussions on sustainability and nearly all had identified the components to sustain.

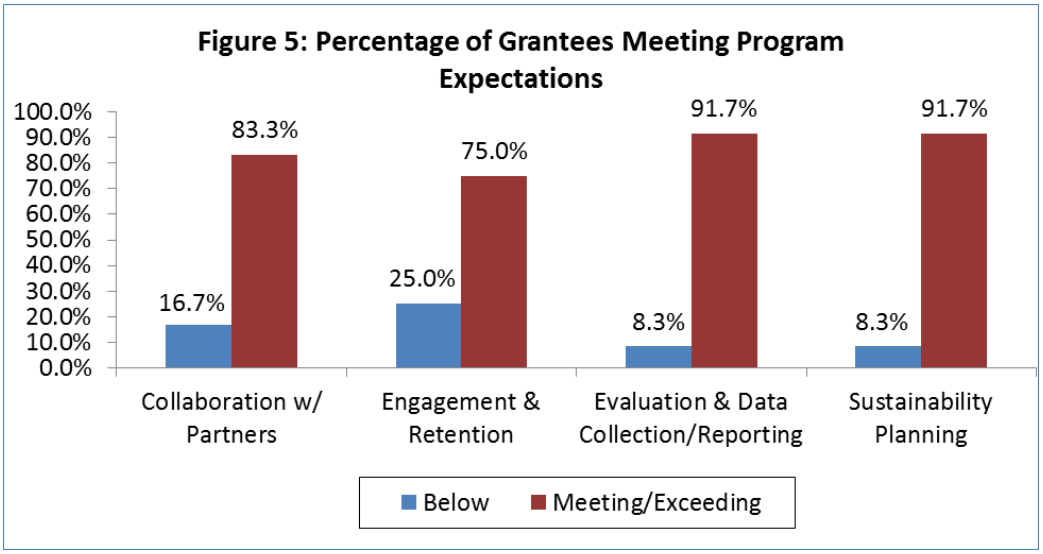
[24] **One site had changes in CAM staff and one site had a change in child's attorney.**

Grantees focused greater efforts on and identified more barriers to sustainability since the last reporting period (see Table B8 in Appendix B). At the time of the last report, one or more grantee indicated six different barriers compared with the current reporting period during which they encountered eight including:

- Not having data yet to identify effectiveness (n=5)
- Lack of knowledge regarding available funding streams (n=2)
- Have not figured out how to leverage resources and/or work with existing initiatives (n=2)
- Lack of knowledge regarding current/existing funding streams (n=1)
- Not knowing or lack of agreement on what to sustain (n=1)
- A very narrow target population and trust issues within the collaboration (n=1)
- Effectiveness not established and efforts in process seeking state funding for coordinators (n=1)
- Ineffective or poor relationships and communication across systems (n=1)

Cumulative Progress Ratings

In addition to rating the grantees' achievements during the past six months, the PMLs rated the grantees' cumulative progress to determine if they met program expectations in the areas of collaboration with partners, client engagement and retention, evaluation and data reporting and sustainability (see Figure 5). Ten of the 12 grantees (83.3%) met or exceeded expectations in the area of collaboration with their partners. Nine of the 12 grantees (75.0%) met or exceeded expectations in the area of client engagement and retention. Eleven of the 12 grantees met or exceeded expectations in the area of evaluation and data collection/reporting. Overall, eleven of the 12 grantees (91.7%) met or exceeded expectations in the area of sustainability planning. Eleven of the 12 grantees (91.7%) were effective in both identifying and responding to the needs of the children in their programs (see Table B5 in Appendix B). Additionally, PMLs believe that eight of the 12 grantees (66.7%) have the potential to sustain the program in its current form or model (see Table B8 in Appendix B).



Grantee Performance

On July 11th, 2013, the Acting Assistant Secretary for the Administration on Children and Families, the Administrator for the Centers for Medicare and Medicaid Services and the SAMHSA Administrator co-authored a letter to state directors of human service agencies regarding the importance of cross-systems approaches to address trauma and improve child well-being. Although the CAM program pre-dated this letter, CAM addressed most, if not all, of the issues raised by HHS. This alignment is illustrated in that CAM grantees reported on five of the eight outcome and performance dimensions listed in the Assistant Secretary and Administrators' letter including:

- Reduction in the number of children with a clinical level of need receiving no services;
- Increase in the number of children receiving evidence-based screening, assessment and treatment;
- Reduction in the use of "deep-end" services, including emergency department visits for acute crisis stabilization and residential treatment for extended periods;
- Reduction in the use of foster home placements to include re-entries into care; and,
- Improvements in child functioning across well-being domains and reductions in trauma systems.

CAM grantees reported on these five measures and 13 others on the child, adult and family levels as outlined in Table 2.

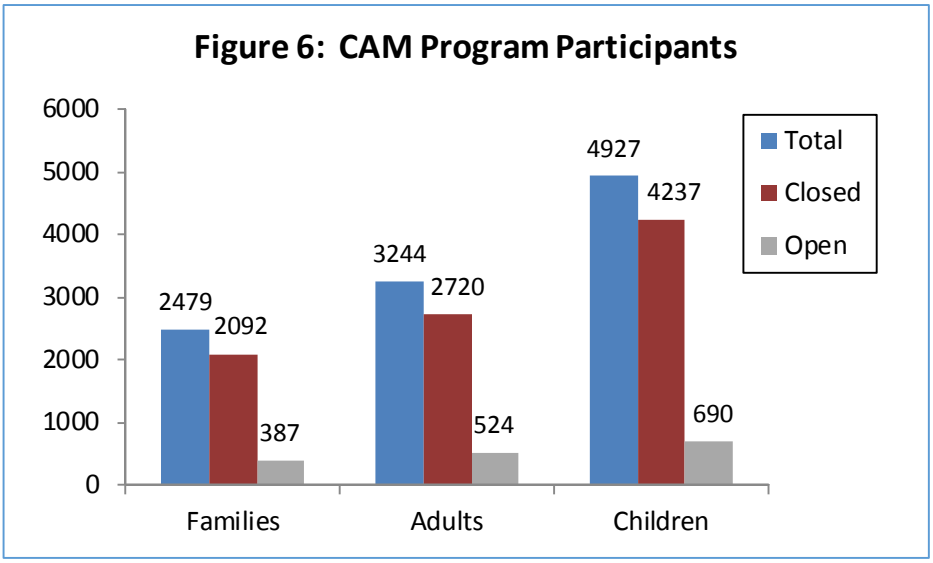
Table 2: Children Affected by Methamphetamine (CAM) Program Performance Indicators

Child/Youth	Adult
C1. Children remain at home	A1. Access to substance abuse treatment
C2. Occurrence of child maltreatment	A2. Retention in substance abuse treatment
C3. Average length of stay in foster care	A3. Reduced substance use
C4. Re-entries to foster care placement	A4. Parents/caregivers connected to supportive services
C5. Timeliness of reunification	A5. Employment
C6. Timeliness of permanency	A6. Criminal behavior
C7. Prevention of substance-exposed newborns	
C8. Children connected to supportive services	
C9. Improved child well-being	
Family/Relationship	
F1. Improved parenting	
F2. Family relationships and functioning	
F3. Risk/protective factors	

Grantees began submitting case-level data to the CAM Data System in December 2011 and uploaded their cumulative data to the CAM Data System every six months (December 15 and June 15 of each program year). This report is based on the seventh and final upload submitted in September 2014,[25] which included data from 11 of the 12 grantees (Dunklin County, MO is not required to upload data) and focuses on data from the CAM participant population.

[25] **Data submission includes October 1, 2010 through September 30, 2014.**

Number and Characteristics of Families Served[26]



The grant programs served a total of 2,479 families as of September 30, 2014 (see Table 1 in Appendix B for site level details). The average number of families served per grantee was 207 with great variability by site ranging for a low of 59 families to 869 families. This broad range reflects the diversity of the 12 grantee program models, the geographic regions served and the differences in selected target populations.

Approximately a seventh of the families (15.6%) were still enrolled and receiving services at the time of data submission with one of the grantees actively providing services to more than half of their enrolled families. Of the families who are no longer receiving CAM services (n=2092), the average duration of CAM services was 209.8 days (6.9 mos.) with a low of 140.0 days or 4.6 months to a high of 586.5 days or 19.3 months. This range reflects the variation in grantee program models and participant populations.

Child Demographic Data

The 2,479 families participating in the CAM program included 4927 index and 204 non-index children.[27] The index children are those children who were the primary focus of the CAM intervention while non-index children may have participated in a CAM service, but were not the primary or intended beneficiary. The following analyses do not include the non-index children because of their small number (4.1%) and because they are not the focus of CAM intervention efforts. Table 3 shows that nearly half (47.0%) of the 4776 children participating in CAM program services were age 3 years or younger with a mean age of 5.3 years. Children who were less than 6 years of age make up 62.7% of those participating in CAM services. The children served by the CAM programs were predominately Hispanic (42.0%), while those of Asian/Native Hawaiian/Other Pacific Islander descent make up the smallest percentage (0.5%). Approximately a third of the children are White (33.8%) and 8.8% are Black, while 2.6% are American Indian/Alaska Native. A small percentage of the children were Multi-

[26] Includes information from all 12 grantees.

[27] Includes 151 children who received CAM program services in Dunklin. No demographic information is available for these children.

Racial (3.2%). Over a third (40.1%) of the children had been a prior victim of a substantiated or indicated maltreatment that occurred before the family's outreach and engagement in CAM services (i.e., it was a past incident that was not associated with the reasons for CAM program involvement).

Table 3: Selected Demographic Characteristics of Children Participating in CAM Services

	Number	Percent
Total Children	**4,776**	**100%**
Gender[28]		
Female	2,396	50.4%
Male	2,356	49.6%
Age[29]		
Under 1 Year	917	19.3%
1-3 Years	1,316	27.7%
4-5 Years	746	15.7%
6-8 Years	787	16.6%
9-12 Years	625	13.2%
13 and Older	360	7.6%
Mean Age (years)		
	5.3	
Race/Ethnicity[30]		
White Non-Hispanic	1,614	33.8%
Black Non-Hispanic	418	8.8%
American Indian/Alaska Native Non-Hispanic	123	2.6%
Asian/Native Hawaiian/Other Pacific Islander Non-Hispanic	26	0.5%

[28] **Gender information was missing for 24 of the 4776 children.**

[29] **Age information was missing for 25 of the 4776 children.**

[30] **Race/Ethnicity information was unknown for 436 of the 4776 children.**

	Number	Percent
Race/Ethnicity		
Hispanic (any race)	2,004	42.0%
Multi-Racial Non-Hispanic	155	3.2%
Unknown	433	9.1%
Prior Victim of Maltreatment – Not Associated with CAM Entry or Involvement[31]	1,356	40.1%

Adult Demographic Data[32]

The 2,479 families participating in the CAM program were comprised of 3,244 adults (see Table 4) and nearly three-fourths (70.7%) were female. The mean age of all adults served was 31.6 years with nearly half (45.5%) of adults under 30 years of age. The adults served by the CAM programs were predominately White (51.5%), while those of Asian/Native Hawaiian/Other Pacific Islander descent made up the smallest percentage (0.7%). Hispanics made up over one quarter (28.8%) of the adult population while Blacks made up 8.4%. American Indian/Alaska Native made up 2.5% while Multi-Racial made up 0.8% of the adult population.[33]

The majority of the adults (77.6%) were the primary caregiver and more than half (54.1%) were never married. More than half (58.0%) of the adults had 12 or more years of education. Over three-fourths were unemployed (47.8%) or not in the labor force (31.8%) at entry into CAM program services. Over one-third (42.9%) of the adults in the CAM treatment population had been a prior perpetrator of substantiated or indicated maltreatment that occurred before the family's engagement in the CAM program (i.e., it was a past incident that was not associated with reasons for CAM program involvement). For two-thirds (69.6%) of the adults, methamphetamine use or production was identified as a contributing factor to the risk of child maltreatment.

[31] Child was prior victim of substantiated/indicated maltreatment that occurred before outreach and engagement in the CAM program (i.e., it was a past incident that is not associated with reasons for involvement in the CAM program). Percentage excludes missing information (1395 children).

[32] Dunklin County included in total number of families and adults, gender, age, race/ethnicity, marital status and methamphetamine as a contributing factor only.

[33] The differences in reported Race/Ethnicity information for adults and children may be due to sites reporting only one code (either Race/Ethnicity). Children may also have parents of differing racial or ethnic backgrounds.

Table 4: Selected Demographic Characteristics of All Adults in the CAM Treatment Groups

	Number	Percent
Total Adults	**3,244**	**100%**
Gender[34]		
Female	2,285	70.7%
Male	945	29.3%
Age[35]		
Under 21 years	99	3.1%
21 to 24 years	475	14.6%
25 to 29 years	884	27.6%
30 to 34 years	830	25.9%
35 to 39 years	442	13.8%
40 to 44 years	244	7.6%
45 years and older	226	7.1%
Mean Age (years)		
	31.6	
Race/Ethnicity[36]		
White Non-Hispanic	1670	51.5%
Black Non-Hispanic	273	8.4%
American Indian/Alaska Native Non-Hispanic	80	2.5%
Asian/Native Hawaiian/Other Pacific Islander Non-Hispanic	23	0.7%
Hispanic (any race)	933	28.8%
Multi-Racial Non-Hispanic	26	0.8%
Unknown	239	7.4%

[34] Gender information was missing for 14 of the 3244 adults.

[35] Age information was missing for 43 of the 3244 adults. Represents age at entry to CAM program.

[36] Race/Ethnicity information was unknown for 239 of the 3244 adults.

	Number	Percent
Primary Caregiver[37]	2,400	77.6%
Relationship to Child		
Biological Mother	2,042	66.0%
Biological Father	721	23.3%
Other[38]	217	7.0%
Not known	113	3.7%
Females Pregnant at CAM or Substance Abuse Treatment Admission[39]	133	4.3%
Education[40]		
Less than 12 years	1,161	42.0%
12 to 15 years	1,556	56.3%
16 years or more	49	1.8%
Employment Status[41]		
Employed Full/ Part Time	525	20.3%
Unemployed	1,235	47.8%
Not in Labor Force	821	31.8%
Living Arrangement[42]		
Independent	2,152	77.9%
Dependent[43]	329	11.9%

[37] A primary caregiver is defined as the person who has consistently assumed responsibility for the housing, health and safety of the child(ren) and who carries out and/or oversees the tasks related to the daily lives of the child(ren), which includes caring for their physical, educational, social, emotional and other needs. States unknown for 130 of the 3093 adults.

[38] Includes step mother/father, adoptive mother/father, foster mother/father, presumptive father, grandmother/grandfather, aunt, uncle, significant other or other relationship not otherwise specified.

[39] Pregnancy information was missing for 142 of the 3093 adults.

[40] Education information missing for 327 of 3093 adults.

[41] Employment status information missing for 512 of 3093 adults.

[42] Living arrangement information is missing for 332 of 3093 adults.

[43] Dependent living is clients living in a supervised setting such as a residential institution (including jail/prison), halfway house or group home.

	Number	Percent
Homeless	280	10.1%
Primary Source of Income/Support		
Wages/salary	464	15.0%
Public assistance	730	23.6%
Retirement/ pension	22	0.7%
Disability	99	3.2%
Other/Not known	945	30.6%
None	833	26.9%
Marital Status[44]		
Never married	1,484	54.1%
Now married	652	23.8%
Separated	279	10.2%
Divorced	293	10.7%
Widowed	33	1.2%
Prior Perpetrator of Child Maltreatment – Not Associated with CAM Entry or Involvement[45]	815	42.9%
Methamphetamine is Contributing Factor[46]	2,092	69.6%

[44] **Marital Status information is missing for 503 of 3244 adults.**

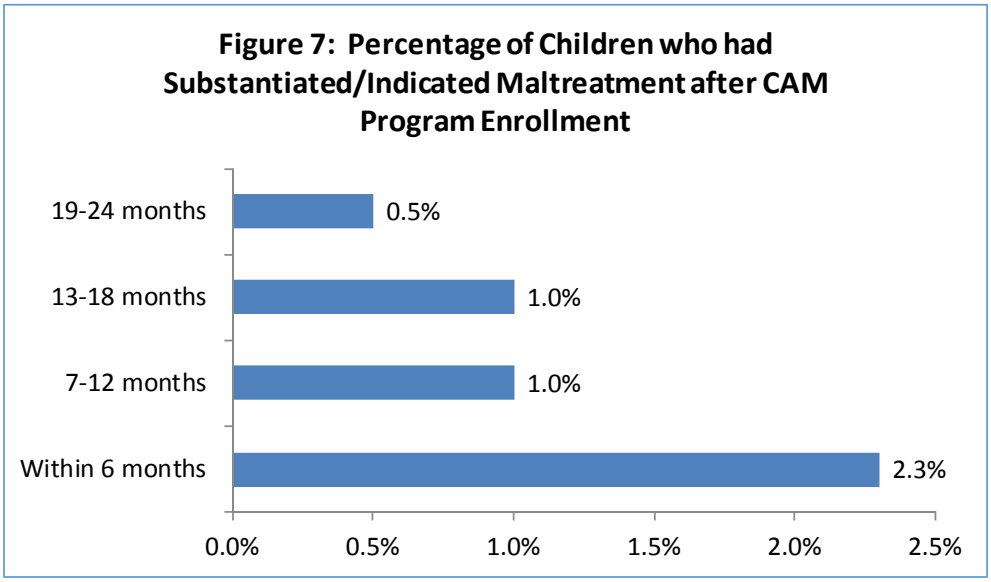
[45] **Adult was prior perpetrator of substantiated/indicated maltreatment that occurred before outreach and engagement in the CAM program (i.e., it was a past incident that is not associated with reasons for involvement in the CAM program). Percentage excludes missing information (1194 of 3093 adults).**

[46] **Methamphetamine use or production identified as a contributing factor to the risk of child maltreatment. Missing data for 237 of 3244 adults.**

Safety Performance Indicators

Safety performance indicators include the occurrence or recurrence of child maltreatment and prevention of substance-exposed newborns.

Reoccurrence of Child Maltreatment



Of the children served by the 11 grantees reporting on this indicator, 4.7% (224 children) were a victim of a substantiated or indicated maltreatment within 24 months following entry into the CAM program (see Figure 7; see Appendix C for site level summaries).[47] One hundred and nine children, or 2.3%, were a victim of maltreatment within six months of entering into the CAM program. Two of the grantees had no reports of substantiated/indicated maltreatment post-CAM enrollment. This performance is especially favorable when considered in the context of the communities served by grantees where the average six-month recurrence rates are estimated to be nearly four percentage points higher (6.0%).[48]

Prevention of Substance-Exposed Newborns

A total of 50 children in nine CAM programs were born after enrollment in the CAM program. Grantees submitted information on 5 of those newborns and three tested positive for substance exposure at birth (see Appendix C for site level summaries).

Permanency Performance Indicators

Permanency performance is comprised of the indicators for children remaining at home, the average length of stay in foster care, re-entries to foster care placement, timeliness of reunification and timeliness of permanency.

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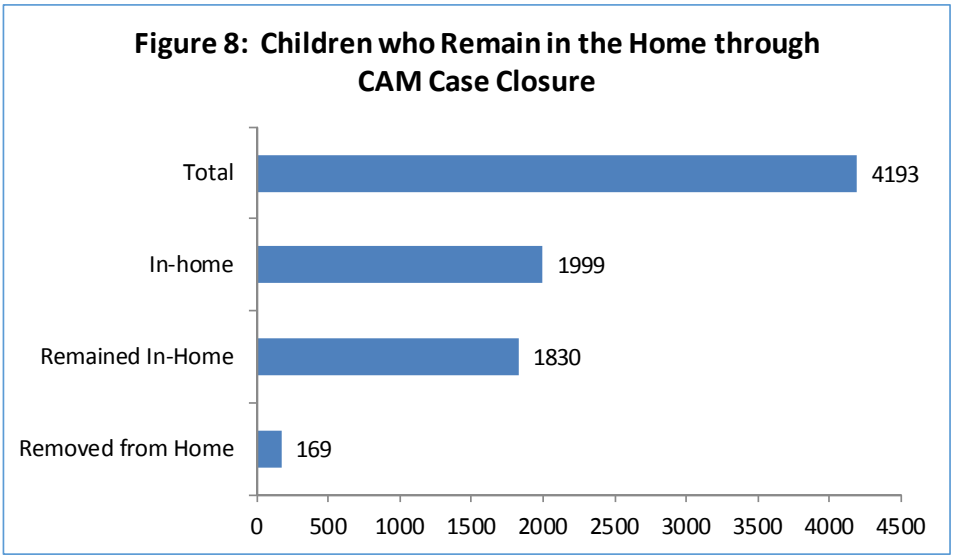
[47] Can only be calculated for those families no longer receiving CAM services.

[48] Contextual information is included for indicators where state or county-level measures are similar in definition and publicly available. More information about the sources of this information for each grantee community is included in the site level summaries in Appendix C of this report.

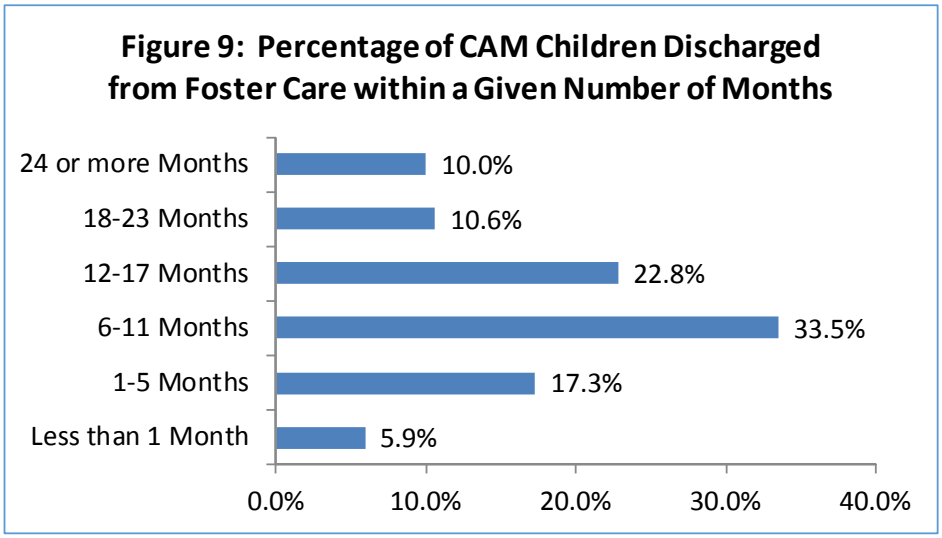
Children Remain at Home While Participating in CAM Services



Overall, nearly half (48.3%) of the children were in-home at the time of CAM enrollment (see figure 8).[49] Nearly all (91.5%) of the children who were in-home at the time of CAM enrollment remained in their home with their parent/caregiver through their family's participation in CAM services. The percentage of children, by grantee, who remained in the home ranged from a low of 33.3% to a high of 97.6% (see Appendix C for site level summaries). The number of children in-home at CAM enrollment and remaining in-home is highly influenced by two of the grantees. More than any other grantees, these CAM projects are designed to reach a far larger number of families prior to the removal of their children. Brief descriptions of each project's design and components are included in Appendix C at the end of this report.

[49] Can only be calculated for those families no longer receiving CAM services.

Average Length of Stay in Foster Care[50]



Overall, the median length of stay in out-of-home care for all children receiving CAM services was 10.2 months (310.0 days). The median length of stay in out-of-home care ranged from 140.0 days to 645.5 days by site (see Appendix C for site level summaries).

While over half of the children discharged (56.7%) were discharged from out-of-home care in less than 12 months, approximately a quarter of children (23.2%) were discharged in less than six months. Two of the 11 grantees (18.2%) had a median length of stay of less than six months (or 182.5 days). Four of the 11 (36.4%) grantees had a median length of stay between 6 and 11 months (see Figure 9).

The majority (84.9%) of CAM children exiting out-of-home care were discharged to reunification.[51] The median length of stay in out-of-home care for those reunified was 7.7 months. This finding is favorable considered in the context of the communities served by grantees where the overall median length of stay in out-of-home care for children reunified with their parents is approximately 11.3 months.[52] Of the children exiting from out-of-home care, 225 (15.5%) were discharged to adoption with a median length of stay in out-of-home care of 22.3 months.

[50] Foster care refers to those children in out-of-home care.

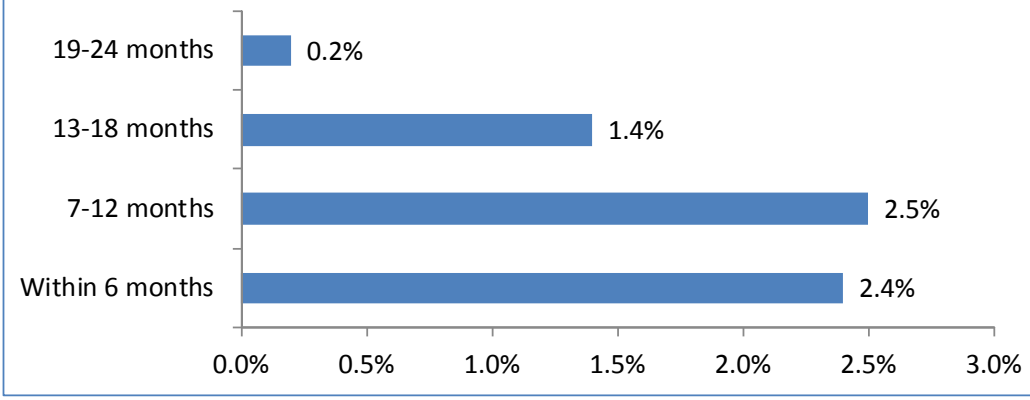
[51] For purposes of calculating the CFSR measures, those discharges coded as "living with other relative" are counted as a valid reunification.

[52] Contextual information is included for indicators where state or county-level measures are similar in definition and publicly available. More information about the sources of this information for each grantee community is included in the site level summaries in Appendix C of this report.

Re-entries to Foster Care[53]

Of the 1232 children in CAM programs who reunified,[54] only 81 children (6.6%) re-entered out-of-home care within 24 months after being returned home (see Appendix C for site level summaries). Only 5.0% of CAM children re-entered out-of-home care within 12 months after being returned home, while 2.4% re-entered within six months (see Figure 10). This can be considered favorable in the context of the communities where CAM grantees operated where rates are estimated to be more than five times higher (13.2%).[55]

Figure 10: Percentage of Children Returned Home that Re-entered Foster Care



[53] **Foster care refers to those children in out-of-home care.**

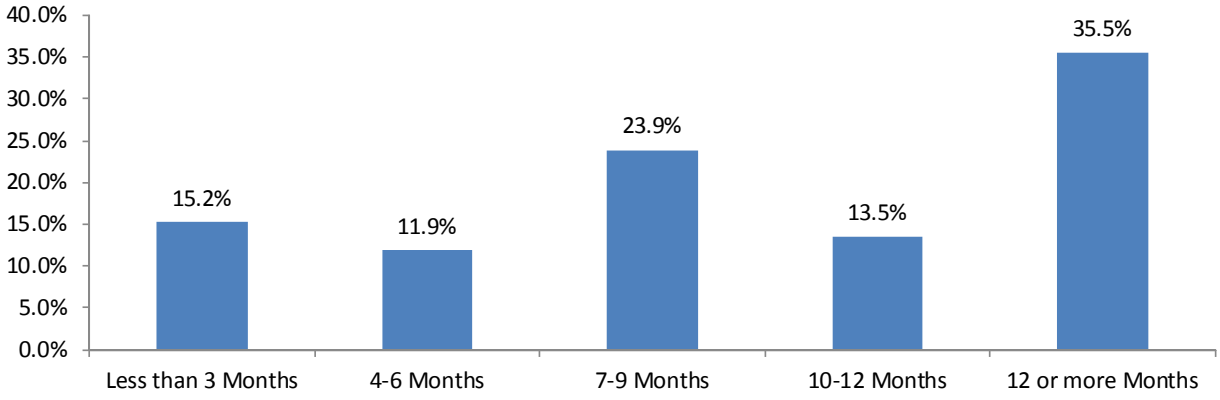
[54] **Includes discharge reasons of both reunification and living with other relative. For purposes of calculating the CFSR measures, those coded as living with other relative are counted as a valid reunification.**

[55] **Contextual information is included for indicators where state or county-level measures are similar in definition and publicly available. More information about the sources of this information for each grantee community is included in the site level summaries in Appendix C of this report.**

Timeliness of Reunification

Of the 1232 children in CAM programs who were reunified with their parent/caregiver,[56] nearly two-thirds (64.5% or 776 children) were reunified in less than 12 months (see Figure 11; see Appendix C for site level summaries). This finding is positive especially when considered in the context of data from the communities in which the grantees were situated where the overall proportion of children returned home within 12 months is estimated at 54% (approximately 12% lower than CAM participants).[57] All grantees reported reunifications for children and approximately one-sixth (15.2%) of the children were reunified in less than three months. Over a third of all grantees (4 of the 11) had 75% or more of the children in their programs reunified within 12 months. The median time to reunification was 267.0 days (8.8 months).

Figure 11: Percentage of CAM Children Reunified



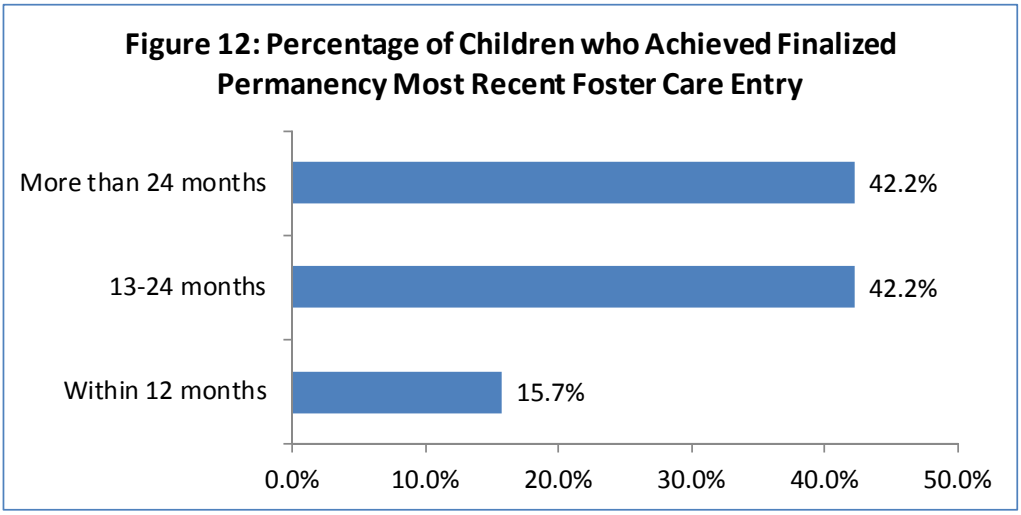
[56] **Includes discharge reasons of both reunification and living with other relative. For purposes of calculating the CFSR measures, those coded as living with other relative are counted as a valid reunification.**

[57] **Contextual information is included for indicators where state or county-level measures are similar in definition and publicly available. More information about the sources of this information for each grantee community is included in the site level summaries in Appendix C of this report.**

Timeliness of Permanency

As noted above, the majority of children exiting out-of-home care were reunified. To date 225 children have been discharged to finalized adoption or legal guardianship with the over half (57.8%) exiting to permanency in less than 24 months (see Figure 12; see Appendix C for site level summaries). This is a rate far higher than what is estimated for the areas served by grantees where overall less than one-third of children appear to be discharged to adoption or guardianship within 24 months.[58] Of the CAM children discharged from out-of-home care to adoption, 33.2% achieved finalized adoption within 24 months and 24.7% achieved guardianship within 24 months.

Figure 12: Percentage of Children who Achieved Finalized Permanency Most Recent Foster Care Entry



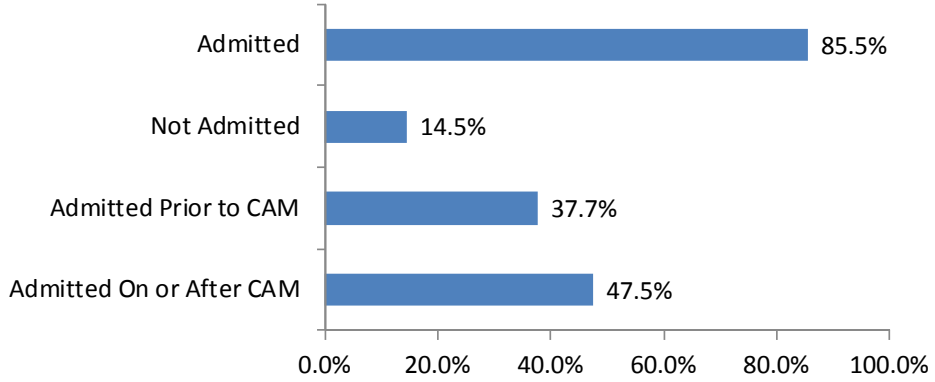
[58] **Contextual information is included for indicators where state or county-level measures are similar in definition and publicly available. More information about the sources of this information for each grantee community is included in the site level summaries in Appendix C of this report.**

Recovery Performance Indicators

The recovery performance indicators included access to substance abuse treatment, retention in substance abuse treatment, reduced substance use, employment and criminal behavior.

Access to Treatment

Figure 13: Percentage of Adults Who Accessed Substance Abuse Treatment



A total of 2646 adults (85.5%) were admitted to substance abuse treatment (see Figure 13; see Appendix C for site level summaries). Over one-third (37.7%) were admitted to substance abuse treatment prior to entering the CAM program, while nearly half (47.5%) were admitted the same day as or after CAM program entry. Over one-eighth of the adults (14.5%) were not admitted to substance abuse treatment because they did not need those services.[59] The different treatment entry time points reflect the diversity in the grantees' program approach and their client referral and engagement processes.

Data showing time between entry into substance abuse treatment and CAM entry date varied among the grantees due to their program model and many grantees providing substance abuse treatment prior to entry into CAM services. The proportion of participants receiving substance abuse treatment before entering CAM services ranged from 54.1% to 100%. Five of the grantees began providing treatment services to the majority of their clients on or after CAM program entry and comprise the bulk of the participants for calculations on time between CAM enrollment and treatment enrollment. Adults admitted to substance abuse treatment the same day as or after CAM program entry accessed treatment within an average of 22.3 days (the median was 0.0 days indicating that it was most common for adults to access care the same day they entered CAM services).

[59] The majority of these adults was from one site (57.5%, Sacramento) and this may be due to their program design where the focus is on parent training for drug court participants who might already be in recovery or in other treatment programs.

Retention in Substance Abuse Treatment

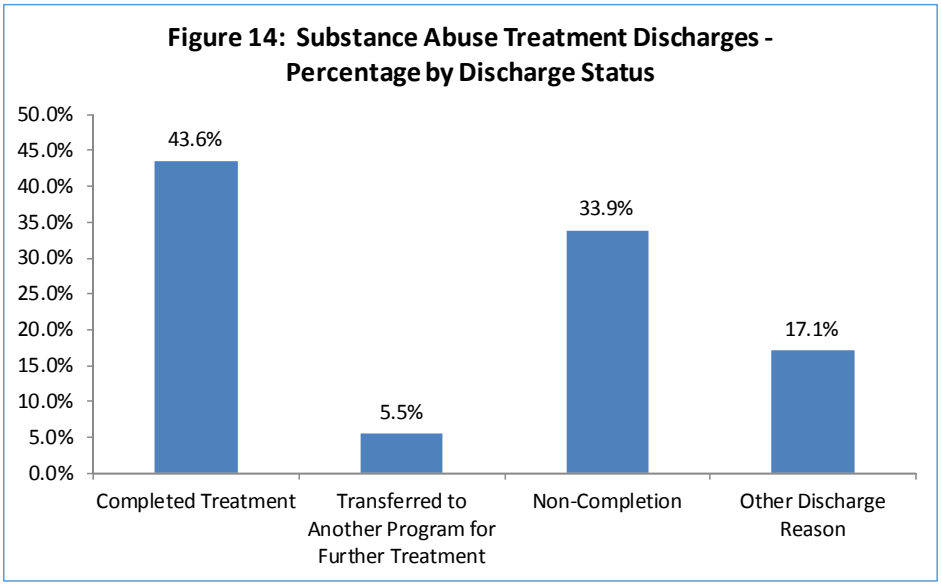


Figure 14 shows the treatment episodes for the adults discharged from treatment for those whose discharge status was known. Nearly half of treatment episodes resulted in positive outcomes with 43.6% of the treatment episodes completed and 5.5% were transferred to another program or facility for further treatment.[60] Over a third of treatment episodes (33.9%) were not completed or were transferred and did not report to another facility, while the remaining 17.1% had some other type of discharge status (e.g., terminated by facility, incarcerated, death or other reason out of the adult's or program's control). The treatment discharge status varied by site with non-completers ranging from 5.9% to a high of 61.1%.

Higher non-completion rates may be due to the variation in length of participation based on the grantee program model. Approximately a third (33.5%) of the overall treatment discharges were due to one site which has a high non-completion rate. Failure to complete the program does not mean that the participant is not in recovery or otherwise successful and low rates of completion (or high rates of non-completion) may be a function of larger numbers of enrollees and how they define a participant as "enrolled."

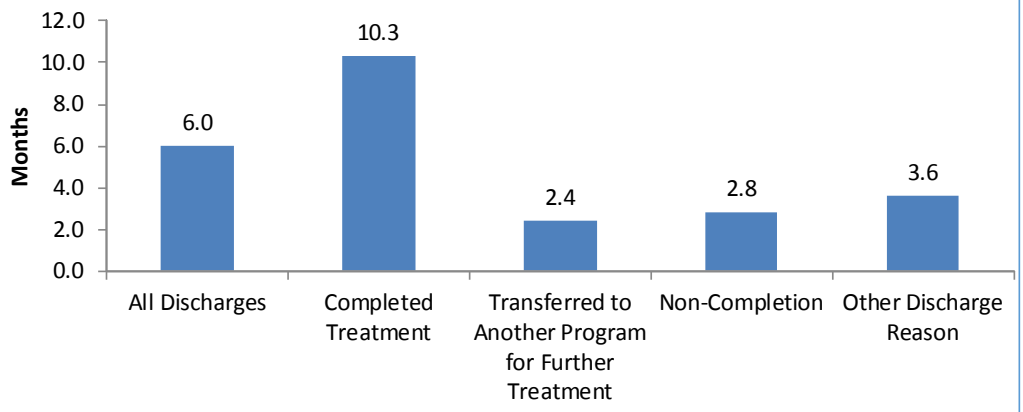
Figure 15 shows the length of stay for the adults discharged from treatment for whom discharge status was known. Across the CAM grantees, the median[61] length of stay in treatment was 183 days (6.0 months). The median length of stay in treatment varied by grantee and ranged from a low of 85.0 days (2.8 months) to a high of 386.0 days (12.7 months). Overall, those who completed treatment stayed in treatment longer (312.5 days or 10.3 months) than those who were transferred to another

[60]Transferred to another treatment program/facility for further treatment and known to report and completed treatment are considered a positive treatment outcome per Federal TEDS treatment discharge reporting.

[61] The *median* number of days is reported here, in contrast to the *mean*, as the median is considered a better measure of the typical length of stay for adults in the treatment sample, especially since the sample sizes for treatment discharges for many of the individual grantees is small. Because the *mean* is the arithmetic average of the entire range of possible values, it tends to be more sensitive to and affected by outliers, particularly very high values.

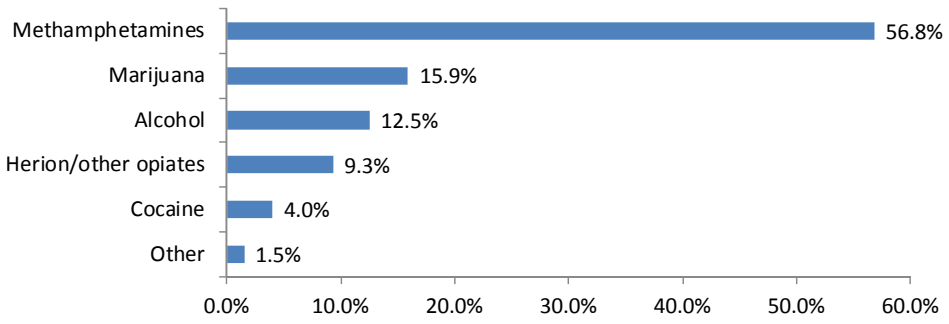
program and known to report. Those who completed also stayed treatment longer than those who were classified as non-completers[62] or had some other discharge status.[63]

Figure 15: Median Length of Stay in Substance Abuse Treatment by Discharge Status



Substance Use

Figure 16: Primary Substance at Treatment Admission for CAM Adults
(Percentage of all Admissions, n=2030)



Other includes hallucinogens, barbituates, other tranquilizers and sedatives, and other drugs.
Percentages exclude those missing primary substance data.

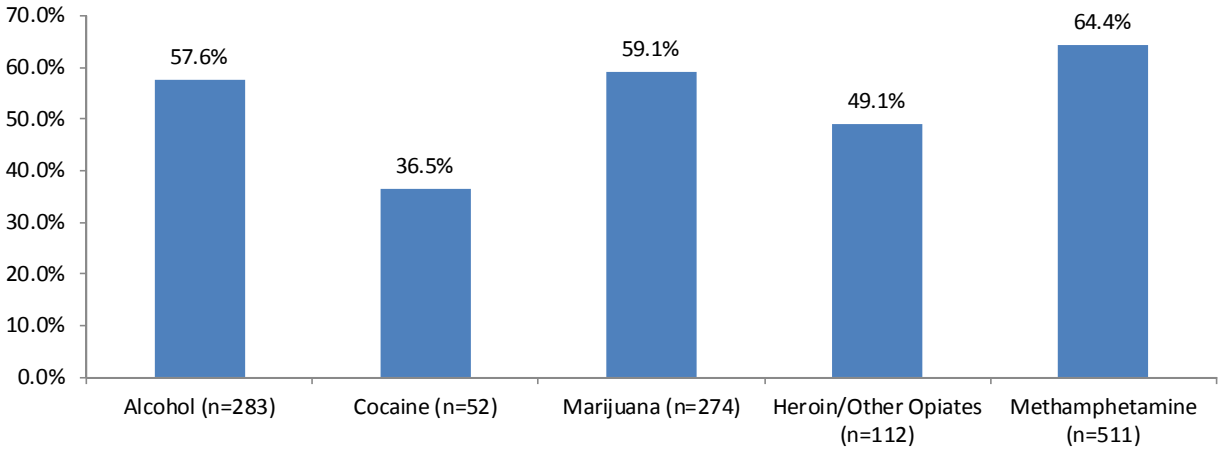
[62] **Includes transferred to another facility but did not report.**

[63] **Includes terminated by action of facility, incarcerated, death and other reason somewhat outside of client's control.**

For the adults reporting a primary substance problem at treatment admission, over half (56.8%) reported methamphetamine as their primary substance followed by marijuana (15.9%), alcohol (12.5%), heroin/other opiates (9.3%), cocaine (4.0%), and other drugs (1.5%) (see Figure 16). For those adults who reported any use in the past 30 days at treatment admission, there was a reduction in substance use from admission to discharge. This reduction ranged from 36.5% to 64.4% depending on the substance used. The greatest percent reported a reduction in use for methamphetamine (64.4%), closely followed by those using marijuana (59.1%), alcohol (57.6%) and heroin/other opiates (49.1%) (see Figure 17 below; see Appendix C for site level summaries).

Figure 17: Percentage of CAM Adults with Reduction in Substance Use from Treatment Admission to Discharge

(Among Adults Who Reported Any Use in the Past 30 Days at Admission)

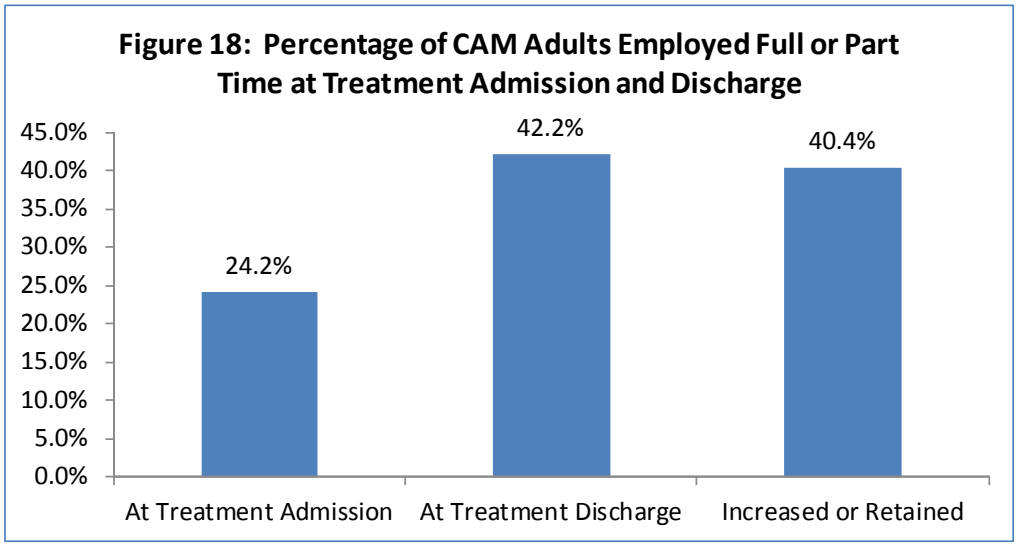


Of note is the substantial number of CAM adults participating in substance abuse treatment who reported no use of particular substances at both treatment admission and discharge (ranging from 29.0% to 88.0%), as shown below. The high percentage of "no use" are likely due to program models in which parents are already enrolled in treatment services when they begin participating in CAM services. The high percentages of no use at treatment admission impacts the ability to calculate reduction in substance use.

Table 5: Adults Reporting No Recent Use at Both Treatment Admission and Discharge

Type of Substance	Number	Percent
Alcohol (n=655)	372	56.8%
Cocaine/Crack (n=435)	383	88.0%
Marijuana (n=740)	466	63.0%
Heroin/Other Opiates (n=499)	387	77.6%
Methamphetamine (n=1932)	560	29.0%

Parents or Caregivers Employment or Educational Status



For the adults discharged from treatment who reported employment information at treatment admission and discharge, 24.2% were employed full or part-time at treatment admission and 42.2% were employed full or part-time at treatment discharge (see Figure 18). Over a third of the adults (40.4%) increased or maintained their employment from treatment admission to discharge. The percentage of adults who increased or maintained their employment ranged from 13.6% to 57.4% by site (see Appendix C for site level summaries). Over half of the adults (54.2%) were unemployed at both treatment admission and discharge.

For the adults discharged from treatment who reported educational or vocational information, 3.9% were enrolled in an educational or vocational training program at treatment admission and 8.0% were enrolled in an educational or vocational training program at treatment discharge (see Figure 19). From treatment admission to discharge, 7.9% of adults maintained or achieved enrollment in an educational or vocational training program. The percentage of adults who maintained or achieved enrollment in an educational or vocational training program ranged from 0.5% to 12.3% by site (see Appendix C for site level summaries).

Figure 19: Percentage of CAM Adults Enrolled in Educational/Vocational Program at Treatment Admission and Discharge

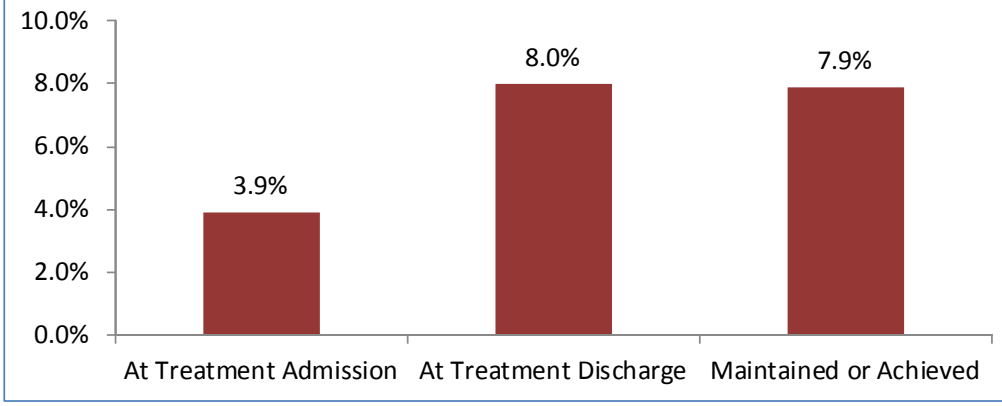
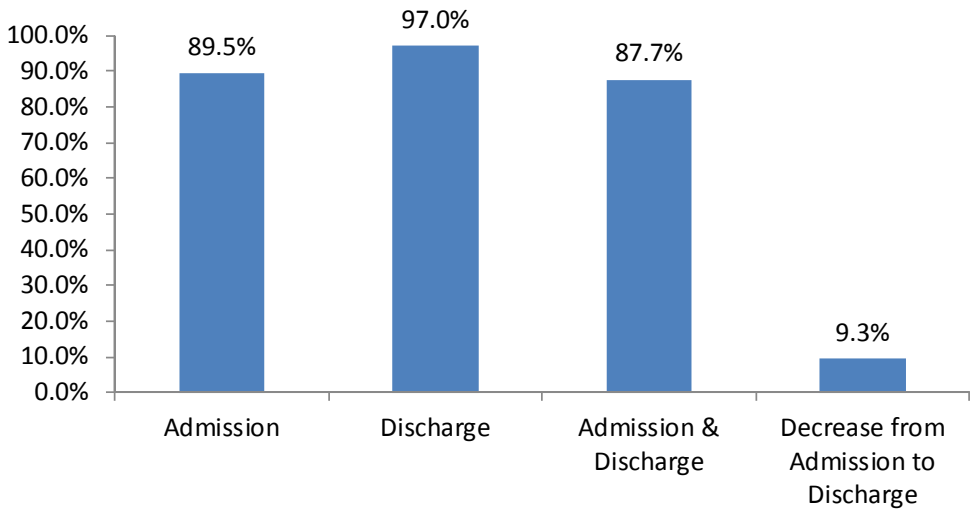


Figure 20: Percentage of Adults with no Arrests in the Prior 30 days



Criminal Behavior

For the adults discharged from treatment who reported arrest information at treatment admission and discharge, 87.7% reported no arrests at both treatment admission and discharge (see Figure 20). The percent of CAM adults who reported no arrests at both treatment admission and discharge ranged from 59.5% to 94.1% by site (see Appendix C for site level summaries). Nearly all of the adults who reported arrests at admission reported a decrease in the number at discharge.

Well-being Performance Indicators

The well-being performance indicators are comprised of the data for children connected to supportive services, improved child well-being, adults connected to supportive services, improved parenting, family relationships and functioning and risk or protective factors.

Children Connected to Supportive Services

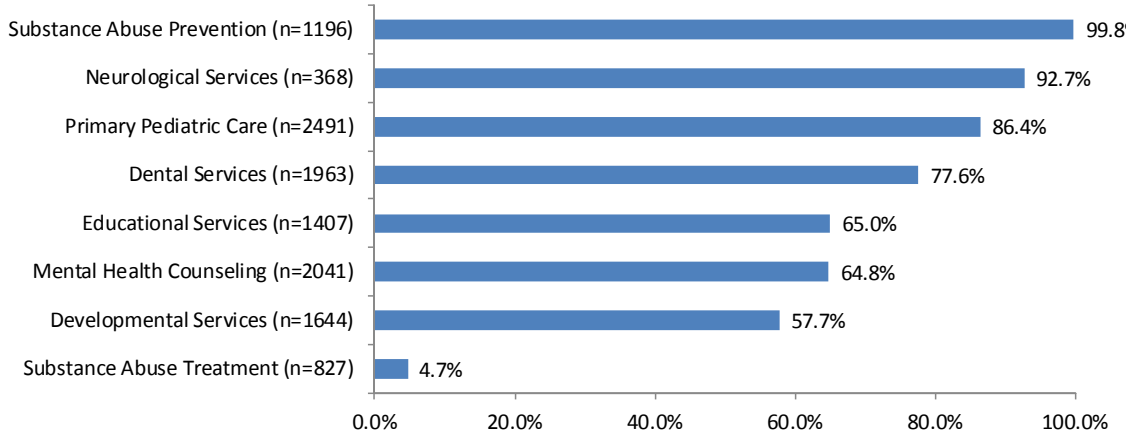
Supportive services needs assessments were conducted for the majority of CAM children (see Appendix C for site level summaries). The number of children screened/assessed ranged from 97.6% to 99.8% depending on the type of supportive service. Ninety-eight percent or more of children were screened/assessed for primary pediatric care, educational services, substance abuse prevention services, substance abuse treatment services, dental services, and mental health counseling while the remaining supportive services were assessed/screened at between 97.0% and 98.0% (developmental services and neurological services at 97.6% and 98.0%, respectively).

Overall, the majority of CAM children identified as needing a given supportive service received it.[64] Nearly all of the children who needed substance abuse prevention services and neurological services received them (99.8% and 92.7%, respectively). More than three-quarters received primary pediatric care (84.6%) and dental services (77.6%). Nearly two-thirds received educational services (65.0%) and mental health counseling (64.8%) while over half received developmental services (57.7%; see Figure 21 below). However, only 4.7% of the children who screened positive for needing substance abuse treatment received those services.[65] Variability in service is related to whether the grantee is funding those activities or is dependent on another agency or organization. Many grantees explain that participants have trouble accessing some community services or that the community does not have some of the services to which the child has been referred.

[64] In certain cases, a grantee may find that a given supportive service is not needed or pertinent to a particular individual's situation (i.e., the child is already receiving developmental services or is not displaying in delays in development).

[65] This low percentage is likely due to the lack of availability of these services in the community.

Figure 21: Percentage of CAM Children Who Received Selected Supportive Services
(Of those Assessed and for Whom a Given Service was Identified as a Need)



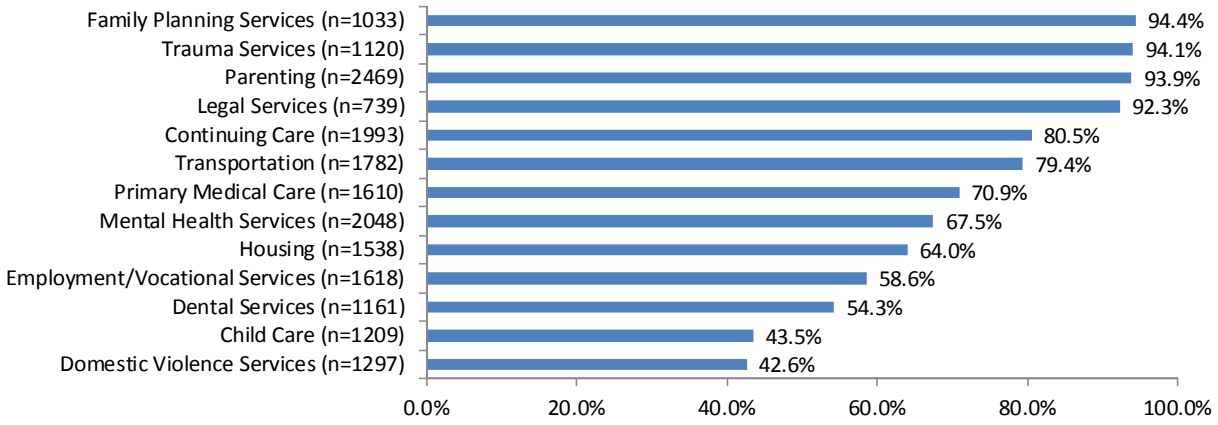
Parents or Caregivers Connected to Supportive Services

Supportive services needs assessments were conducted for the majority of CAM adults (see Appendix C for site level summaries). The number of adults screened ranged from 94.9% to 99.5% depending on the type of supportive service. Nearly all of the adults were screened for domestic violence services (99.5%), primary medical care (99.3%) and legal services (99.2%) while the supportive service least frequently screened was trauma services (94.9%).

Overall, the majority of CAM adults identified as needing a given supportive service received it.[66] Nearly all of the adults who needed family planning services, trauma services, parenting services, and legal services received them (94.4%, 94.1%, 93.9% and 92.3%, respectively). Approximately three-quarters of the adults who needed continuing care services (80.5%) and transportation services (79.4%) received them. Approximately two-thirds who needed primary medical care (70.9%), mental health care services (67.5%) and housing (64.0%) received them. Over half of the adults who needed employment/vocational services (58.6%) and dental services (54.3%; see figure 22 below) received them. However, gaps remain where some services are provided to fewer than 50% of those for whom such services were identified as needs, including child care and domestic violence services. As in the case of children's supportive services, variability in service receipt may have been due to service availability in the community and whether the grantee is funding those activities or is dependent on another agency or organization. Where there are gaps, grantees report that there is limited service capacity in their communities.

[66] In certain cases, a grantee may find that a given supportive service is not needed or pertinent to a particular individual's situation (i.e., the adult already has child care or housing).

Figure 22: Percentage of CAM Adults Who Received Selected Supportive Services
(Of those Assessed and for Whom a Given Service was Identified as a Need)



Family and Child Well-being

Grantees measured family and child well-being by using the North Carolina Family Assessment Scale-G+R (NCFAS-G+R). The NCFAS-G+R is a family functioning assessment tool used to inform case management and family treatment options across ten domains of family functioning (see description in Appendix D). Grantees assessed each family at program intake and closure. Across 11 grantees, 1836 intake and 1301 closure NCFAS-G+R scores were submitted yielding 1274 matching cases. Of these, the number of matching cases varied by the scale (or subscale) from 776 to 1201.

Figure 23 presents the assets and challenges at intake for the ten domains for the matched cases. Nearly two-thirds of the families experienced challenges in self-sufficiency while approximately half experienced challenges in readiness for reunification, parental capabilities and family safety at intake. Approximately half of the families were rated as baseline/adequate for ambivalence, child well-being and social/community life at intake. Over a quarter of families experienced strengths in family health.

Figure 24 presents the assets and challenges at closure for the ten domains for the matched cases. Fewer families experienced challenges at closure across all ten of the domains compared to intake. Over a quarter of the families experienced challenges in readiness for reunification down from over half of families at intake. Over a quarter of the families experienced challenges in self-sufficiency down from nearly two-thirds of families at intake.

Analyses revealed significant[67] improvement from intake to closure for all of the 10 domains of family functioning including the environment,[68] parental capabilities, family interactions, family safety, child well-being, social/community life, self-sufficiency, family health, caregiver/child ambivalence and readiness for reunification (see Figure 25). At intake the mean scores for 9 of the 10 domains fell between the rating categories of a mild problem and baseline/adequate[69] (family health was between

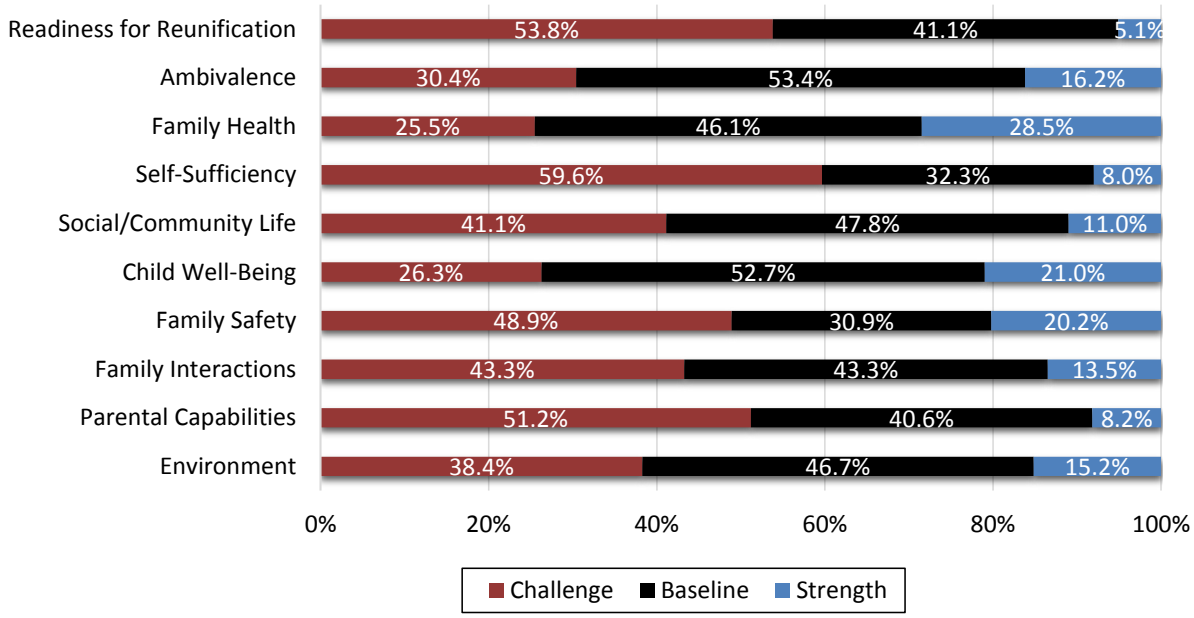
[67] Matched paired t-tests are significant at $p < .05$.

[68] Includes the areas of housing stability, safety in the community, environmental risks, housing habitability, personal hygiene, and learning environment.

[69] The "baseline/adequate" level of functioning is the level above which there is no legal, moral or ethical reason for exercising an intervention mandate.

the ratings of mild strength and baseline/adequate), while at closure the mean scores for the 10 domains fell between the rating categories of baseline/adequate and a mild strength (lower scores indicate improvement).[70] The largest mean differences representing the domains that families showed the greatest improvement were for the domains of family safety followed by parental capabilities and self-sufficiency.

Figure 23: Assets and Challenges for NCFAS-G+R Domains at Intake



[70] **More information about the NCFAS is on Appendix D page 5.**

Figure 24: Assets and Challenges for NCFAS-G+R Domains at Closure

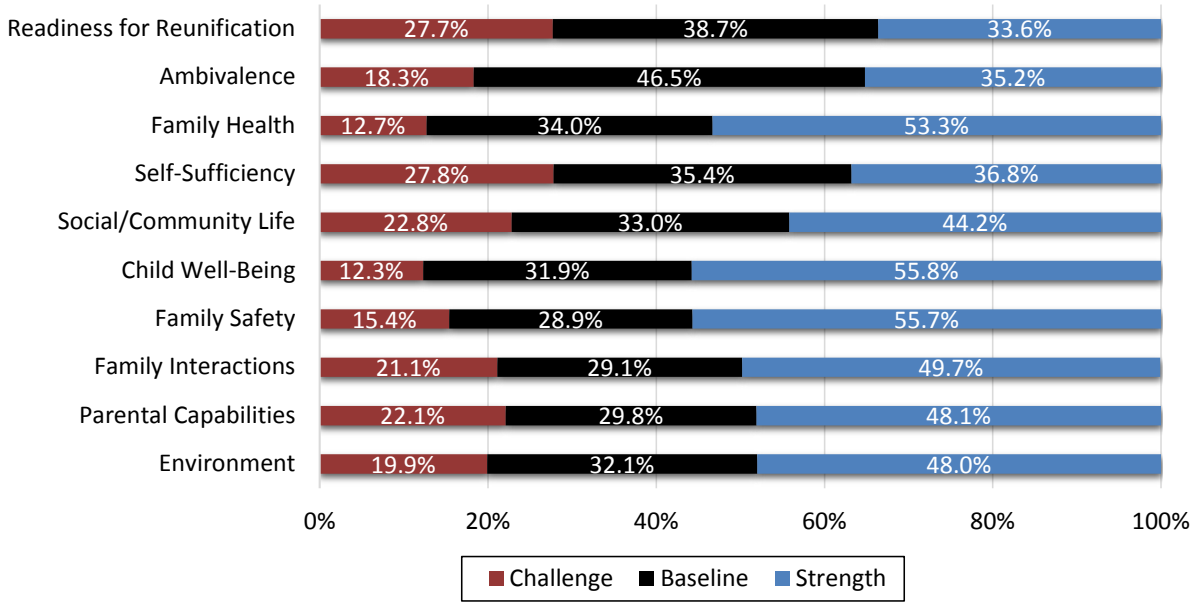
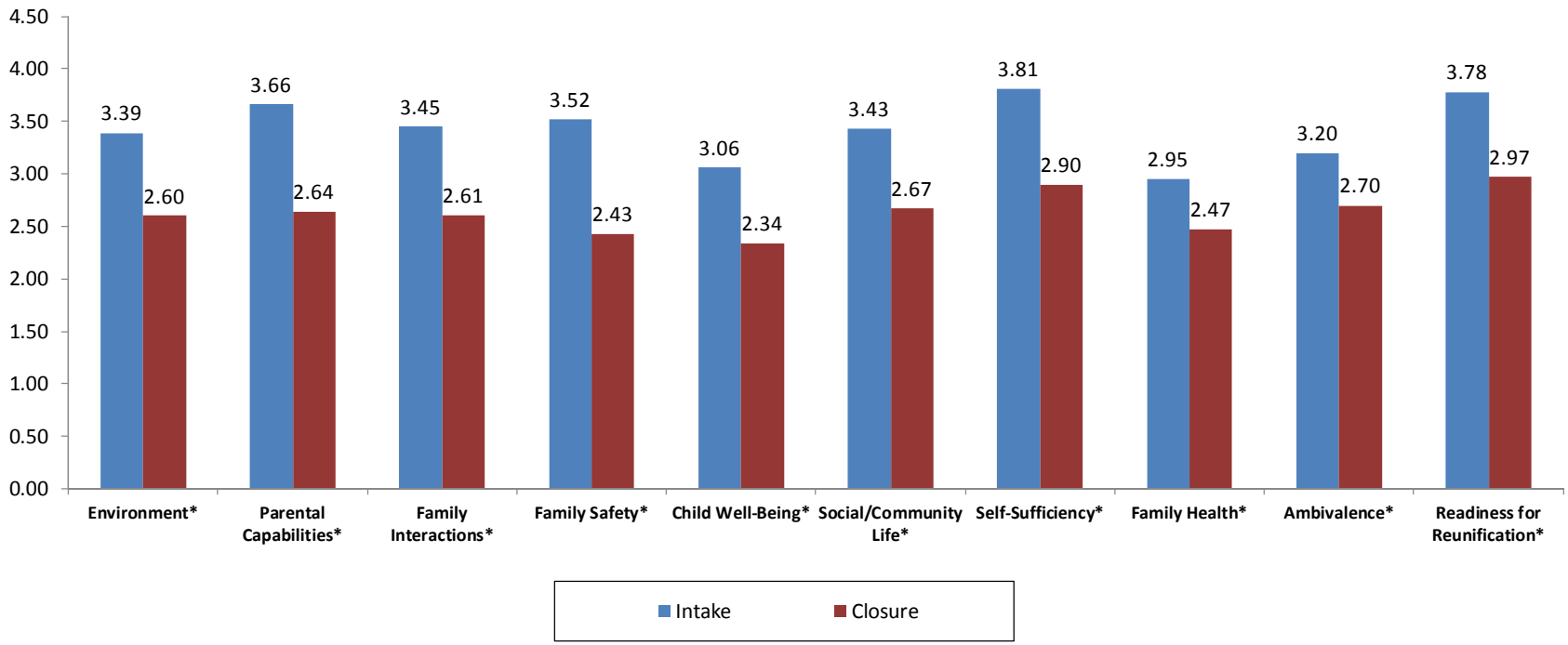


Figure 25: Overall Mean NCFAS Scores for Each Domain



Note. * signifies significant differences between intake and closure at $p < .05$. Lower scores indicate improvement.

Sustainability

Sustainability has multiple meanings in the context of health and human services programs. It can refer to a program that is re-funded, a successful program that is replicated and expanded, or a much broader impact when an innovation is fully institutionalized. This section describes the ways in which CAM grantees addressed sustainability including their successes, challenges and relevant elements of the implementation environment. Data for this section were principally drawn from semi-structured telephone discussions and email correspondence with grantees after their final (fourth) grant year, as well as reviews of grantees' annual and semi-annual progress reports. All twelve grantees participated in these voluntary follow-up activities.

As noted elsewhere in this report, each grantee implemented their projects in diverse communities and took unique approaches to address the needs of their FDC participants. This diversity is also evident in their sustainability efforts. As one respondent explained:

> Having the ability to do the sustainability that fits the needs of the locality [contributes to success]. It is overwhelming to think about applying a standard sustainability 'pre-programmed' approach. We needed to increase credibility first and also needed to consider the culture of the community.

This section is organized by themes that emerged from qualitative analysis of the data sources summarized above. Themes include leadership qualities and actions, implementation context, sustained components and sources of support, data used to identify effective components and garner support, and technical assistance that supported sustainability efforts.

Leadership

Grantees cited an array of key attributes of and decisions made by individuals in different leadership positions. Most grantees noted that leaders were collaborative and inclusive in their efforts to gain buy-in and nurture the relationships necessary to secure support from funding sources as well as partner agencies necessary for continuing services after grant funding. As one grantee noted, "Cold calling doesn't work. It is about relationship building and deep roots." Another grantee identified the value of personal connections and networking among leaders by describing how the judge and the state's governor, attending a mutual friend's wedding, talked about the value of FDCs. Another described an effective FDC coordinator as "politically savvy."

Some grantees noted the importance of leaders in communicating the value of CAM services. For example, a respondent stated, "We were determined to keep on it, don't let the communication lapse; we continued with monthly emails highlighting the CAM connection [to good outcomes] to keep it at the forefront." Others noted how effective leaders established support by communicating frequently with stakeholders through other structures including the active engagement of inter-agency committees.

Leaders willing to challenge their partners and the current system seemed to be particularly effective in sustaining their projects, according to some grantees. For example, one respondent suggested, "Our FDC coordinator was willing to challenge the mindset that sustainability should be based on additional grants." Some grantees also noted the value of leaders' ability to engage in difficult negotiations; as one interviewee said, "The sharing of costs across agencies was a challenge at times, but proved to be helpful in improving collaborative capacity." Another shared the value of

questioning "long standing practices and why they are the way that they are." The importance of leaders' commitment to difficult change is illustrated in a statement from another respondent:

> If you do this work well, the community is changed forever. If you just go about it as another grant and do the minimum and meet the numbers, you are not going to make the changes. If you engage on an emotional level, your community will be better forever.

Other important leadership factors cited by grantees included engaged and supportive judges and administrative leaders willing to challenge the mindset that sustainability of good practice relies on additional grants. Some leaders found that bringing partners to conferences and training led to additional support for CAM services. Several specifically mentioned the value of the grantee meetings and NADCP conferences in garnering other leaders' support and attention. One grantee also reported how CAM funded training for front-line child welfare staff led to support that helped child welfare leaders commit resources to continuing CAM services.

Finally, leaders varied in how they timed their formal sustainability planning. A couple of grantees started when they wrote the grant, a couple of others talked about it "from day one," one started at the beginning of year 3, one started at year 2, and one reported having a strong sustainability plan in place before CAM funding. The timing seems to have been triggered by different factors for each grantee. Some noted the requirement included in the SAMHSA funding application, others described the accumulation of evidence necessary to guide sustainability decision-making, while some grantees described the influence of their PML's encouragement and what some termed "nagging" in regular conference calls and as a key agenda item for site visits.

Implementation Context

Most grantees described factors in the policy and implementation environment that impacted sustainability. The most common contextual factor was turnover among key leaders. In one case, the respondent noted that the turnover competed for attention with the FDC's sustainability efforts. Two other grantees described such changes as instrumental to the successful continuation of CAM services. Another grantee saw the explosion of dependency cases in their county support the growth and expansion of their CAM services. Changes in funding policy were also critical to the success of sustainability according to some grantees. These changes included passage of the Affordable Care Act and approval of special state or local taxes specifically allocated to providing behavioral health services. Two respondents noted that the continuing effects of the economic recession inhibited sustainability planning efforts, especially during the first years of their grant.

Sustained Components

> Sustainability is as much about building buy-in, support and changing the culture as it is about getting more money

Some CAM components required new or re-directed funding. Other elements did not necessarily have a cost and were integrated as part of the enhanced integrative capacity (e.g., improved efficiency and greater coordination) gained through greater collaboration, or as policy and protocol changes. The components in the latter category may have funding implications but the changes themselves do not require direct fiscal support. Among the most ambitious sustainability efforts, one grantee has begun planning for replication of their FDC with CAM components in the southern portion of their county given the success demonstrated by CAM in the northern region. Another grantee will sustain all of their CAM services through a new grant from SAMHSA. Another used a variety of strategies including new fee-for-service billing practices to double the capacity of their FDC. The following subsections

describe the specific components and sustainability strategies organized according to whether the component would require ongoing funding or would be sustained without direct funding.

Funded Components

The two components that grantees mentioned sustaining most often were children's services and service coordinators. Sustained children's services specifically identified by respondents include CF! and Circles of Security. FDC coordinators were sustained through new funding from the administrative office of the courts or child welfare agencies. One grantee accessed TANF funds to fund a children's coordinator position. Another grantee funded their coordinator position, in part, through participant fees and new funding from the child welfare agency. New and enhanced children's services were sustained with funding from a combination of newly tapped sources including Medicaid and early intervention services for 0-3 year-olds. One grantee accessed Medicaid funding by moving children's services under the county behavioral health system. Another grantee was able to support CF! through funding redirected from residential treatment by the mental health services agency.

Several grantees also sustained their recovery support specialists, parenting programs and family services. One grantee partially supported their recovery support specialists by redirecting funding from drug testing and having clients pay for positive drug tests. Another funded their RSS through new funding from the child welfare agency. One funded their parenting program by purchasing the services from a vendor who had a fee for service structure that enabled reimbursement from the state substance abuse treatment agency. Finally, one grantee developed a system of loans and fees to pay for related supports including housing, medical and dental services.

Independent evaluation was most often cited as the component that would not be sustained. Two grantees indicated they now have internal capacity for evaluation that obviated the need for an external evaluator. One grantee will sustain their evaluation at a reduced level using existing county funds set aside for evaluating collaborative courts. However, several grantees did emphasize the value of the evaluation information. For example, one respondent stated, "The success and sustainability of the CAM program can be attributed, in part, to the skillful way that our evaluator was able to take otherwise dry numbers and facts and bring them to life, weaving in photos and stories that paint a fuller picture of the efforts of CAM staff and the impacts of those efforts on the lives of the families they serve."

Finally, one grantee reported that they will not sustain CF!, another will not continue staff training that had been funded through CAM, and one other respondent said they will not continue to fund CASA services.

Components that Did Not Require Continued Funding

There are potential cost implications (both expenditures and savings) with the components described below, but the costs are indirect and grantees did not describe how they will affect or be affected by funding decisions.

Changes in attitude and atmosphere were the most frequent components that will be sustained without continued funding. Several grantees noted the change in court tone because judges now ask about participants' children and the parent-child relationship. One respondent observed, "Now looking at the whole family makes a big difference-makes the parents see that we care about the whole family." Another noted the change in attitude and culture in the child welfare agency. Some grantees described how becoming more trauma-informed will be sustained as an ongoing priority.

One grantee modified their model so that all parents in dependency cases would be eligible to receive services initiated under CAM. The consequence of this policy change may be the complete integration of the FDC into the larger dependency court system. Some grantees noted more modest practice and protocol changes such as extending the duration of the FDC program, improving the phasing structure to match visitation schedules, streamlining referral processes, and improving communication among service providers. One of these grantees noted that the credibility that came from Federal funding and their status as a Peer Learning Court raised their visibility and brought faster referrals. Also speaking to improving referrals, a different respondent noted that training child welfare workers resulted in more appropriate referrals to the FDC which led to higher retention.

> One respondent noted the nuanced and developmental nature of sustainability by stating, "The beginning was doing good work to get the numbers. By the third year of the grant we had good outcomes that could be used at higher levels. In the fourth year we got state-level leaders to meet."

Barriers to Sustainability

Grantees noted a variety of barriers to sustainability including, most often, a lack of child welfare buy-in and support; as one respondent said, "The Department of Human Services should have contributed financial resources given the amount of money they are being saved by services for families in-house, and also providing the outreach needed to have eyes and ears on families who are in the process of reunification." Another respondent noted that they will not expand capacity because of a shortage of child welfare workers dedicated to the FDC. Grantees also cited changes in leadership either in the CAM project team or agency as barriers for sustainability planning. Finally, one grantee was hampered because their evaluation only included one outcomes report that will be completed during their no-cost extension period - too late to inform sustainability planning.

Data used for Sustainability Planning

As noted in the Leadership subsection above, effective leaders tailored how they used information to their audience. Thus, the definition of data is not restricted to that which was formally collected through evaluations or other structured mechanisms. This subsection reviews the wide variety of information types and sources that grantees used to make the case for continuing CAM components after grant funding and illustrates the variety of data gathering and dissemination strategies used by grantees.

Most frequently, grantees cite anecdotal and emotionally evocative evidence as most effective in garnering sustainability support. One grantee went so far as to say, "We don't often talk about the numbers… We sell the innovative practices and how we are a model for best practices." Another respondent noted, "Videos [of parents and their children] were most impactful." Another grantee observed that the judge was most compelled by positive comments from participants and parent aids. One grantee created a DVD video of the CAM project in Year 2 and revised it with updated data in Year 3-4 as part of their marketing and sustainability efforts to community stakeholders.

Several respondents described the value of witnessing the success of families through observations of graduations and other milestones. For example, one grantee noticed buy-in from executive leadership of key agency partners immediately following their observation of an FDC graduation. A few grantees also talked about the value of partners' participation in training and conferences, especially what they learned at NADCP and grantee meetings. For example, one grantee described how the judge learned about the impact of substance use during pregnancy which further convinced her of the preventative and ameliorative value of (and therefore her support for) CAM services.

Grantees also frequently mentioned the value of systematically collected data. Three grantees specifically noted the value of the NCFAS-G+R in demonstrating the effectiveness of their CAM services. Another grantee described the instrumental role of their evaluation in sustainability planning:

> Data showing success in retention and graduation led to additional funding from child welfare services. The continued funding beyond the grant was a direct result of the project's [evaluation data] demonstrating impact on families. The process evaluation allowed the program to make data-driven decisions to ensure that fidelity to the model was preserved and any gaps in service were addressed.

Three grantees talked about changes to their data system that supported sustainability planning. In each case, these changes involved better tracking of families in the child welfare system. Two grantees also noted the importance of sharing information at regular stakeholder meetings and one described how data in their press releases brought positive attention to the program and influenced decision-makers about future funding for the CAM services.

Finally, two grantees mentioned how cost studies impacted their sustainability plans. SAMHSA did not require cost studies and grantees undertook these efforts as part of their local evaluations. One talked about the immediate and strong influence that their cost study had on funders' decisions. This grantee felt that the result was an increase in TANF funding for their parenting services provider and increased support from the child welfare agency that recognized savings related to a significant reduction in time to reunification. The other grantee described their experience with cost studies more ambivalently. This grantee said, "Previous attempts to formulate detailed costs savings have not resulted in financial backing in the county; instead, strong political will sustained services… CAM drew political will to the program."

Technical Assistance for Sustainability

Grantees were asked to describe what technical assistance had been most helpful in their sustainability efforts. The most-frequently cited support noted by grantees was the regular reminders during their monthly PML calls and site visits. Two grantees described this (positively) as "nagging," and, as another respondent described, "Helped us get focused on sustainability and helped bring the stakeholders together around a vision." One grantee described the particular value of their PML's suggestion that they use the cost avoidance related to preventing substance use during pregnancy to help support their argument for sustained funding. Two grantees reported the benefit they found in meetings with other grantees that were facilitated or coordinated by their PML. Finally, one grantee summarized the significant advantage brought by the grantee meeting:

> Being able to take the whole team to the [grantee meeting and NADCP conference] was critical, trained everyone, team building and the same message- we have money in other grants but other FPOs are not allowing the full team to attend… the importance can't be overstated- we felt deeply trained.

Conclusions and Recommendations

Findings in this report reflect the grantees' implementation progress and performance over the four years of project implementation. This section summarizes findings and provides recommendations to support program-level improvements and future directions. It is difficult to generalize findings across grantees or groups of grantees because of the relatively small number of grantees, the lack of detailed information about intervention dosage and fidelity and the unique project designs. However, even considering these limitations, important conclusions can be drawn from the qualitative and quantitative data presented in this report. Importantly, grantees were meeting and exceeding targets related to enrolling children, youth and adults in CAM services, ensured the safety and permanency of children and youth, improved adults' recovery and improved family functioning. Other findings include:

- Collaboration – PMLs reported that the grantees' collaborative efforts paid off and partners are developing and implementing policies and practices to institutionalize systemic change.
- Data management – most grantees submitted more information on participants and the data appeared cleaner, suggesting that the grantees may have recognized the value of data-driven decision-making and became more familiar with their data systems.
- Safety – the percentage of children that had an occurrence or recurrence of maltreatment within six months (2.3%) was the same as the previous reporting period (2.3%).
- Permanency – nearly all children in-home at CAM entry remained in the home; more than half of the children discharged from out-of-home care in less than 12 months; the majority of children exited out-of-home care to reunification; nearly two-thirds of the children were reunified in less than 12 months; a small percentage of children re-entered out-of-home care within 12 months of reunification; and, over half of the children achieved finalized adoption or guardianship within 24 months.
- Recovery – nearly half of treatment episodes resulted in a positive treatment outcome; over a third increased or maintained employment from treatment admission to discharge; adults reported reduction in substance use ranging from 36.5% to 64.4% depending on the substance used; and, nearly all adults reported no arrests at treatment admission and discharge.
- Well-being – supportive services for children and adults were generally assessed and received at a high rate and significant improvement from intake to closure was demonstrated across all 10 domains of family functioning assessed by the NCFAS-G+R.

- Sustainability – grantees proceeded in diverse and uneven courses toward sustaining their initiatives; key factors for success seem to be flexibility, leadership, external technical assistance, and, for some, the availability of evaluation data to market the success of their initiatives.
- Evaluations with Comparison Groups – three of the FTDCs found significant improvement in outcomes when parent and child services were added.[71]

[71] **See site level summaries for Clark, Oklahoma and Sacramento in Appendix C.**

Appendices

Appendix A: Methodological Issues

Methodological Issues

In general, the data provided by grantees to measure CAM performance was clean with few coding errors. During individual site feedback, several sites reported concerns with performance measurement outcomes. The issues were resolved prior to the data upload for this report.

The overarching concern for the remaining ten sites was the large amount of missing or unknown data that affected overall sample sizes and the ability to adequately interpret CAM performance on individual indicators. CFF conducted follow-up with grantees to determine why this occurred and what action or assistance was needed to address the problem. Due to the consistent monitoring of these issues and providing technical assistance (TA) to grantees, the issues of missing or unknown data decreased over time as grantees' data collection and quality control capacities improved. What follows is a discussion of issues specific to the different types of data.

Core Demographic and Case Data

The 11 grantees have varying evaluation research designs ranging from quasi-experimental designs with comparison groups to treatment-only designs. Three[72] of the sites have quasi-experimental designs with a comparison group.

In addition, the CAM data set included a large amount of missing or unknown data for certain core child and adult demographics. Specifically there were challenges with children's demographic data related to race/ethnicity and whether they are a prior victim of substantiated/indicated maltreatment. Grantees improved on their reporting of age data for children and race/ethnicity over the grant period. There were challenges with adults' demographic data related to race/ethnicity, pregnancy, educational status, employment status, living arrangements, marital status, whether the adult was prior perpetrator of substantiated/indicated maltreatment and if methamphetamine use/production was identified as a contributing factor to the risk of child maltreatment. Grantees improved on their reporting of pregnancy data and if methamphetamine use/production was identified as a contributing factor to the risk of child maltreatment for adults over the grant period.

Follow-up with selected grantees was needed to obtain complete and timely data on CAM file open and closure dates and child welfare open dates in order to accurately calculate duration of CAM services and develop a more precise understanding of CAM program enrollment and service utilization. It also appeared that duplicate child welfare data was entered for selected grantees. This improved over the grant period.

Child/Youth Indicator Data

Follow-up with grantees was required for two of the eight child/youth indicators. There was a high degree of missing data on information related to substance-exposure at birth for children born after enrollment in the CAM program (C7). There was a high degree of missing data for children connected to supportive services (C8). Follow-up determined the grantee's missing data ranged from 16.8% to 21.6% depending on the supportive service (there were slightly higher percentages of missing data

[72] The three sites with comparison groups are Clark County, Oklahoma and Sacramento.

for the initiation of supportive services than screening of supportive services). This improved over the grant period.

Adult Indicator Data

Follow-up with grantees was required for two of the six adult indicators. There was missing data for adults connected to supportive services (A4) that required follow-up with selected grantees with missing data ranges from 5.6% to 10.0% depending on the supportive service (there were higher percentages of missing data for the initiation of supportive services than screening of supportive services). There was a high degree of missing data for employment and educational information for adults who have discharged from substance abuse treatment (A5) that required follow-up with selected grantees. This improved over the grant period.

Family/Relationship Indicator Data

Discharge data was only available for approximately two-thirds of the data (65.2%, up from 70.9%) for the last report. The matching cases were even lower depending on the scale (or subscale) analyzed. Follow-up with selected grantees will determine if the data is missing or whether it is not applicable (due to the program design).

Appendix B: Detailed Data Tables

This appendix includes tables detailed by site for performance indicator measures for adults and children for safety, permanency, recovery and well-being and for grantee project design and implementation.

List of Tables

Table B: Total Number of Families Participating in CAM Programs and Average Duration of CAM Services among Families Who No Longer Receive CAM Services

							Average Length of Services for Closed CAM Cases[73]			
	Families Enrolled in CAM Services (% of Total)		Families with Open CAM Cases		Families with Closed CAM Cases		Mean Number of Days/ Months		Median Number of Days/Months	
	N	%	N	%	N	%	Days	Mos.	Days	Mos.
Total – All CAMs	2479	100.0%	387	15.6%	2092	84.4%	209.8	6.9	140.0	4.6
Butte County	73	2.9%	14	19.2%	59	80.8%	255.7	8.4	267.0	8.8
Clark County	59	2.4%	24	40.7%	35	59.3%	586.5	19.3	539.0	17.7
Colorado	104	4.2%	23	22.1%	81	77.9%	259.3	8.5	251.0	8.3
Nebraska	143	5.8%	50	35.0%	93	65.0%	382.1	12.6	320.0	10.6
Oklahoma	85	3.4%	13	15.3%	72	84.7%	288.1	9.5	271.0	8.9
Pima County	142	5.7%	50	35.2%	92	64.8%	256.2	8.4	220.5	7.3
Riverside	265	10.7%	40	15.1%	225	84.9%	229.6	7.6	238.0	7.8
Sacramento	869	35.1%	80	9.2%	789	90.8%	191.9	6.3	121.0	4.0
San Luis Obispo	423	17.1%	25	5.9%	398	94.1%	89.6	3.0	112.0	3.7
Santa Barbara	138	5.6%	26	18.8%	112	81.2%	186.6	6.1	147.5	4.9
Santa Cruz	**74**	**3.0%**	**11**	**14.9%**	**63**	**85.1%**	**271.2**	**8.9**	**247.0**	**8.1**

[73] **Based on 2086 cases, 6 cases missing file closed date. Closed cases refer to those families no longer actively participating in CAM services.**

Table B1: Overall Assessment of Grantees and Site Visit Recommendations

	Requires intervention – for example, grantee is significantly behind in serving clients, obtaining needed performance indicator data or lagging in involvement and buy-in from key partners	**Meets Expectations** – for example, grantee is making steady progress with no major problems and/or is working effectively to address identified problems	**Exceeds Expectations** – for example, grantee is meeting or exceeding projected number of clients served, has developed protocols and processes to collect indicator data and is not experiencing any problems reporting data, has implemented evidence-based practices to serve clients, and has made significant changes in practice that appear likely to improve child and family outcomes	**Priority** – grantee experiencing multiple challenges and needs site visit ASAP
TOTAL (12)	**1**	**10**	**1**	**0**
Butte		Y		
Clark County		Y		
Colorado		Y		
Dunklin County		Y		
Nebraska		Y		
Oklahoma		Y		
Pima		Y		
Riverside		Y		
Sacramento			Y	
San Luis Obispo		Y		
Santa Barbara	Y	Y		
Santa Cruz				

Table B2: Grantees in Which Given Area[74] was Assessed as One of Grantee's Greatest Successes or Greatest Challenges

	TOTAL (12)		Butte		Clark County		Colorado		Dunklin County		Nebraska		Oklahoma		Pima		Riverside		Sacramento		San Luis Obispo		Santa Barbara		Santa Cruz	
	Success (S)	Challenge (C)	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C	S	C
Collaborative Values/ Principles	7 58.3%	1 8.3%	Y								Y			Y	Y		Y		Y		Y				Y	
Client Screening/ Assessment	1 8.3%	1 8.3%									Y							Y								
Client Engagement/ Retention	3 25.0%	4 33.3%	Y									Y			Y			Y			Y			Y		Y
Services to Children	3 25.0%	0 0.0%			Y								Y												Y	
Information Sharing/Data Systems	2 16.7%	3 25.0%		Y		Y				Y			Y				Y									
Joint Accountability/ Shared Outcomes	2 16.7%	2 16.7%		Y									Y			Y	Y									
Budget/ Sustainability	10 83.3%	1 8.3%	Y		Y			Y	Y		Y		Y		Y				Y		Y		Y		Y	
Staff Training/ Development (inc. hiring staff)	3 25.0%	2 16.7%				Y	Y				Y			Y							Y					
Working with Related Agencies	8 66.7%	2 16.7%			Y		Y			Y	Y		Y		Y				Y		Y		Y	Y		
Building Community Supports	5 41.7%	0 0.0%							Y						Y				Y				Y		Y	
Other: (see footnotes)	0 0.0%	2 16.7%										Y										Y				

Note: Other challenges include continuing challenges with poor performance by some of the contracted therapists (NE) and staff retention (SLO).

[74] **Areas reflect the 10-Element Collaborative Framework. Of the 10 elements, PMLs could indicate more than one area as a success or a challenge. Percentages reflect if a given element was checked off; percentages do not add to 100 because an element may not have been indicated as either a success or a challenge.**

Table B3: Grantees Overall Program Status

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Changes to Program Model/Design													
No	9 75.0%	N	N	N	N	N			N	N		N	N
Yes	3 25.0%						Y	Y			Y		
If yes, types of changes:													
Project Staffing	1 8.3%										Y		
Addition of services/ component	2 16.7%						Y	Y					
Expanded scope of target population	1 8.3%						Y						
Achieving Primary Project Goals	12 100%	P	SP	SP	SP	P	SP	P	SP	SP	P	P	P
Grants Management Issues	1 8.3%											Y	

Note: P = progress; SP = significant progress.

Table B4: Collaboration with Partners

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Challenges with Adequate Identification, Engagement and/or Support of Key Partners:													
No	6 50.0%		N					N	N	N	N		N
Yes	6 50.0%	M		M	M	M	M					M	
Partner Problems													
New	0 0.0%												
Ongoing	6 50.0%	0		0	0	0	0					0	
Type of Problem													
Child Welfare	2 16.7%						Y					Y	
Substance Abuse Treatment	3 25.0%					Y	Y					Y	
Family Drug Court/Judge	2 16.7%	Y					Y						
Dependency Court/Judge	2 16.7%	Y					Y						
Adult Mental Health	3 25.0%				Y	Y	Y						
Children's Mental Health	3 25.0%				Y	Y	Y						
Other: (see footnotes)	1 8.3%			Y									
Stage of Collaboration		3	3	2	3	2	2	4	3	3	3	2	3
Factors Assisting Collaboration													
Breadth of Collaboration	3 25.0%		Y					Y				Y	

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Oversight	7 58.3%	Y	Y					Y	Y	Y	Y		Y
Policy Leaders involved	4 33.3%			Y				Y		Y	Y		
Program Leadership Support	10 83.3%	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y
Forged a Strong & Influential Cross-Systems Collaboration beyond Scope of CAM	5 41.7%							y	y	Y	Y		Y
Regularly Reviews Barriers to Collaboration	6 50.0%		Y	Y				Y	Y	Y	Y		
Identify, Acknowledge & Work through Value-laden issues	1 8.3%							Y					
Use Results to Improve Outcomes	2 16.7%						Y	Y					
Regularly Reviews Outcomes & Resources to Address Challenges	3 25.0%							Y	Y		Y		
Engages in Sustainability Discussions w/ Partners	3 25.0%		Y			Y		Y					
Asks Partners what is needed to improve outcomes	2 16.7%							Y	Y				
Tracks referred clients receipt of services	1 8.3%							Y					
CAM fully Integrated in FTDC													
Yes	12 100%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Overall Assessment of Collaboration													
Below Expectations	2 16.7%					Y						Y	
Meeting Expectations	8 66.7%	Y		Y	Y		Y		Y	Y	Y		Y

***Note*: S = significant challenges with key partners. M = moderate challenges with other partners. Other problem types included problems with probation (CO).**

Table B5: Identifying and Enrolling/Serving Clients

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Grantee submitted and COTR approved reduction in numbers to be served													
No	12 100.0%	N	N	N	N	N	N	N	N	N	N	N	N
Met and/or exceeded projected numbers													
Children	8 66.7%	Y	N	Y	Y	N	Y	Y	Y	Y	Y	N	N
Adults	7 58.3%	Y	N	Y	Y	N	Y	N	Y	Y	Y	N	N
Families	5 41.7%	Y	N	Y	Y	N	N	N	Y	Y	N	N	N
If not met, primary reasons													
Getting referrals	4 33.3%		Y			Y		Y				Y	
Engaging/enrolling after referral	1 8.3%							Y					
Shifts in target population	1 8.3%											Y	
Other	4 33.3%	Y				Y	Y	Y					
If not met, new or ongoing problem													
New	2 16.7%		N				N						
Ongoing	4 33.3%					0		0				0	0
Degree identified& addressing problem													

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Identified next steps, but no concrete action taken yet	1 8.3%											Y	
Concrete steps expect increase in numbers	4 33.3%		Y			Y		Y					Y
Other	1 8.3%						Y						
Overall Assessment of Engagement/ Retention													
Below Expectations	3 25.0%					Y		Y				Y	
Meeting Expectations	8 66.7%	Y	Y	Y	Y		Y		Y		Y		Y
Exceeding Expectations	1 8.3%									Y			
Identifying and Responding to Children's Needs													
Progress in Year 4													
Effective in both identifying and responding	11 91.7%	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
Effective in both identifying and providing referrals	1 8.3%									Y			
Overall assessment													
Effective in both identifying and responding	11 91.7%	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
Effective in both identifying and providing referrals	1 8.3%									Y			

Note: Other reason not met included major shift in staffing at CPS with new dedicated unit opening in January 2014 (Pima), lower number of children per family than estimated (NE), New staff/team members and changes at child welfare (Clark), and families low because serving more two parent families than originally anticipated (OK). Other reason for degree identified is that no action is needed as only low in number of families (OK).

Table B6: Staffing/Training

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Grantee facing programmatic staffing challenges (e.g., turnover, vacancies):	5 41.7%		Y		Y	Y	Y	y					
Staff turnover/ retention of key positions	3 25.0%		Y		Y		Y						
Staff vacancies impacting service delivery	2 16.7%				Y			Y					
Hiring qualified staff	1 8.3%							Y					
Other staffing changes	2 16.7%					Y	Y						
Grantee facing evaluation staffing challenges (e.g., turnover, vacancies, evaluators not working with program staff):	2 16.7%							Y			Y		
Staff turnover/ retention of key positions	2 16.7%							Y			Y		
Lack of communication - program and evaluation	1 8.3%							Y					
Insufficient evaluation staff/resources for tasks	1 8.3%							Y					

Note: Other staffing challenges included staffing changes imposed by the judge (OK) and poor performance for some contracted therapists despite efforts of the Project Director (NE).

Table B7: Evaluation/Data Collection and Reporting

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Difficulty in *collecting* needed performance indicator data:													
No	9 75.0%	N		N	N	N			N	N	N	N	N
Yes	3 25.0%		Y				Y	Y					
If yes, type of data having trouble accessing:													
Difficulty accessing child welfare data	*2* *16.7%*		*Y*				*Y*						
Problems quality/consistency of data	1 83.3%							Y					
Difficulty analyzing/interpreting data	1 83.3%							Y					
Other data problem	1 83.3%							Y					
Difficulty in accessing/collecting *comparison/control group* data:													
No	1 83.3%									N			
Yes	2 16.7%		Y				Y						
No comparison/ control group	9 75.0%	Y		Y	Y	Y		Y	Y		Y	Y	Y
If yes, type of data having trouble accessing:													
Difficulty accessing child welfare data	2		Y				Y						

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
	16.7%												
Provided Local Evaluation Report	10	1		1		1	2	3	1	3	1	1	2
	83.3%												
Overall Assessment of Evaluation and Data Collection/Reporting													
Below Expectations	1							Y					
	8.3%												
Meeting Expectations	10	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y
	83.3%												
Exceeding Expectations	1						Y						
	8.3%												

Note: Other treatment group data concern is the team has identified problems with their uploaded data and is working new evaluator to solve problem. Evaluation report 1 = BAPR only, 2 = separate report, 3 = BAPR & separate report.

Table B8: Budget and Sustainability

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Grantee experiencing any major budgeting problems:													
No	11 91.7%	N	N	N	N	N	N	N	N	N	N		N
Significantly under budget	1 8.3%											Y	
Status on sustainability planning													
Initial sustainability discussions	1 8.3%								Y				
Engaged in active sustainability discussions	11 91.7%	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Sustainability tasks:													
Developed inventory of major funding sources	4 33.3%				Y		Y	Y			Y		
Developed sustainability plan	5 41.7%				Y		Y	Y		Y	Y		
Identified components to sustain	11 91.7%	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Identified outcomes to market	6 50.0%		Y		Y	Y	Y	Y					Y
Identified targets for future/ redirected funding	9 75.0%		Y	Y	Y	Y	Y	Y		Y	Y		Y
Identified targets for policy/practice changes	6 50.0%	Y	Y	Y		Y	Y	Y					
Identified/ Engaged stakeholders for discussion	12 100%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Applied for grant, pending funding	4 33.3%		Y		Y		Y						Y

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Received grant	4 33.3%		Y			Y		Y	Y				
Engaged in/plan to do cost analysis	4 33.3%		Y	Y			Y		Y				
Biggest barriers to sustainability:													
Lack of knowledge re: available funding streams	2 16.7%				Y				Y				
Lack of knowledge re: current/existing funding streams	1 8.3%				Y								
Have not figured out how to leverage resources and/or work with related initiatives (e.g., ATR)	2 16.7%				Y		Y						
Do not have data yet to identify effectiveness	5 41.7%	Y	Y	Y				Y	Y				
Do not know/lack of agreement on what to sustain	1 8.3%								Y				
Other	3 25.0%			Y		Y	Y						
PML sustainability assessment:													
Potential to sustain in current form/model	8 66.7%		Y		Y	Y	Y	Y		Y		Y	Y
Potential to sustain only specific components	3 25.0%	Y		Y							Y		
Unable to determine at this time	1 8.3%								Y				
Overall Assessment of Sustainability													
Below Expectations	1 8.3%			Y									

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Meeting Expectations	8 66.7%	Y			Y	Y	Y		Y	Y		Y	Y
Exceeding Expectations	3 25.0%		Y					Y			Y		

Note: Other sustainability barriers include a very narrow target population (criminal cases only) and trust issues within the collaboration (CO), effectiveness not established and efforts in process seeking state funding for coordinators (NE) and ineffective or poor relationships and communication across systems (OK).

Table B9: Significant Community/Contextual Events

	TOTAL (12)	Butte	Clark County	Colorado	Dunklin County	Nebraska	Oklahoma	Pima	Riverside	Sacramento	San Luis Obispo	Santa Barbara	Santa Cruz
Grantee experiencing any significant community/contextual events:													
No	6 50.0%	N	N		N	N				N			N
Yes	6 50.0%			Y			Y	Y	Y		Y	Y	
Larger contextual events													
Budget cuts/layoffs	1 8.3%										Y		
Legislative/policy changes	1 8.3%			Y									
State/County/Other agency personnel changes	1 8.3%							Y					
New grant/related initiative changes	1 8.3%						Y						
Other contextual event	2 16.7%						Y		Y				
Environmental/community factors													
Changes in substance use/treatment trends	2 16.7%			Y				Y					
Changes in child welfare trends/caseloads	1 8.3%											Y	
Impact of budget cuts/layoffs	1 8.3%												
Reductions/changes in other agency staff	1 8.3%										Y		

Note: Other contextual events include child welfare hiring approximately 100 social workers (Riverside) and federal injunction requiring massive reconstruction of child welfare system (OK).

Appendix C: Grantee Level Summaries

Each grantee's progress is summarized in this appendix. Site summaries provide information about the activities the grantee proposed to implement, any key changes to that plan, important accomplishments, and plans to sustain their efforts after grant funding ends. Each summary ends with a table including all of the site's performance indicators. The performance indicator table includes, for the first time in this report, a column including contextual information regarding the communities served by the grantee. In most cases, these data are drawn from the state's Adoption and Foster Care Reporting System (AFCARS) and Treatment Episode Data System (TEDS). These data are reviewed along with the rest of the site summary during site visits and the information is used in discussions about sustainability planning.

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Butte Site Summary

The Butte County Children Affected by Methamphetamine (CAM) Project, served children and families participating in the Family Treatment Court (FTC). The CAM Project's objectives were to expand and enhance services to young children, their parents and caregivers by creating a comprehensive family-centered approach. CAM services were provided to children aged 0-5 who were participating in the FTC. Key service elements included the following:

- *Nurturing Parenting in Recovery* –a 16-week evidence-based interactive parenting program which offered parenting classes, parent modeling and coaching and involved the entire family, as parents and children learned skills to prevent future abuse and neglect. Parents participated in classroom instruction, followed by group time with their children. This program was co-facilitated by a child welfare social worker and AOD counselor and included in-home coaching.
- *Ages and Stages Questionnaires (ASQ)* –were completed for all children as they entered the CAM program. By implementing systematic ASQ screenings, the Project staff ensured that children were assessed for developmental disabilities and received necessary early intervention services.
- *Peer Parent Mentor Support* – worked with participants to provide peer support throughout the family's participation in CAM and FTC programs. Drawing from their own experiences as FTC graduates, mentors also provided educational support to child's foster or kin care provider regarding the process of recovery as well as providing advocacy to the parents as they participated in the FTC program.

The CAM/FTC program was part of the one strategy in the Butte County's System Improvement Plan (SIP) to improve re-entry rates following reunification. According to the grantee, CAM related services have increased Butte County's ability to provide comprehensive services to children, parents, and caregivers to enhance success and reduce potential for re-entry into the program.

What did the site set out to accomplish?

Butte CAM proposed to serve 124 children and 96 adults throughout the four-year grant program. Through August 2014, Butte CAM has served 91 adults and 130 children. As of the end of August 2014, Butte CAM exceeded its four-year goal for serving children and served 95.8% of proposed adults. The CAM project set out to expand and enhance services to the existing FTC program by providing the following services:

- Nurturing Parenting in Recovery (NPR)
- Ages and Stages Questionnaires (ASQ)
- Peer Parent Mentors (PPM)

Service enhancements focused particular attention to the developmental expectations and consistent parenting that help children thrive. In addition to NPR, the caregiver education and support groups, developmental screenings and PPMs, all promote the sensitive, consistent and development-informed parenting that CAM children needed. This focus started in out-of-home placement and continued through reunification and reflected the comprehensive approach of CAM service delivery.

How did that plan change and why?

This plan has been successfully implemented despite some unanticipated changes during Year 3 of the grant. There were several staffing changes on the county level, and a new judge was assigned to the dependency and FTC court programs (effective January 2013). Shortly thereafter, in March 2013,

judicial leadership in FTC was again transferred to another judge at the request of the dependency court judge; resulting in the implementation of a parallel court model (Butte County FTC had followed an integrated model since its inception in 2007) and changes to the court schedule. The abruptness of these changes created some confusion initially, but there have been no significant issues as a result of this transition.

Butte CAM fell behind in projected numbers of new entries for Year 3, for several months, due to an overall reduction in referrals to Child Welfare. This reduced client intake was monitored closely to ensure that all prospective families were identified and referred to the program. During the Year 3 site visit, several ideas were discussed to see if other strategies would result in new entries into the program including increasing the age eligibility criteria from 0-5 years to 0-8 years. Butte County CAM piloted the increased age criteria for several months, but this did not result in any new families entering the program. Beginning in Spring 2013, referrals to Child Welfare returned to a more normal level, families were identified for the program and goals were met for this reporting period. These adjustments did not result in changes to the overall plan and goals of the grant. Butte CAM successfully implemented the identified services and met the four-year goals of the grant.

What was unique about this effort?

One highlighted feature of the CAM project included the provision of training and support to foster parents and relative caretakers for the CAM children. In partnership with the Options for Recovery Program, training and support was provided for out-of-home caregivers with particular focus on ways to deal effectively with family dynamics, sensitive parenting techniques and education. Participant caregivers have provided positive feedback regarding their participation in these groups. The Project also provided training and education to kinship caregivers by implementing the Nurturing Parenting curriculum to ensure that children would receive consistent care by having parent and relative caregivers receive the same parenting information and skills. Caregivers provided strong positive feedback and appreciated the opportunity to connect with other caregivers in a safe and nurturing environment. Additionally, Parent Peer Parent Mentors also spoke at foster parent training and provided information about the recovery process to foster parents and relative caregivers.

What were the key accomplishments?

One of the key accomplishments for the Butte County CAM Project was the implementation of the Nurturing Parenting (NP) in Recovery Program. With direct consultation with the principal author of the Nurturing Parenting Programs® (NPP) curriculum, Stephen Bavolek, Ph. D, the grantee developed an integrated curriculum called Nurturing Parenting in Recovery (NPR) to address the unique learning needs of parents in recovery. NPR combined curriculum material from the NPP Infant, Toddler and Pre-school Program and Substance Abuse Programs. Co-facilitation of the Nurturing Parenting in Recovery parenting NP Program, both in-class and in-home instruction, was implemented by a substance abuse counselor and CWS social worker. By offering multi-agency facilitators in classrooms and in-home settings, the grantee was able to meet the ongoing and complex learning needs of CAM parents. Overall, participants were pleased with the program and the facilitators' enthusiasm, knowledge, training skills and ability to make them feel welcome.

Another accomplishment was the grantee's progress in the hiring, training and supervision of three Parent, Peer Parent Mentors. The Peer Parent Mentors participated in an array of training and professional development activities, including parent leadership development, child welfare system trainings, and Signs of Safety. As a result, the supervision and training provided to the Parent Mentors significantly enhanced their skills and increased their professionalism.

Finally, the grantee was successful in building collaborative support services across agencies. The majority of the CAM and FTC services were provided by CWS and AOD. With strong and regular participation of CWS and AOD staff, the staff meetings provided a comprehensive discussion about individually participating families, including progress in placement stability, extended family support and other CWS developments that may influence the case plan.

Table C1: Butte Performance Indicators

Indicator	Grantee Performance[75]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	33.3% Of those who were at home at time of enrollment[76]	Not Available
C2. Recurrence of maltreatment	No recurrence reported Within 6 months of CAM entry	7.4% *Disposed Oct 1, 2012 to Mar 31, 2013 – Victims Re-victimized within 6 Months (California Child Welfare Indicators Project)*
C3. Median Length of Stay in Foster Care	262.0 days	270.0 days *Median Length of Stay in Foster Care Oct 1, 2012 to Mar 31, 2013 (California Child Welfare Indicators Project)*
C4. Re-entries to Foster Care within 12-months of reunification	0.0%	13.8% *Butte County Children Removed to Foster Care During Oct 1, 2011 to Sep 30, 2012 – Re-entries to Foster Care within 12 months of Previous Discharge (California Child Welfare Indicators Project)*
C5. Timeliness of reunification	81.6% Reunified within 12 months of removal	50.0% *Butte County Children Discharged During April 1, 2012 to Sep 30, 2012 – Discharged to Reunification within 12 Months (California Child Welfare Indicators Project)*
C6. Timeliness of permanency	100.0% Exited to adoption or guardianship within 24 months of removal	14.7% *Butte County Children Exited to Permanency During Oct 1, 2011 to Sep 30, 2012 – Exits to Permanency, less than24 months in care (California Child Welfare Indicators Project)*

[75] **Grantee performance through September 30, 2014.**

[76] **For Butte, 6.6% of the children were in-home at time of CAM enrollment.**

Indicator	Grantee Performance[75]	Other Contextual Performance Information (specify)
C7. Prevention of SEN	One birth subsequent to CAM enrollment did not test positive for substance exposure	Not available
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Developmental: 60.0%	Not available
A1. Access to Treatment[77]	Mean: 22.7 days Median: 7.0 days	Mean: 2.1 days Median: 0.0 days *Days Waiting to Enter Treatment within Butte County During 2010 (TEDS-A78)*
A2. Retention in Substance Abuse Treatment	54.4% Completed 4.4% Transferred Completed Median length: 443.0 days Transferred Median length: 243.0 days	49.5% Completed *Reasons for Discharge within Butte County During 2010 (TEDS-D)*
A3. Substance Use (reduction)	Alcohol: 87.5% Marijuana: 84.6% Heroin/Other Opiates: 100.0% Methamphetamine: 91.7%	Not available
A4. Connected to Supportive Services	Of those assessed, percentage who received services: Mental Health: 100.0% Transportation: 100.0% Housing: 100.0% Parenting: 100.0% Continuing Care: 100.0%	Not Available
A5. Employment Status	Employed F/T or P/T Admission: 6.7%	Admission: 13.8% Discharge: 16.8%

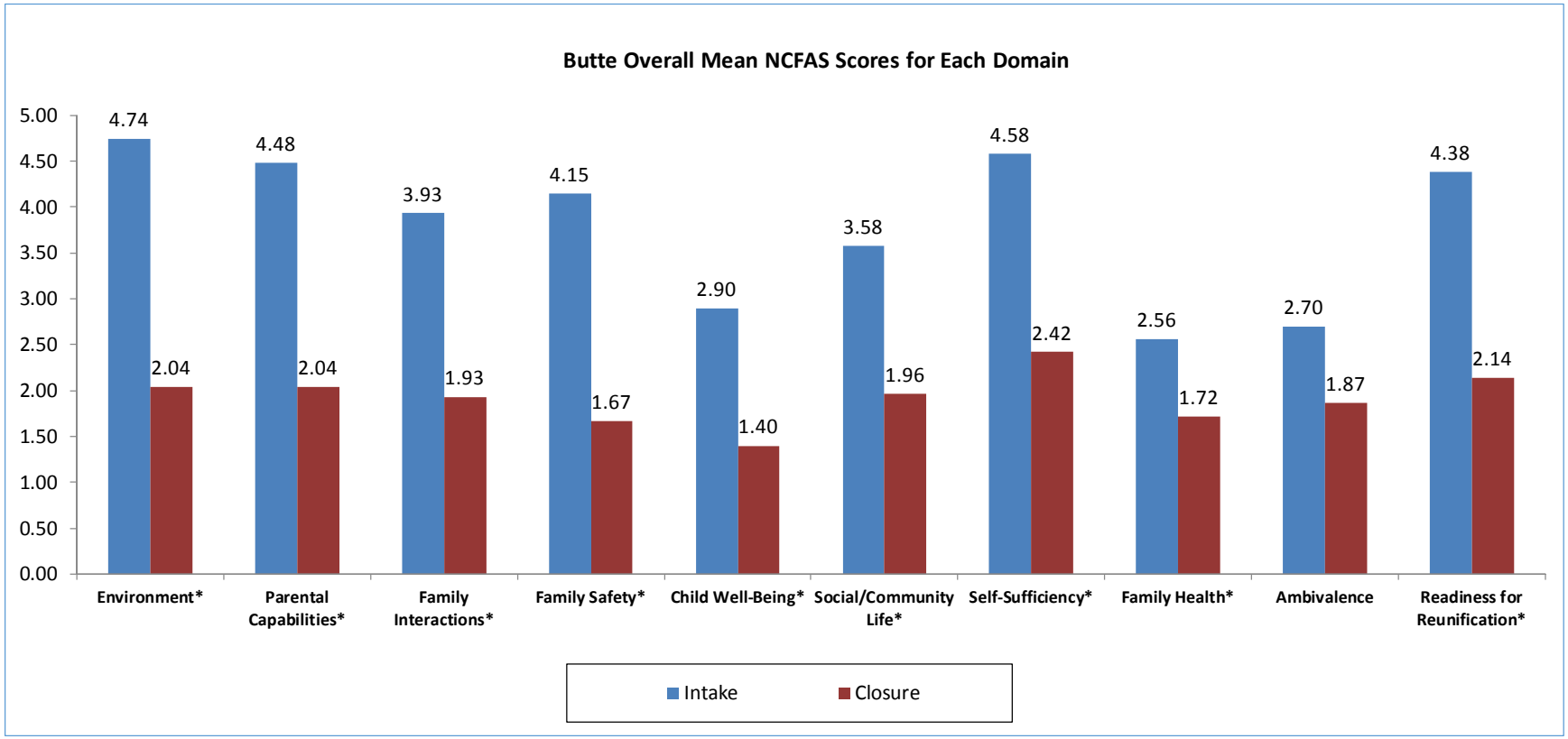
[77] The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Butte, this was 14.6% of the adults who entered substance abuse treatment services.

[78] Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions (TEDS-A) and discharges (TEDS-D) through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Indicator	Grantee Performance[75]	Other Contextual Performance Information (specify)
	Discharge: 50.0% Enrolled in education or vocational training Admission: 1.6% Discharge: 3.3%	*Employed F/T or P/T within Butte County During 2010 (TEDS-A, TEDS-D)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 72.63% Discharge: 96.8%	Admission: 91.0% Discharge: 90.6% *Arrests within Butte County During 2010 (TEDS-A, TEDS-D)*
Average Length of Services for Closed CAM Cases[79] Median number of days (months) engaged in CAM	267.0 days (8.8 months) Based on 59 of 73 families	Not available

[79] **See Table 1 in Appendix B for more details.**

Figure C1: Butte Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$. Lower scores indicate improvement.

Clark Site Summary

The Clark County Children Affected by Methamphetamine (CAM) project provided family-centered services to participants in the Family Treatment Court-Striding Towards Excellent Parenting (FTC-STEP) program. The program applied results of in-depth neuro-psychological testing to better understand behavioral strengths and needs of the children and parents.

The number of children and families that entered the FTC and accessing CAM services was below targets from the last year. However, the team identified and addressed challenges with the referral process and recognized positive changes to the numbers served by the court. According to the monthly numbers reported to the PML in August 2014, 87 adults and 126 children received CAM services. These numbers are 111.5% and 92.6% of the projected adult and children targets, respectively.

What did the grant set out to accomplish?

The Clark county Family Treatment Court proposed to treat children affected by methamphetamines and their parents utilizing evidence-based neuro-psychological testing and individualized parent coaching services.

Specific, grant-funded strategies included:

- *Delis-Kaplan Executive Function System (D-KEFS)* – In-depth neuro-psychological testing for parents. The psychologist who conducted the tests and analyzed the results attended FDC team and parent staffing meetings to offer insight into parenting behaviors, skills and needs for support.
- *COACHES - Enhanced Model* – Neuro-cognitive behavioral intervention and service coordination supported a therapeutic recovery process for the children.
- *Parent training programs* – Multiple parenting programs were available and provided based on the specific needs of each family. Options included Triple P (Positive Parenting Program), Incredible Years, and Circles of Security; and,
- *Parent-Child Interaction Therapy (PCIT)* – Treatment for young children with emotional and behavioral disorders that focused on improving the quality of the parent-child relationship. PCIT included both child and parent directed interactions, strategies for safe and effective disciplinary actions and development of new behaviors and communication skills.

How did this plan change, and why?

This grantee's program was implemented largely as planned with just a few modifications to CAM services.

- The program name was changed from CAM to "Enhanced Services" to decrease stigma;
- PCIT was not implemented as part of the enhanced services but was available for families through referral from child welfare;
- Alumni and peer mentoring services were added; and,
    - The Children's Center added a second psychologist to sustain increased demands and to amplify responsiveness to the court's requests for more timely report submissions.

They also made changes to the family drug court program including the additions of:

- A 4th phase which allowed the team to continue supporting families after reunification and aligned the timing of the child welfare case with FDC graduation; and,
- A "status docket" which allowed the team to remain in contact with families who needed more time to fully engage or to reengage in treatment.

What did this project accomplish?

Clark is the only CAM-funded site that applied comprehensive neuro-psychological evaluations to educate the parents and team members about cognitive strengths and weakness. The team's psychologist suggested modifications or supports necessary for the parent to successfully complete their case plan/treatment plan. She also explained to the parents how the brain would continue to heal as they moved further into recovery.

Other significant accomplishments included:

- Revision of the program handbook to assist with orientation and parent engagement;
- Consistent implementation of program improvement efforts based on recommendations from the local evaluation team; and,
- Soliciting, listening to and acting on concerns from child welfare about the heavy workload for CW workers with families participating in FDC.

Clark is planning to sustain all of the program components previously supported by CAM funding. Specifically:

- Child welfare, local tax revenue, and mental health funding would support some, if not all of the parenting education programs, the neuropsychological evaluations (including recommended treatment), and the Case Coordinator position;
- The team operated to negotiate use of substance abuse block grant funds to support peer-to-peer mentoring;
- The Administrative Offices of the Court (AOC) would continue to support the FDC Coordinator position; and,
- Clark County would support the Treatment Coordinator Position.
- Select results from the locally conducted evaluation for Clark County were extracted from their final report and are included below.

Comparison Group Outcomes.

The Grantee used a historical comparison group to examine the effectiveness of the implementation of the CAM enhancement in their local evaluation report (a summary of outcomes follows). The FTC-CAM participants included in the evaluation are those that enrolled between October 2010 and June 2013. The historical comparison groups (FTC Pre-CAM) were all participants who entered FTC between January 2007 and August 2010. Analyses found significant differences in child safety and permanency outcomes and adult outcomes due to the CAM enhancement.

- Parents in families that received the CAM enhancement (FTC-CAM) were perpetrators in maltreatment allegations significantly less often than FTC Pre-CAM parents at 2 year post entry.
- FTC-CAM children were victims of fewer allegations over time compared to FTC Pre-CAM children, although this trend was not statistically significant.
- FTC CAM children spent fewer days in out of home care over time than FTC PreCAM, though the differences were not statistically significant.
- When the days in out of home placements for all the children of each FTC-CAM parent were combined and compared to the combined days of FTC Pre-CAM parents, the difference in days *per parent* was statistically significant. FTC-CAM *parents* showed significant reduction in days their children spent out of home (at 2 years). For all of their children combined the averaged total for FTC-CAM parents was 363 days out of home and the averaged total for all of the children combined for FTC Pre-CAM parents was 615 days out of home.
- FTC-CAM participants had fewer removals post program entry for children than FTC Pre-CAM participants, although the difference was not significant.
- The percentage of FTC Pre-CAM children who experienced any changes in placement while out of home was significantly higher than FTC-CAM children each year up to 3 years after entry.
- FTC-CAM showed improved reunification rates compared to FTC Pre-CAM, though the difference was not significant.
- FTC-CAM participants also had fewer rearrests than FTC Pre-CAM participants. While these results were not statistically significant, the difference between groups is large enough to be meaningful in each year post program entry.
- FTC-CAM participants did show a trend for reduction in arrests when compared to FTC Pre-CAM participants across all types and levels, though the differences were not statistically significant.
- For those program participants who entered residential treatment, FTC-CAM participants were significantly more likely to have successfully completed within 2 years than FTC Pre-CAM participants.

Table C2: Clark Performance Indicators

Indicator	Grantee Performance[80]	Other Contextual Performance Information (Specify)
C1. Children Remain at Home throughout CAM participation	87.0% Of those who were at home at time of enrollment[81]	Not Available
C2. Recurrence of maltreatment	1.6% Within 6 months of CAM entry	7.5% *Recurrence of Maltreatment within 6 Months in Washington During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C3. Median Length of Stay in Foster Care	645.5 days	444.0 days *Median Length of Stay in Foster in Washington During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C4. Re-entries to Foster Care within 12-months of reunification	0.0%	10.1% *Re-entries to Foster Care within 12 months of Previous Discharge in Washington During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C5. Timeliness of reunification	10.4% Reunified within 12 months of removal	64.0% *Discharged to Reunification within 12 Months in Washington During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C6. Timeliness of permanency	0.0% Exited to adoption or guardianship within 24 months of removal	38.2% *Exits to Permanency, less than24 months in care, in Washington During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C7. Prevention of SEN	Two of five births subsequent to CAM enrollment tested positive for substance exposure	Not available

[80] Grantee performance through September 30, 2014.

[81] For Clarke, 28.4% of the children were in-home at time of CAM enrollment.

Indicator	Grantee Performance[80]	Other Contextual Performance Information (specify)
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Primary Pediatric Care: 99.1% Mental Health: 98.9% Developmental: 97.5% Neurological: 100.0%	Not available
A1. Access to Treatment[82]	Mean: 132.4 days Median: 45.0 days	Not Available
A2. Retention in Substance Abuse Treatment	56.6% Completed 4.8% Transferred Completed Median length: 208.0 days Transferred Median length: 123.0 days	46.2% Completed *Reasons for Discharge within Clark County During 2010 (TEDS-D83)*
A3. Substance Use (reduction)	Alcohol: 25.0% Marijuana: 50.0% Heroin/Other Opiates: 20.0% Methamphetamine: 34.5%	Not available
A4. Connected to Supportive Services	Of those assessed, percentage who received services: Primary Medical Care: 84.6% Mental Health: 94.6% Child Care: 93.2% Transportation: 100.0% Housing: 96.7% Parenting: 96.4% Continuing Care: 90.9% Trauma: 93.2%	Not Available

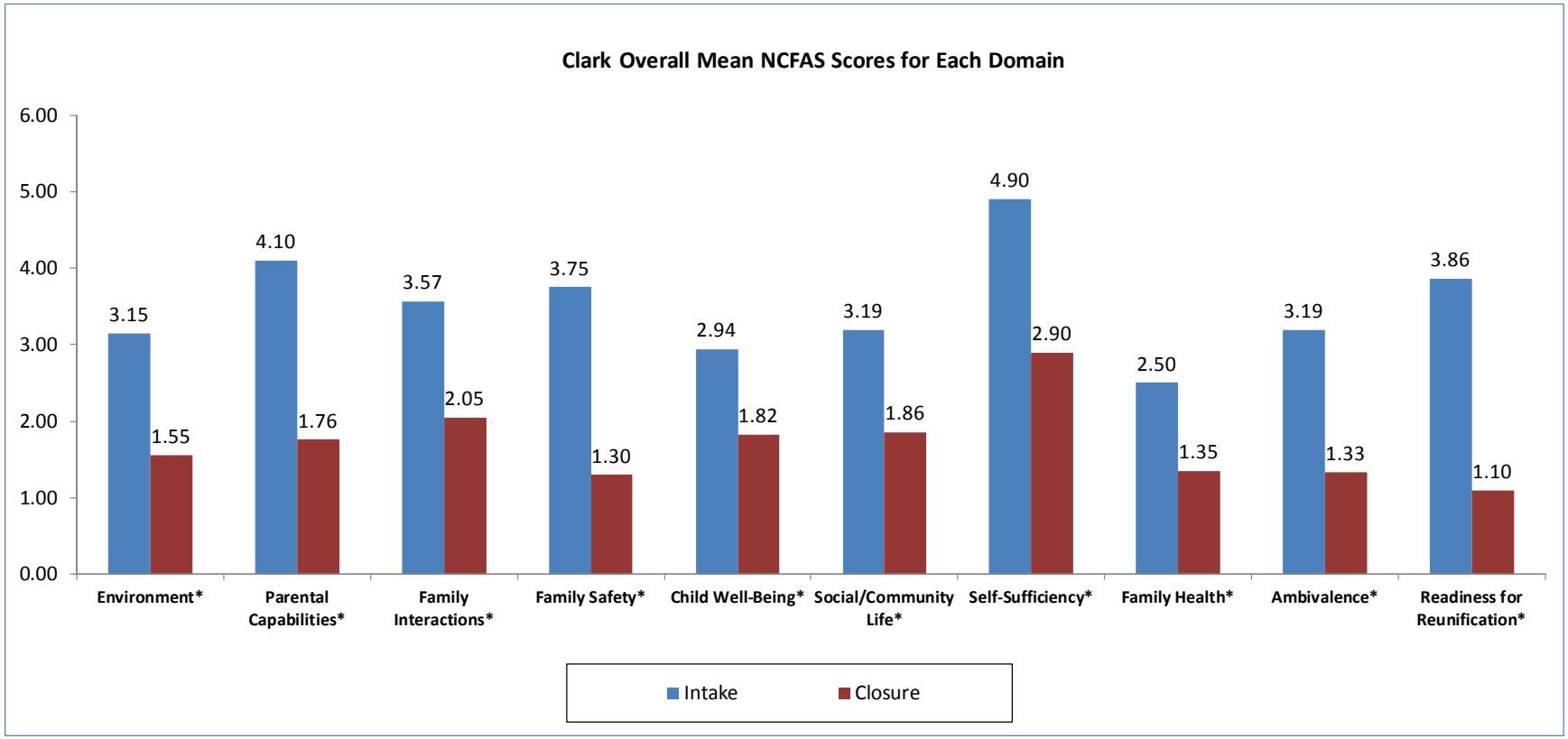
[82] The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Clark, this was 56.2% of the adults who entered substance abuse treatment services.

[83] Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions (TEDS-A) and discharges (TEDS-D) through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Indicator	Grantee Performance[80]	Other Contextual Performance Information (Specify)
	Legal: 100.0%	
A5. Employment Status	Employed F/T or P/T Admission: 5.1% Discharge: 13.6% Enrolled in education or vocational training Admission: 1.6% Discharge: 3.1%	Admission: 27.4% Discharge: 26.4% *Employed F/T or P/T within Clark County During 2010 (TEDS-A, TEDS-D)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 87.5% Discharge: 92.2%	Admission: 93.1% Discharge: 93.0% *Arrests within Clark County During 2010 (TEDS-A, TEDS-D)*
Average Length of Services for Closed CAM Cases[84] Median number of days (months) engaged in CAM	539.0 days (17.7 months) Based on 35 of 59 families	Not available

[84] See Table 1 in Appendix B for more details.

Figure C2: Clark Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$.

Colorado Site Summary

The Children Affected by Methamphetamine (CAM) program in Denver, also known as CAMDEN, is part of the Denver Juvenile and Family Justice, Treatment Accountability for Safer Communities (TASC) program and the Family Integrated Drug Court (FIDC). CAMDEN is unique among CAM grantees for serving families who have an open child welfare case and a concurrent (though not necessarily related) criminal case with a sentence to probation or a high likelihood of a sentence to probation. They served families involved with Denver District Probation and expanded to include Denver County Probation in January 2013.

The Grantee was placed on a Corrective Action Plan (CAP) in 2012 for not completing their projected target numbers for adults and children. As a result of the CAP and the commitment of CAMDEN's leadership, significant adjustments were made to the program. The first change was a new partnership with the Denver County Courts and the Department of Probation leading to expansion of the target population and a second FIDC docket. The grantee was then on track to meet its goals in terms of the number of families served.

What did the grant set out to accomplish?

The grantee designed the CAMDEN project to expand services for the existing family treatment drug court program by adding the Community Outreach Program – Esperanza (COPE) intervention and the SafeCare home visitation model. The grantee designed this effort to address the immediate needs of children and youth who have been members of methamphetamine abusing families and provided treatment and intervention to help impede intergenerational cycles of substance abuse, criminal system involvement and other risk behaviors for parents and caregivers. The grantee intended to serve 200 children and 80 parents/caregivers throughout the life of the CAMDEN project.

Specific, grant-funded strategies included:

- Immediate screening and assessment for children and youth of parents with methamphetamine use involved in the FIDC;
- Evidence-based, culturally competent treatment and follow-up services for trauma-exposed children and youth ages 0 - 17 with methamphetamine abusing parents; and,
- Developed both the parents and caregivers, parenting capacity through evidence-based home visitation programming

How did this plan change, and why?

This grantee struggled early in the project to meet goals for the number of families to be served. Initially, referrals into the FIDC were on track to meet those goals but began to falter by the close of the first year of funding. With support from SAMHSA and the NCSACW, CAMDEN turned to three specific strategies to address this problem:

- Technical assistance from the NCSACW to focus on critical components of a treatment court model included the need for immediate identification and engagement in working with families impacted by substance use and mental illness;
- Worked with the Denver Department of Human Services (DDHS) to co-locate TASC staff at a DDHS facility; and,

- Identified cases at a county court level to improve recruitment into CAMDEN services

Significant improvements in recruitment and participation also came through new partnerships with the Denver County Probation and court system. TASC, with strong support and advocacy from the FIDC Judge created a new docket for parents involved with Denver County Probation and who had a concurrent Dependency and Neglect case with DDHS. Since beginning this new docket, referrals for parents from County Probation remained steady.

Another challenge for this team was the often slow movement of the criminal case relative to the mandated timelines for the dependency case. Originally, parents were not eligible to enroll in the FIDC until they were sentenced to Probation. Sentencing could occur several months or a year or more after the dependency case opened, too late for participation in the FIDC to be effective. With encouragement from CAMDEN leadership, the FIDC Judge and, Defense Counsel, County Probation agreed to address this problem by accepting parents into the FIDC prior to sentencing.

Finally, the grantee implemented SafeCare and COPE as planned. To be eligible for SafeCare, families needed to have physical custody of their children. Those in out-of-home care or guardianship were ineligible and did not receive this intervention.

What did this project accomplish?

Through August 2014 monthly numbers to the PML, CAMDEN had served 189 children and 101 adults since the initiation of the program. This represented 99.5% and 132.9% of the targets for children and adults, respectively.

CAMDEN services were provided to parents and children prior to enrollment in the family drug court, creating a unique setting compared with many of the other CAM sites. Services begin as soon as families were screened, contacted by TASC/CAMDEN staff and consented to participate. Another definitive strength of TASC/CAMDEN was active and continuous outreach. The Director, Coordinator and staff spent time out of the office searching for, and attempting to connect with, parents and their children. They recognized the challenges presented by addiction and they did not wait until the parent demonstrated that they were "ready for treatment." Instead, they utilized motivational interviewing and therapeutic use-of-self to engage parents receiving services. Use of assertive outreach did not end once the parent had enrolled in services. When parents relapsed or failed to arrive for treatment, court or other appointments the team followed up to re-engage them in treatment and services. Additionally, they continued to connect with clients even if they were in an in-patient or residential setting.

CAMDEN leadership would like to sustain all CAMDEN services and they were working to identify ongoing funding. They secured funding from the State Court Administrators Office (SCAO) for a permanent Specialty Court Coordinator. This new position was filled by the CAMDEN Children's Services Coordinator. They relied on grant funding for many of their services and continued to look for appropriate opportunities.

This year, they considered a request to the State Court Administrator's Office and the Department of Human Services for additional funding to support the following CAMDEN services:

- Trauma services provided by a community behavioral health center
- SafeCare

- COPE
- Intensive Case Management

Table C3: Colorado Performance Indicators

Indicator	Grantee Performance[85]	Other Contextual Performance Information (Specify)
C1. Children Remain at Home throughout CAM participation	75.8% Of those who were at home at time of enrollment[86]	Not Available
C2. Recurrence of maltreatment	1.8% Within 6 months of CAM entry	4.4% *Recurrence of Maltreatment within 6 Months in Colorado During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C3. Median Length of Stay in Foster Care	210.0 days	396.0 days *Median Length of Stay in Foster in Colorado During 2012(Children Bureau's Child Welfare Outcomes Report Data)*
C4. Re-entries to Foster Care within 12-months of reunification	12.5%	20.3% *Re-entries to Foster Care within 12 months of Previous Discharge in Colorado During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C5. Timeliness of reunification	76.0% Reunified within 12 months of removal	78.9% *Discharged to Reunification within 12 Months in Colorado During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C6. Timeliness of permanency	89.0% Exited to adoption or guardianship within 24 months of removal	55.4% *Exits to Permanency, less than 24 months in care, in Colorado During 2012(Children Bureau's Child Welfare Outcomes Report Data)*
C7. Prevention of SEN	The three births subsequent to CAM enrollment did not test positive for substance exposure	Not available

[85] **Grantee performance through September 30, 2014.**

[86] **For Colorado, 34.6% of the children were in-home at time of CAM enrollment.**

Indicator	Grantee Performance[85]	Other Contextual Performance Information (specify)
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Educational: 97.2% Mental Health: 100.0% Developmental: 100.0% Substance Abuse Prevention: 100.0% Substance Abuse Treatment: 92.1%	Not available
A1. Access to Treatment[87]	Mean: 21.7 days Median: 2.5 days	Mean: 3.4 days Median: 0.0 days *Days Waiting to Enter Treatment within Denver County During 2010 (TEDS-A88)*
A2. Retention in Substance Abuse Treatment	52.0% Completed 6.7% Transferred Completed Median length: 314.0 days Transferred Median length: 40.0 days	75.9% Completed *Reasons for Discharge within Denver County During 2010 (TEDS-D)*
A3. Substance Use (reduction)	Alcohol: 73.1% Cocaine: 62.5% Marijuana: 73.3% Heroin/Other Opiates: 71.4% Methamphetamine: 72.7%	Not available
A4. Connected to Supportive Services	Of those assessed, percentage who received services: Mental Health: 91.8% Child Care: 90.6% Transportation: 96.3%	Not Available

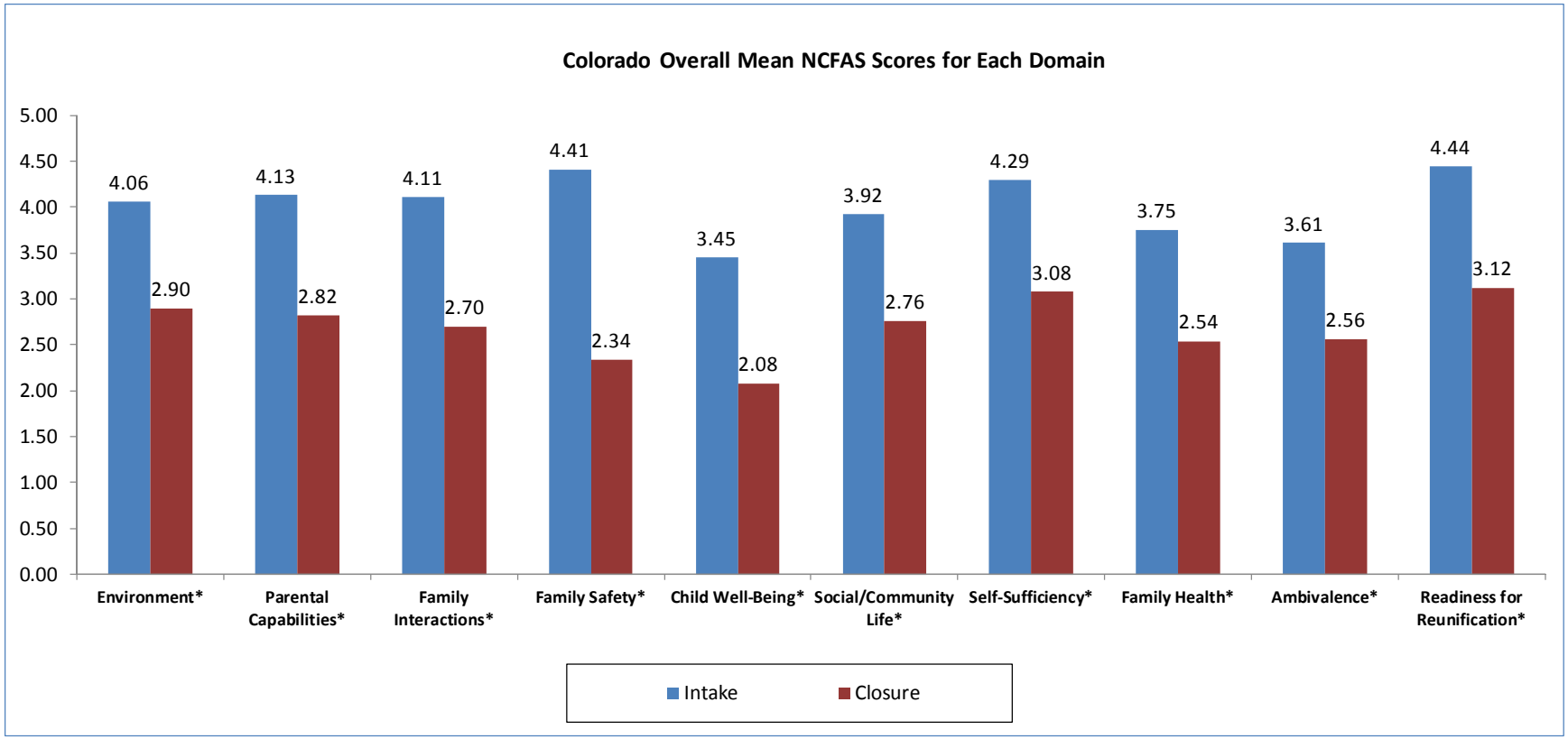
[87] The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Colorado, this was 65.4% of the adults who entered substance abuse treatment services.

[88]Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions (TEDS-A) and discharges (TEDS-D) through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Indicator	Grantee Performance[85]	Other Contextual Performance Information (specify)
	Housing: 91.2% Parenting: 93.3% Domestic Violence: 91.4% Employment: 80.8% Continuing Care: 90.9% Trauma: 95.0%	
A5. Employment Status	Employed F/T or P/T Admission: 32.0% Discharge: 46.0% Enrolled in education or vocational training Admission: 2.8% Discharge: 9.9%	Admission: 35.7% Discharge: 27.6% *Employed F/T or P/T within Denver County During 2010 (TEDS-A, TEDS-D)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 70.0% Discharge: 82.9%	Admission: 88.6% Discharge: 92.8% *Arrests within Denver County During 2010 (TEDS-A, TEDS-D)*
Average Length of Services for Closed CAM Cases[89] Median number of days (months)	251.0 days (8.3 months) Based on 81 of 104 families	Not available

[89] **See Table 1 in Appendix B for more details.**

Figure C3: Colorado Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$. Lower scores indicate improvement.

Dunklin County Site Summary

The Dunklin County Children Affected by Methamphetamine (CAM) Project expanded and enhanced services provided to the children and families of the 35th Judicial Circuit Family Dependency Treatment Court (FDTC). This also included Dunklin and Stoddard Counties in the far southeastern corner of Missouri, a very rural part of the state (the population of Stoddard and Dunklin Counties is 60,000). Primary CAM services included Nurturing Parenting (group and home-based components) and Parents as Teachers. These services were well integrated into the family drug court.

Dunklin consistently served more clients than their initial projections. Through August 31, 2014 they served 218.8% and 223.1% of the target populations for adults and children, respectively.

What did the grant set out to accomplish?

The grantee designed enhanced services for clients participating in the Family Treatment Court program to expand and enhance the services provided to the children and families of the 35th Judicial Circuit Family Dependency Treatment Court. The goals included:

- Provide an effective case management system;
- Increase access to supportive services for the children;
- Increase the clients' understanding of healthy child development; and,
- Assist in the ongoing care of their children.

These goals were designed to be fulfilled by the following resources:

- Creation of a service coordinator position to assess family needs and make appropriate referrals;
- Strengthening of partnership with community resources;
- Contracting with a parent aid;
- Implementing the evidence based Strengthening Families Program; and,
- Providing support services for the parents.

How did this plan change, and why?

The grantee initially planned to implement Strengthening Families Programs. However, the grantee found that the training costs for this program were higher than expected. The Project Director worked closely with the Performance Management Liaison (PML) and the Contracting Officer's Representative (COR) to identify other evidence-based options that could meet the same need but have lower initial training costs. The grantee, with approval from the COR, opted to use Celebrating Families (CF) instead of the Strengthening Families Program. Staff members were trained in suitable locations, both Dunklin and Stoddard Counties were quickly secured. The first families started in the program early in Year 2.

After implementing the curriculum for a little over a year, attendance at CF was low and the Project Director was receiving consistent feedback from parents and staff that the CF curriculum and the in-house substance abuse treatment curriculum covered much of the same content. Furthermore, some participants and staff found that CF content did not seem culturally relevant to families living in rural Missouri. With support from the PML, the Project Director compared the curriculum of CF, Nurturing

Parenting, and Parents as Teachers to identify overlap in content and consider which, if any, would best meet the needs of their clients. This comparison revealed that shifting to the Nurturing Parenting program added content that was missing for the FDC parents. These topics included child development, bonding and attachment, while not losing any of the key content included with CF. Two local therapists were already trained to provide Nurturing Parenting so there were no additional training expenses. After careful consideration, the Project Director formally requested approval from the COR to discontinue CF and implement Nurturing Parenting. This change was approved and Nurturing Parenting was fully implemented by the end of Year 3.

What did this project accomplish?

This effort is unique because it is a successful FDC in a very rural location. The grantee also developed an effective partnership with a local physician's office where clients could receive their medical care and Medication Assisted Treatment, if needed. Many FDCs struggle sharing information with physicians, but this challenge has been resolved in Dunklin. In addition, the grantee developed an alumni group and coordinated efforts to remodel space in order to provide children's services. Perhaps, most impressively, all families in the child welfare system impacted by substance use were referred to the FDC.

Dunklin was working hard to maintain several key components of its CAM project. Specifically, the grantee was gathering data to support their effort to maintain the case coordinator position. These data would be used to request funding from child welfare. The grantee also negotiated the use of State FDC funds to pay for parenting education, beginning in late 2014. Finally, the grantee secured ongoing funding from the state to support the FDC Coordinator position.

Table C4: Dunklin County Performance Indicators

Indicator	Grantee Performance[90]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	Not Available	Not Available
C2. Recurrence of maltreatment	Not Available	2.1% *Recurrence of Maltreatment within 6 Months in Missouri During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C3. Median Length of Stay in Foster Care	Not Available	369.0 days *Median Length of Stay in Foster in Missouri During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*

[90]Only contextual data is available at this time. The grantee applied for a reduced level of funding and did not participate in the performance monitoring effort because they did not have sufficient resources for a complete evaluation.

Indicator	Grantee Performance[90]	Other Contextual Performance Information (specify)
C4. Re-entries to Foster Care within 12-months of reunification	Not Available	10.8% *Re-entries to Foster Care within 12 months of Previous Discharge in Missouri During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C5. Timeliness of reunification	Not Available	68.3% *Discharged to Reunification within 12 Months in Missouri During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C6. Timeliness of permanency	Not Available	40.4% *Exits to Permanency, less than24 months in care, in Missouri During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C7. Prevention of SEN	Not Available	Not available
C8. Children Connected to Supportive Services	Not Available	Not available
A1. Access to Treatment	Not Available	Not available
A2. Retention in Substance Abuse Treatment	Not Available	52.7% Completed *Reasons for Discharge within Missouri During 2010 (TEDS)91*
A3. Substance Use (reduction)	Not Available	Not available
A4. Connected to Supportive Services	Not Available	Not Available
A5. Employment Status	Not Available	Admission: 34.8% Discharge: 38.0% *Employed F/T or P/T within Missouri During 2013 (National Outcome Measures)*

[91]Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions and discharges through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Indicator	Grantee Performance[90]	Other Contextual Performance Information (specify)
A6. Criminal Behavior No arrests in past 30 days	Not Available	Admission: 91.6% Discharge: 94.7% *Arrests within Missouri During 2013 (National Outcome Measures)*

Nebraska Site Summary

The Nebraska Children Affected by Methamphetamine (CAM) Project served children and families participating in the Family Treatment Drug Court (FTDC). A service element of the program included the use of Child Parent Psychotherapy (CPP). This intervention improved attachment and bonding between parents and children, helped parents develop practical parenting skills and kept parents engaged in treatment. Since the implementation of CPP, the FTDC team members gained knowledge about attachment and bonding and were able to use this information to recognize the ability of many FTDC parents that improved their parenting skills as they transitioned from treatment into recovery.

Project Safe Start – Nebraska enrolled parents at levels consistent with their overall targets. The number of children enrolled was lower than expected as were the overall number of families being referred to the FTDCs. Through August 31, 2014, the Project served 125 children and 110 parents. These numbers represented 59.0% and 88.7% of their target for children and adults, respectively.

What did the grant set out to accomplish?

Nebraska planned to assess 220 families and of those, they anticipated 196 parent-child pairs would need CPP. Enrolled families participated in Child-Parent Psychotherapy (CPP) with expected improvements in child developmental progress, emotional status, and responsiveness to their parent. Parents were expected to improve their emotional and behavioral responsiveness to their child. As a result of these improvements, the grantee expected reunification and timeliness to permanency rates of the participating child-parent pairs to be enhanced compared to the averages in the 3 counties that the project served. These counties included Lancaster and Douglas; Sarpy County was added after the CAM grant award.

Specific, grant-funded strategies included:

- Training in CPP for community based and private providers;
- Contract with community based and private providers to assess and treat Family Treatment Drug Court (FTDC) clients and to report on needs and progress to FTDC teams;
- Group case consultation once per month with Nationally recognized expert, Dr. Joy Osofsky and local therapists; and,
- Coordination of services and information exchange from providers to FTDC teams by a Service Coordinator.

How did this plan change, and why?

Nebraska experienced delays in start-up activities and was unable to begin serving clients until March 2011, three months later than expected. The project was delayed due to contextual circumstances that included hiring freezes, significant budget reductions and privatization of child welfare. The original target for numbers served was based on parent-child pairs. Separate targets for parents and children were developed based on 1 parent to 1.7 child ratio. Early in Year 2, with approval from the Federal Project Officer, the grantee began reporting the number of families, children and parents who completed the CPP assessment as the numbers served. This decision was based on the length of time required and intensive nature of the assessment process. The implementation context has substantially changed since the CAM funding began. Specifically:

- The child welfare system was privatized and then largely shifted back to public management;
- The child welfare system promoted more voluntary cases reducing the number of court cases and therefore reducing the number of potential FTDC referrals;
- Completion of a full course of CPP participation took longer than expected;
- FTDCs served fewer families than expected so the grantee added the FTDC in Sarpy County in year 2 in an effort to increase CPP referrals;
- The Children's Services Coordinator role expanded significantly – she became a key information source and trainer for all FTDCs on best practices; and,
- Staffing and the challenge of finding qualified providers delayed implementation.

What did this project accomplish?

The addition of CPP to the FTDC service array was unique and proved successful for FTDC families according to the local and cross-site evaluation. The intervention effectively identified and addressed behavior, attachment or mental health problems in young children (0-5 years) who had experienced at least one traumatic event. The grantee indicates that CPP resulted in improved parenting skills, parent-child attachment and bonding and infant/toddler mental health. In addition, implementation of CPP provided a mechanism for FDC team members to learn about and understand trauma in young children, the importance of parent-child attachment and bonding and the potential for people with substance use disorders to learn and improve their ability to parent.

The Project Safe Start leadership team actively disseminated the results of CPP with FTDC families at policy meetings and conferences beginning at the end of Year 2. As a result, they gained buy-in from state level administrators and CPP was added as a Medicaid benefit for all child welfare families. This was a major policy change and a significant accomplishment for this CAM grant program.

A local private foundation provided three years of funding (with the possibility of three additional years) to the Court Improvement Program to continue the efforts started by Project Safe Start. Funds would support a full-time infant/toddler mental health specialist and part-time consulting attorney. The purpose of those positions was to promote system changes that improved access to mental health assessments and services for very young children involved in the court and child welfare systems. Funds would also provide CPP training for therapists and consultation for FTDCs teams.

Twenty-four (24) therapists provided CCP to families across the five participating FTDCs. Since early in the program, Dr. Joy Osofsky, a national expert on childhood trauma and CPP, provided case

consultation each month via video conference for all trained providers. Her efforts provided professional development, quality assurance and on-going training opportunities. In addition, Project Safe Start coordinates, monthly, in-person case consultations for therapists in each county. During year 4 of the grant, Dr. Osofsky trained four therapists to continue providing monthly case consultation following the video conference model. The new grant mentioned above would support the monthly consultations.

Each year project leadership discusses the need for FTDC Coordinators but they have not secured funding. At the end of Year 3, the local CASA agency in Sarpy County committed to provide a coordinator for one year to keep the FTDC moving forward. In the meantime, the Administrative Office of the Courts was working to identify ongoing funding for one full-time FTDC Coordinator for Sarpy and Douglas Counties.

FTDC partners in Lancaster County were using FDC principles to develop a universal approach for child welfare families with substance use disorders. Beginning in Year 4, Lancaster County Judges would order all child welfare families with substance use disorders to the drug court docket. This new docket would replace the Lancaster County FTDC. Child welfare was developing a specialized unit to support families with substance use disorders and to work closely with the drug court team.

Nebraska would sustain these efforts through a range of activities, including:

- Providing CPP for families involved in Child Welfare and using Medicaid as the primary payer;
- Funding a FTDC Coordinator (Sarpy County) through the local Court Appointed Special Advocates agency;
- Implementing a three-year system level, court improvement effort aimed at increasing access to mental health assessment and treatment for very young children in the child welfare system with funding from a private foundation;
- Continuing CPP training, monthly video case consultations for CPP providers and consultation for FTDC teams with funding from a private foundation;
- Developing a universal approach and new docket for child welfare families with substance use disorders in Lancaster County. This universal approach was designed to provide access to treatment and recovery supports for more parents than previously participated in the Lancaster County FTDC; and,
- Proposing funding through the Administrative Office of the Courts for an FTDC coordinator for Sarpy and Douglas Counties.

Table C5: Nebraska Performance Indicators

Indicator	Grantee Performance[92]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	75.0% Of those who were at home at time of enrollment[93]	Not Available
C2. Recurrence of maltreatment	0.0% Within 6 months of CAM entry	Lancaster 12.1% Sarpy 1.6% Douglas 9.3% *Disposed April 2011 to March 2012 – Victims Re-Victimized within 6 Months (Fostering Court Improvement)*
C3. Median Length of Stay in Foster Care	553.0 days	Lancaster 723.0 days Sarpy 417.0 days Douglas 576.0 days *Discharged During October 2012 through September 2013 – Median Length of Stay in Foster Care (Fostering Court Improvement)*
C4. Re-entries to Foster Care within 12-months of reunification	0.0%	Lancaster 5.0% Sarpy 5.5% Douglas 5.9% *Children Removed to Foster Care During October 2012 through September 2013 – Re-entries to Foster Care within 12 months of Previous Discharge (Fostering Court Improvement)*
C5. Timeliness of reunification	17.6% Reunified within 12 months of removal	Lancaster 49.0% Sarpy 69.0% Douglas 55.0%

[92]Grantee performance through September 30, 2014 is considered in the aggregate across Nebraska's 3 county sites. Each county's overall performance is presented for context. Grantee performance may vary across sites and the disproportionate levels of participation in CAM services across sites influence the aggregate findings presented in this table: Douglas County contributes 68.2% of the cases while Lancaster and Sarpy contribute 21.2% and 10.6% respectively.

[93]For Nebraska, 15.1% of the children were in-home at time of CAM enrollment.

Indicator	Grantee Performance[92]	Other Contextual Performance Information (specify)
		Children Discharged During October 2012 through September 2013 – Discharged to Reunification within 12 Months (Fostering Court Improvement)
C6. Timeliness of permanency	15.4% Exited to adoption or guardianship within 24 months of removal	Lancaster 37.0% Sarpy 0.0% Douglas 24.0% *Children Discharged During October 2012 through September 2013 – Discharged to Adoption within 24 Months (Fostering Court Improvement)*
C7. Prevention of SEN	The ten births subsequent to CAM enrollment did not test positive for substance exposure	Not available
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Mental Health: 94.3%	Not available
A1. Access to Treatment[94]	Mean: 96.4 days Median: 43.0 days	Mean: 2.8 days Median: 0.0 days *Days Waiting to Enter Treatment within Nebraska During 2010 (TEDS)95*
A2. Retention in Substance Abuse Treatment	44.0% Completed 6.0% Transferred Completed Median length: 139.5 days Transferred Median length: 125.0 days	54.1% Completed *Reasons for Discharge within Nebraska During 2010 (TEDS)*
A3. Substance Use (reduction)	Alcohol: 75.0% Cocaine: 100.0% Marijuana: 100.0%	Not available

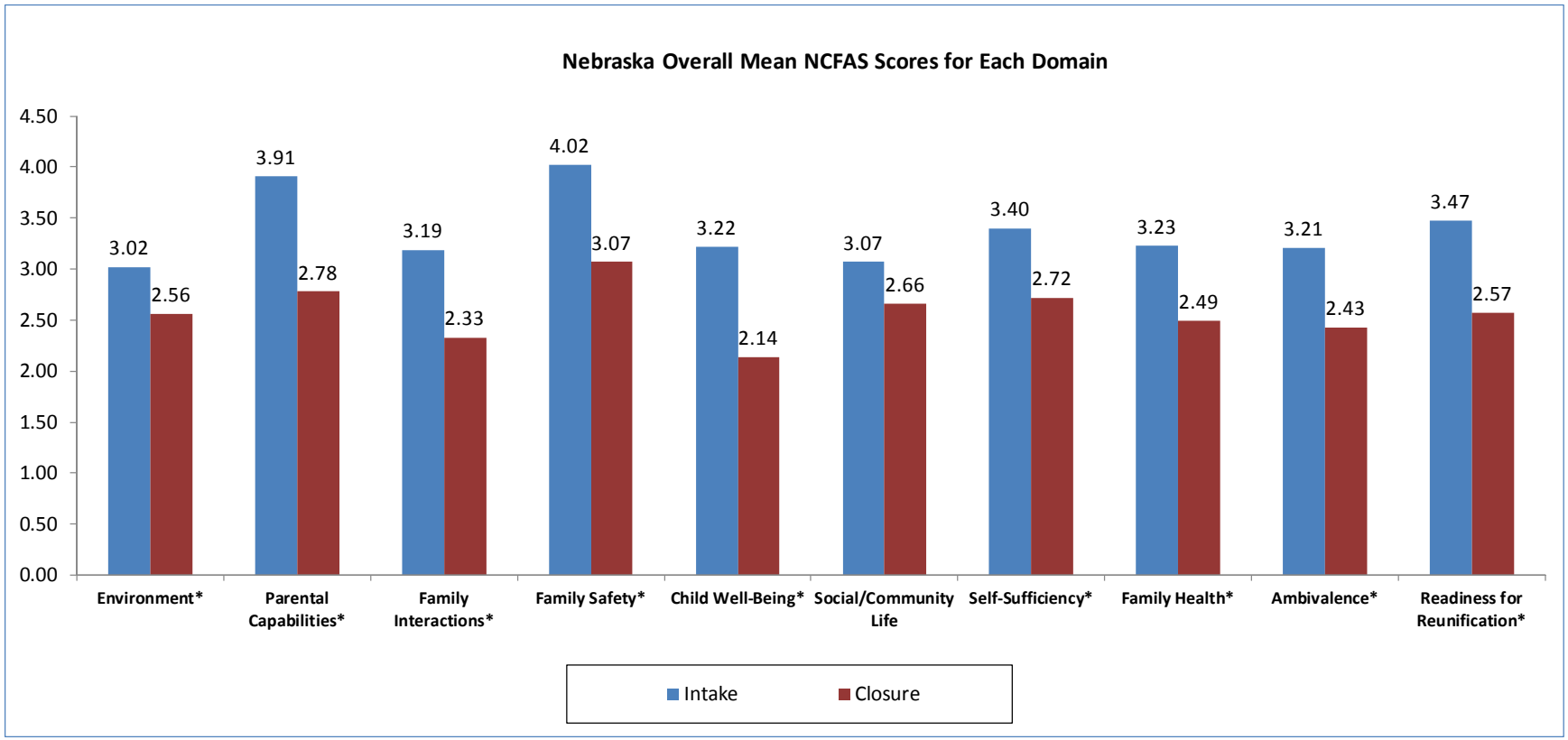
[94] The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Nebraska, this was 46.7% of the adults who entered substance abuse treatment services.

[95]Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions and discharges through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Indicator	Grantee Performance[92]	Other Contextual Performance Information (specify)
	Heroin/Other Opiates: 100.0% Methamphetamine: 66.7%	
A4. Connected to Supportive Services	Not Available	Not Available
A5. Employment Status	Employed F/T or P/T Admission: 40.0% Discharge: 50.0%	Admission: 33.6% Discharge: 40.6% *Employed F/T or P/T within Nebraska During 2013 (National Outcome Measures)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 95.2% Discharge: 97.6%	Admission: 91.0% Discharge: 96.5%% *Arrests within Nebraska During 2010 (National Outcome Measures)*
Average Length of Services for Closed CAM Cases[96] Median number of days (months)	271.0 days (8.9 months) Based on 72 of 85 families	Not available

[96] **See Table 1 in Appendix B for more details.**

Figure C5: Nebraska Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$. Lower scores indicate improvement.

Oklahoma Site Summary

The Tulsa County Family Drug Court (TCFDC) integrated Children Affected by Methamphetamine (CAM) services including Celebrating Families and Strengthening Families. Other CAM supported efforts included linkages with other community agencies for family services and a community education campaign about substance abuse, trauma and child welfare.

Before last year, the number of children and families entering the TCFDC was lower than anticipated. Through August 2014, the court served 229 parents (107.5% of target) and 303 children (114.8% of target).

What did the grant set out to accomplish?

The Tulsa County Family Drug Court proposed the use of interventions in three areas to improve permanency, enhance safety, and increase well-being of participating families. The three initiatives supported through CAM included:

- Overall well-being assessments and service linkages for children and adults that included six key domains (development, education, primary healthcare, mental health, familial substance abuse screening, and comprehensive trauma assessment and treatment);
- The incorporation of two evidence-based parenting education programs (Celebrating Families and Strengthening Families) into the TCFDC's structure designed to increase child, adult, and family functioning, increase the likelihood of timely reunification with birth families, and decrease the likelihood of maltreatment recurrence; and,
- Increasing the capacity of the community through the implementation of a multi-year community- wide education initiative about SA, child welfare, and trauma-informed interventions.

How did this plan change, and why?

The TCFDC team planned to implement CAM activities with three partner agencies for parenting education, substance abuse treatment and mental healthcare. However, two providers decided not to participate due to concerns about reimbursement. There were concerns initially about the capacity of one provider to meet the needs for all parenting education, SA treatment and mental healthcare (including trauma assessment and services). This provider, Center for Therapeutic Interventions, has been able to meet the demand and has been a committed and consistent partner throughout the grant period. The grantee indicated that working with one provider has simplified coordination, planning and communication and resulted in a stable, effective and sustainable partnership.

The grantee also came to need more early childhood programming than they had anticipated because TCFDC families included increased numbers of very young children (0-3) than they had planned for. Neither parenting education program that the grantee chose was designed for families with children under 3. Therefore, with support from the local project evaluator, the CAM team worked with the developers of both programs to develop and implement new curricula for very young children.

What did this project accomplish?

The grantee developed, substantially refined and institutionalized their implementation of parenting programs. They learned that Strengthening Families focused more on bonding and parenting and was

more appropriate for parents early in recovery. After Strengthening Families and with parents further along in their own recovery and better able to focus on family recovery from substance abuse, CAM participants engaged in the Celebrating Families program. Both parenting programs were recognized as essential components of the TCFDC program. The State recognized the effectiveness of the Strengthening Families Program. They sought and received a Systems of Care for Children's Mental Health grant to provide training across the state and expand access to this curriculum statewide. At this time, the programs were offered in the majority of the 77 counties.

Another strength and unique aspect of this court was the high number of fathers involved in the program. Since the inception of its CAM project, this court had engaged fathers in 53% of the TCFDC families. This compares to an average among all CAM grantees of 28%. The team as a whole recognized the important role of fathers in the lives of their children. They actively extended outreach and engaged fathers to help both parents, whether they lived together or not, learn to co-parent their children.

The local evaluation plan included a sophisticated cost analysis which showed strong outcomes and substantial cost offsets. These data have increased system-wide support for FDC growth. The Court system made changes to other dockets to allow for expansion of the FDC to meet growing demands. As the FDC docket expanded, TI, the FDC team, and ODMHSAS worked to identify funding for the corresponding increase in treatment services.

Tulsa also worked diligently to sustain CAM-supported components after grant funding ends. They were still working to secure funding for the Children's Services Coordinator position. Components with secure support included:

- Substance abuse treatment using TANF funds through a contract with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS);
- Transportation to and from parenting programs with a vehicle provide by the Juvenile Justice Bureau and a driver paid by the treatment provider; and,
- Two full-time TCFTDC staff paid for by the Juvenile Justice Bureau.

Select results from the locally conducted evaluation for Oklahoma were extracted from their final report and are included below.

Comparison Group Outcomes.

The Grantee used a contemporaneous comparison group created through propensity score matching[97] to examine the effectiveness of the proposed interventions in their local evaluation report (a summary of outcomes follows). All the cases were tracked from the time period January 2011 through September 2013. The study used survival analysis[98] to compare the probability and rate of reunification between groups. Results suggest that:

- Findings indicate that after controlling for all other variables, the FDC group is associated with a 178% increase in the likelihood of reunification, compared with a matched comparison group.

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[97] Propensity score matching (PSM) is a statistical matching technique that attempts to estimate the effect of a treatment, policy, or other intervention by accounting for the covariates that predict receiving the treatment, thus attempting to reduce the bias caused by confounding variables.

[98] Survival analysis is a set of methods for analyzing data where the outcome variable is the time until the occurrence of an event of interest.

- FDC children moved towards reunification significantly faster than comparison cases, by the 1000 day point from the start of FDC, 56% of the children have been reunified compared to only 24% of the comparison group.
- The typical FDC CAM child spends 227 fewer days in out of home care than their non-FDC counterpart. At a conservative out-of-home care rate of 82.00 per day in child welfare costs, CAM avoids approximately $18,614 per child served in state and federal out-of-home care costs. From program initiation (January, 2010) to end of data collection for this report (September 30, 2013), the CAM grant has served 269 children, yielding a total avoidance in foster care related costs of $5,007,166.00.

Table C6: Oklahoma Performance Indicators

Indicator	Grantee Performance[99]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	58.3% Of those who were at home at time of enrollment[100]	Not Available
C2. Recurrence of maltreatment	No recurrence reported Within 6 months of CAM entry	6.2% *Recurrence of Maltreatment within 6 Months in Oklahoma During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C3. Median Length of Stay in Foster Care	495.0 days	393.0 days *Median Length of Stay in Foster in Oklahoma During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C4. Re-entries to Foster Care within 12-months of reunification	0.0%	10.3% *Re-entries to Foster Care within 12 months of Previous Discharge in Oklahoma During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C5. Timeliness of reunification	22.5% Reunified within 12 months of removal	65.1% *Discharged to Reunification within 12 Months in Oklahoma During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*

[99] **Grantee performance through September 30, 2014.**

[100] **For Oklahoma ,6.4% of the children were in-home at time of CAM enrollment.**

Indicator	Grantee Performance[99]	Other Contextual Performance Information (specify)
C6. Timeliness of permanency	43.6% Exited to adoption or guardianship within 24 months of removal	38.0% *Exits to Permanency, less than24 months in care, in Oklahoma During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C7. Prevention of SEN	The five births subsequent to CAM enrollment did not test positive for substance exposure	Not available
C8. Children Connected to Supportive Services	Not available	Not available
A1. Access to Treatment[101]	Mean: 26.4 days Median: 20.0 days	Not available
A2. Retention in Substance Abuse Treatment	61.4% Completed 5.0% Transferred Completed Median length: 345.5 days Transferred Median length: 294.0 days	41.8% Completed *Reasons for Discharge within Tulsa County During 2010 (TEDS-D102)*
A3. Substance Use (reduction)	Alcohol: 12.5% Cocaine: 11.8% Marijuana: 4.6% Heroin/Other Opiates: 7.4% Methamphetamine: 15.8%	Not available
A4. Connected to Supportive Services	Not available	Not Available

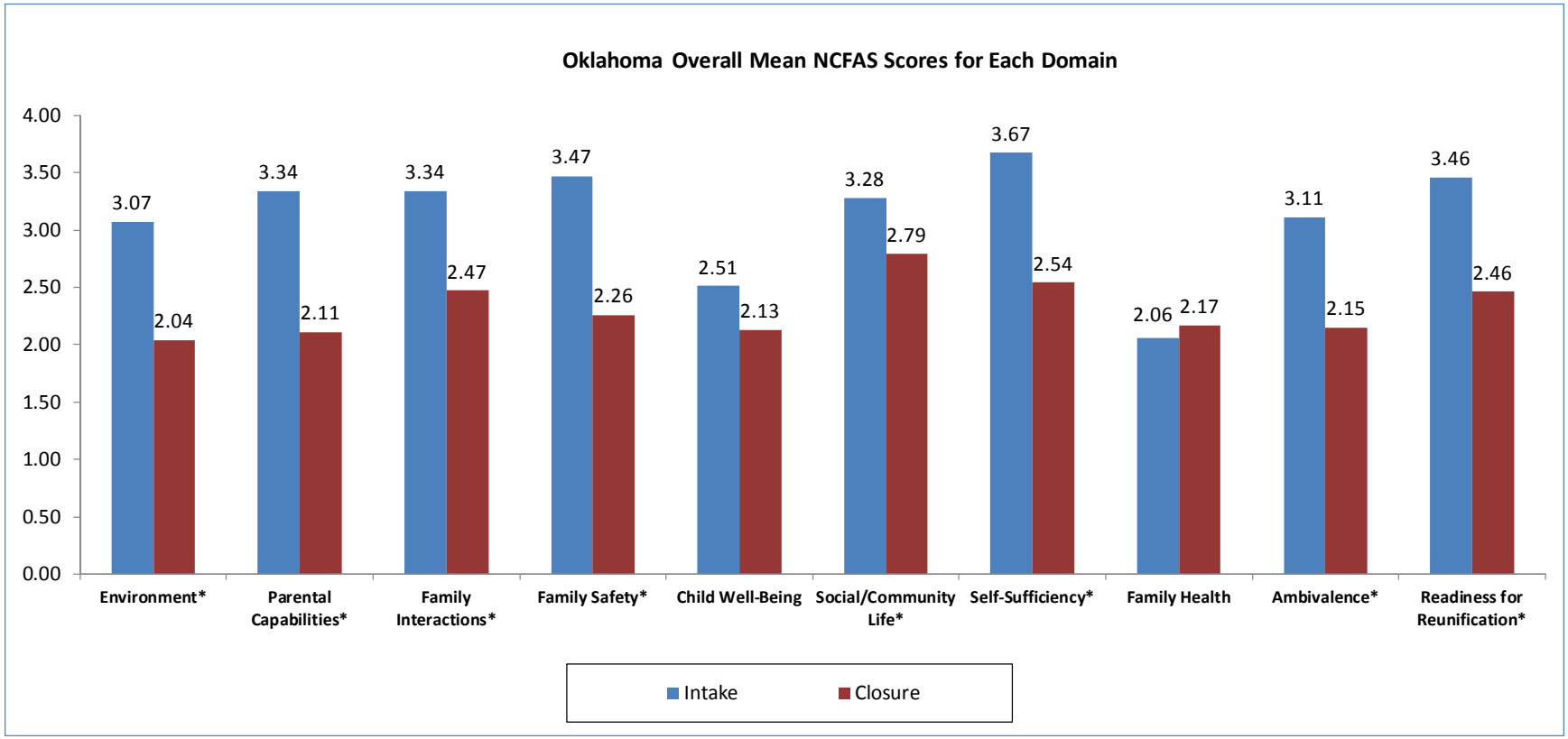
[101] The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Oklahoma, this was 67.3% of the adults who entered substance abuse treatment services.

[102] Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions (TEDS-A) and discharges (TEDS-D) through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Indicator	Grantee Performance[99]	Other Contextual Performance Information (specify)
A5. Employment Status	Employed F/T or P/T Admission: 33.3% Discharge: 57.5% Enrolled in education or vocational training Admission: 3.6% Discharge: 6.4%	Admission: 13.9% Discharge: 15.9% *Employed F/T or P/T within Tulsa County During 2010 (TEDS-A, TEDS-D)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 93.6% Discharge: 95.0%	Admission: 91.2% Discharge: 88.8% *Arrests within Tulsa County During 2010 (TEDS-A, TEDS-D)*
Average Length of Services for Closed CAM Cases[103] Median number of days (months)	220.5 days (7.3 months) Based on 92 of 142 families	Not available

[103] **See Table 1 in Appendix B for more details.**

Figure C6: Oklahoma Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$. N=35

Pima Site Summary

The Pima County Children Affected by Methamphetamine (CAM) project provided an array of family-centered services to Family Drug Court (FDC) participants and their children. Their goal was to increase the graduation rate of their FDC participants and decrease the number of children re-entering the dependency system.

Pima County was generally on pace to meet targets for the number children served and was marginally behind on the number of adults. Through August 2014, 312 adults and 454 children received CAM services. Their cumulative numbers were 84.3% of the adult target and 98.1% of the target for children.

What did the grant set out to accomplish?

The Pima County FDC proposed to expand and enhance services to children and families affected by methamphetamine in child dependency cases by offering the Celebrating Families curriculum, trauma screening and referral for children, a Child Case Specialist, peer support recovery services, an alumni group, Adult Recovery Teams and evidence-based drug testing protocol.

The staffing model implemented by this team included a Family Drug Court (FDC) Intake Coordinator who completed assessments and prepare referrals for services. Each family was matched to a Recovery Support Specialists (RSS) who focused on the recovery of the parents, building parenting skills and confidence and making sure all referred services were received and were meeting the family's needs. The RSSs worked in partnership with the Department of Child Safety (DCS) case workers. They used active outreach and engagement strategies to support each parent and retain them in the program. They formed extremely close relationships with the parents and they were each skilled in maintaining boundaries and high expectations of parents in recovery. Each of the RSSs were several years into their own recovery and one was an early graduate of the FDC.

How did this plan change, and why?

For the most part, the Pima grantee implemented the project as planned. However, in Year 2, the grantee detected that the Child Case Specialist caseload was too high. In response, the team developed and implemented a new staffing model with four Family Case Specialists instead of one Child and three Adult Case Specialists. The Family Case Specialists were responsible for screening, referral and monitoring of services for all family members. This model proved effective and allowed this FDC to provide Family-Centered services and to understand the needs of the children in the context of their family. As part of their sustainability plan, the Department of Child Safety developed a dedicated FDC unit and the Family Case Specialist role was taken on by DCS case workers. Finally, they increased the number of Recovery Support Specialists (RSS) from two to six. In another shift, the team recognized that participation in Celebrating Families! (CF!) had declined. As a result of technical assistance and in consultation with other sites implementing CF!, they changed participation from voluntary to an expected component of FDC participation. This modification increased participation somewhat and the team continued exploring additional changes.

What did this project accomplish?

Highlights of the Project's accomplishments included:

- Successful transition of court supported case specialist positions to child welfare funded case workers specializing in FDC families;
- Designation as a Peer Learning Court;
- Recent SAMHSA grant award to expand substance abuse treatment in the FDC;
- Recent grant award from the Doris Duke Foundation to continue expanding services to FDC children and families; and,
- Ability of the team to effectively identify and understand domestic violence, mental illness and the need for gender specific programming.

An additional strength of the project was the level of training that the staff received. All members of the FDC team received training in this regard. All aspects of the court staffing, court sessions and CAM services were implemented in a trauma sensitive manner. This past year, in addition to the FDC team staff, the Pima County Juvenile Court Center initiated an effort to train everyone working with children and families (including detention, front desk and court office staff) on the effects of trauma in adults and children and effective responses. The CAM Project Director stated that this multi-level training effort would advance them from being "trauma-informed" into "trauma-responsive."

The FDC team worked on sustainability early in the four-year project. They were successful in working with the Department of Children's Safety (DCS) to create a dedicated FDC unit. The DCS case workers began providing the services formerly provided by the Family Case Specialists. Project leadership also began negotiating with other agencies to continue implementing CF! and to provide transportation for FDC participants. RSS positions were supported through grants and the Juvenile Court in the short term and project leaders were working to secure stable, institutionalized funding sources for long-term sustainability.

The following table summarizes Pima's accomplishments in terms of the required performance measures.

Table C7: Pima Performance Indicators

Indicator	Grantee Performance[104]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	50.0% Of those who were at home at time of enrollment[105]	Not Available
C2. Recurrence of maltreatment	0.4% Within 6 months of CAM entry	4.6% *Recurrence of Maltreatment within 6 Months in Arizona During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*

[104] **Grantee performance through September 30, 2014.**

[105] **For Pima, 1.0% of the children were in-home at time of CAM enrollment.**

Indicator	Grantee Performance[104]	Other Contextual Performance Information (specify)
C3. Median Length of Stay in Foster Care	154.0 days	306.0 days *Median Length of Stay in Foster in Arizona During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C4. Re-entries to Foster Care within 12-months of reunification	0.0%	18.4% *Re-entries to Foster Care within 12 months of Previous Discharge in Arizona During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C5. Timeliness of reunification	100% Reunified within 12 months of removal	67.9% *Discharged to Reunification within 12 Months in Arizona During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C6. Timeliness of permanency	0.0% Exited to adoption or guardianship within 24 months of removal	54.0% *Exits to Permanency, less than24 months in care, in Arizona During 2012 (Children Bureau's Child Welfare Outcomes Report Data)*
C7. Prevention of SEN	No children were born subsequent to CAM enrollment	Not available
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Educational: 100.0% Primary Pediatric Care: 100.0% Mental Health: 100.0% Developmental: 100.0% Substance Abuse Prevention: 100.0% Substance Abuse Treatment: 100.0% Neurological: 100.0% Dental: 100.0%	Not available

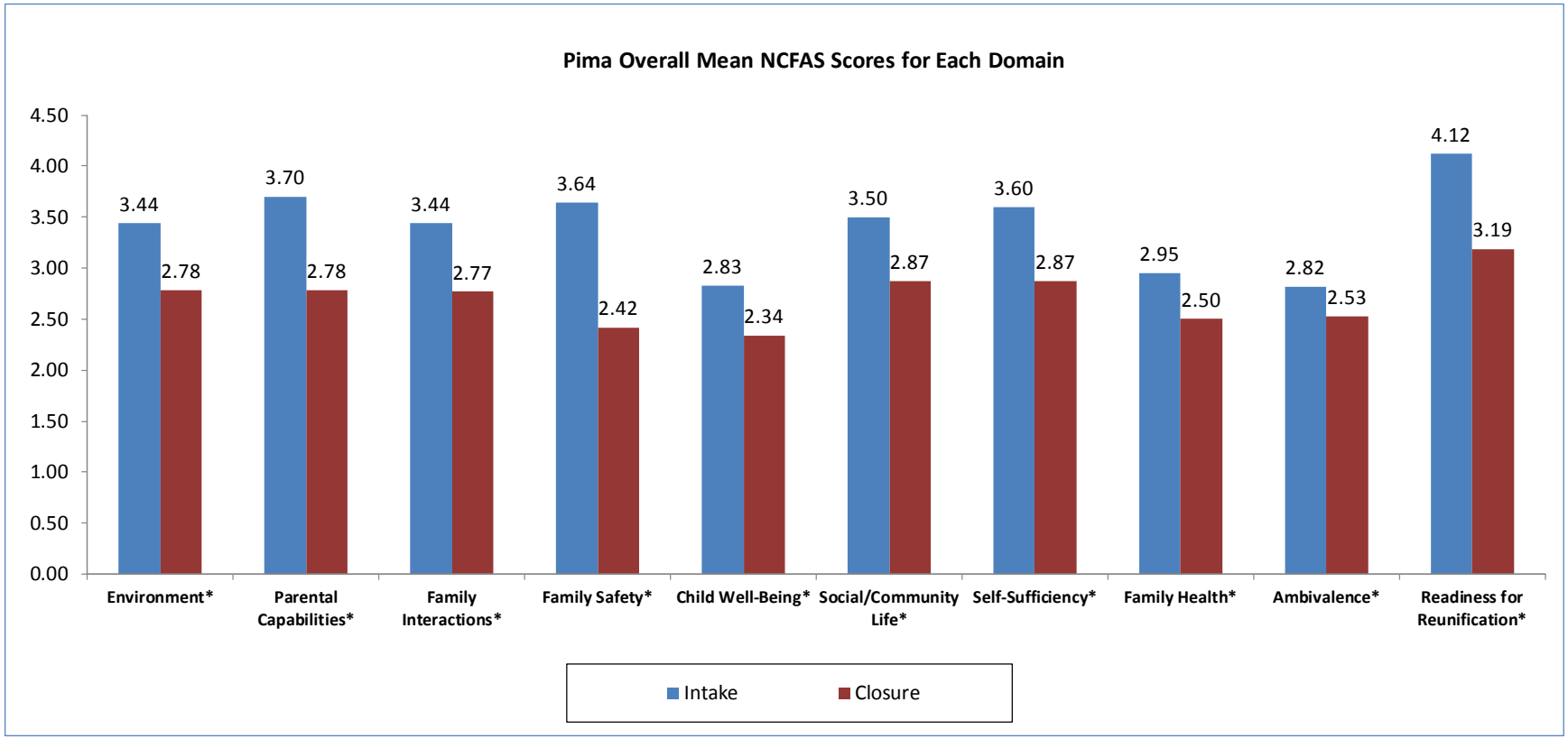
Indicator	Grantee Performance[104]	Other Contextual Performance Information (specify)
A1. Access to Treatment[106]	Mean: 59.8 days Median: 30.0 days	Not available
A2. Retention in Substance Abuse Treatment	66.7% Completed 2.3% Transferred Completed Median length: 296.0 days Transferred Median length: 255.5 days	Not available
A3. Substance Use (reduction)	Alcohol: 50.0% Cocaine: 9.1% Marijuana: 45.5% Heroin/Other Opiates: 28.6% Methamphetamine: 33.3%	Not available
A4. Connected to Supportive Services	Of those assessed, percentage who received services: Primary Medical Care: 100.0% Dental: 100.0% Mental Health: 100.0% Child Care: 100.0% Transportation: 100.0% Housing: 100.0% Parenting: 100.0% Employment: 100.0% Trauma: 100.0% Family Planning: 100.0% Legal: 100.0%	Not Available
A5. Employment Status	Employed F/T or P/T Admission: 27.6% Discharge: 57.5%	Admission: 29.7% Discharge: 31.4%

[106] The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Pima, this was 5.6% of the adults who entered substance abuse treatment services.

Indicator	Grantee Performance[104]	Other Contextual Performance Information (specify)
	Enrolled in education or vocational training Admission: 5.4% Discharge: 8.1%	*Employed F/T or P/T within Arizona During 2013 (National Outcome Measures)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 96.6% Discharge: 93.8%	Admission: 82.4% Discharge: 83.5% *Arrests within Arizona During 2010 (National Outcome Measures)*
Average Length of Services for Closed CAM Cases[107] Median number of days (months)	238.0 days (7.8 months) Based on 225 of 265 families	

[107] **See Table 1 in Appendix B for more details.**

Figure C7: Pima Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$.

Riverside Site Summary

The Riverside County Children Affected by Methamphetamine (CAM) Project served children aged 0-17 and their families participating in the Family Preservation Court (FPC). The CAM Project enhanced the current network of services by providing the following key services:

- *Nurturing Families Program* – a 12-week evidence-based parenting education program using parent modeling and coaching strategies. The program involved the entire family with parents and children participating together to learn skills to prevent future child abuse and neglect.
- *Marriage and Family Therapist (MFT)* – with the assistance of supervised interns, the MFT clinician met individually with all new clients and identified those in need of in-home visitation. The MFT also reviewed the Ages and Stages Questionnaire (ASQ) assessments to identify mental health, trauma and parenting concerns. In addition, the MFT provided recommendations and linkages for appropriate referrals, as well as short-term counseling.
- *Public Health Nurses* – included two public health nurse programs including Health Care Program for Children in Foster Care (HCPCFC) and Safe Care to monitor the health needs of CAM children and to support case coordination of children.

Services were provided to families under two court-filing arrangements:

- *FPC pre-file* – is an intensive court supervised program which serves families prior to CWS filing a petition and at risk of losing their children. The goal is to keep families together while providing intensified services.
- *FPC post-file* – are cases in which children have been removed from their families and a petition has been filed with the Court.

The FPC served approximately 32% family pre-files and 68% post-files in FPC with a reduction in pre-files beginning in Year 3. Since inception, Riverside CAM exceeded their annual projected targets for serving children, adults and families. Through August 2014, the CAM Project served 1,159 adults and 2,271 children. The FPC Program had the capacity to serve a large number of children, parents and families through a strong collaborative design reaching across three service regions in the county—Metro Riverside, Coachella Valley and Southwest Riverside County.

What did the site set out to accomplish?

Riverside CAM proposed to serve 1,438 children and 575 adults, which made it the largest scale of any of the 12 CAM projects. The Grantee set out to expand services to children affected by parental methamphetamine use participating in the FDC by providing the following new specialized services:

- Marriage and Family Therapist;
- Nurturing Parenting Program;
- Educational liaison for school-aged children;
- Assessments and referrals with Public Health Nurses (PHNs) for children;
- Father's Time Program (10-week group-based program designed to engage fathers); and,
- Parent Support Groups (aka Reunification Groups).

The grantee contracted with Mental Health Systems to provide case management and substance abuse treatment services to FPC clients through three regional clinics called Centers for Change. Each of the clinics were "one-stop-shops" and offered individual/group substance abuse counseling, prevention education, reunification and alumni groups, recovery and aftercare support and community outreach.

How did that plan change and why?

The grantee was notified shortly after the grant award that the scope of the Educational Liaison's position would be significantly reduced due to budget cuts. Consequently, the Educational Liaison focused on only those children with the highest educational needs. The grantee's primary response was to meet the educational needs of other children primarily involved educational referrals either by the CWS social worker or to an online referral source.

Toward the end of Year 2, substance abuse treatment funding from CWS to the FPC was reduced by half. Although there was no serious impact on the quality and scope of treatment services, the funding cuts resulted in staff and work hour reductions and reduced the number of people who entered into FPC, particularly as pre-file referrals.

The issue of retention gained greater focus and attention after Year 1 data reported the following:

- 23.5% of CAM families left against professional advice or were terminated;
- 70.4% of CAM families who terminated early did so within the first 90 days of involvement with the program;
- 28.2% of CAM families terminated within the first 180 days; and,
- Less than 1% of the parents terminated after more than 6 months in the program.

The CAM grantee team continued to examine the retention issue from various angles, including: screening and referral processes, engagement and retention, level of understanding for the role of the CWS social worker and appropriately matching service with need. Sharing information and solutions across the three sites was an important challenge. This issue remained one of the primary focuses of the Project. The grantee was developing a process improvement plan to address program retention. During implementation of the process improvement plan, the grantee tracked and made adjustments as necessary to ensure the intended goals of the change were addressed and accomplished. The grantee also explored modifying its client handbook, treatment phases and requirements. Some of these modifications included the requirement that participants have a job before moving to phase 3, which could improve client retention and the clients' ability to meet the demands of the FPC program.

Implementation challenges and collaborative solutions that surrounded the involvement of Department of Public Social Services (DPSS) were also identified. For example, referrals by DPSS social workers increased as a result of informational and outreach efforts to promote FPC and CAM through the department. The grantee also reported improved involvement by DPSS social workers, who began regularly attend the FDC court sessions following a lapse of involvement as a consequence of county furlough scheduling. Significant improvement was made in the area of data sharing after reports in Year 1 created challenges in obtaining child welfare data from DPSS.

Overall, the Project endured a series of staffing modifications, including changes in the Project Director, the Children Services Coordinator, the Evaluator, treatment staff, judicial leaders and the DPSS. Conversely, the collaborative strength and infusion that emerged from the committed and

capable leadership and staff helped mitigate any potential disruption or delays, as a result of the staffing changes.

What was unique about this effort?

There were a few noteworthy aspects regarding the design and scale of the CAM project and FPC program which make Riverside CAM unique. Riverside CAM served more adults and children than any other CAM Grantee. The Project and the FPC program were able to serve a large number of children, parents and families through a collaborative design reaching across three service regions, two court filing arrangements and a parallel court model in which dependency matters and FPC cases are heard on separate dockets by different judicial officers. The majority of FPC clients enrolled as post-file cases (approximately 70% vs. 30% pre-file). Although each of the service regions were set up similarly with a one-stop clinic (aka Center for Change) and regional juvenile dependency court house, each region had its unique staffing and client challenges, service trends and demographics. Service delivery across multiple service regions by multiple agencies and service providers in addition to multiple court sites was a significant task that required ongoing communication.

What were the key accomplishments?

One key accomplishment was the grantee's focus on providing strong parent recovery support within the FPC program and aftercare. Utilization of the MFT clinician, who was funded by CAM, provided key support during participation in CAM services and the FPC program. In the beginning, the parents were suspicious and non-responsive to the services offered by the Marriage and Family Therapist, (MFT). After establishing trust, the families now actively seek the services of the MFT. The interns were a great support to the MFT clinician in serving and keeping track of the 300 families over the three sites. With the help of supervised interns assigned to each clinic, the MFT was able to deliver a variety of key tasks and activities, including home visits to observe parent-child interaction, co-facilitation of the Reunification Groups and review of the family and child assessments in order to provide recommendations and linkages to follow-up services. The MFT utilized diagnostic tools such as the ASQ and NCFAS to identify priority needs and to ensure that the clients were able to access services. The MFT also noted particular success with the pre-file clients, which were parents whose children remained in-home under their care and supervision. The grantee also continued to provide recovery support through its active alumni, Father's Time and Family Reunification groups.

The FPC also established an extensive network of community partnerships to provide ancillary services and additional support to clients that participated in the CAM Project. These organizations included faith-based establishments, public health programs, residential treatment programs and sober living environments, employment and vocational training, housing, emergency assistance and legal aid. The FPC also developed a tracking system to better identify the number of services and the number of clients receiving those services from their partner organizations and providers.

In 2013, the grantee received a SAMHSA grant (three years) which would allow continued funding for most of the CAM project. Following this funding, the Grantee conducted an expenditure study of the FPC program which could lead to policy decisions and permanent funding opportunities as a result of demonstrated cost savings. DPSS, in conjunction with the Grantee also continued a community mapping sub-project to identify all the community partners serving families in CWS that were affected by parental substance use and updated the inventory of community resources to better match the intensity of service to the level required. An initial stakeholder meeting was conducted in August

2013, which provided the Grantee and stakeholders a better understanding of the different treatment vendors and how their programs related to the larger systems (i.e. CWS).

The Grantee also continued to use the results of the CAM Focus Group Report that was completed and released in October 2013, which summarized client feedback on the their experience and participation in FPC, for program and service delivery improvements. The Report identified recommendations to further increase the capacity of FPC to meet the needs of its participants and improve client retention.

The importance of FPC was shared and supported by CWS. The CAM project was one of 14 strategies prioritized in its five-year System Improvement Plan. The themes of the CAM goals – increasing partner capacity to address mental health issues and trauma, assuring that parents, children, and families received appropriate and adequate services – are deeply connected to CWS priorities. These priorities included improving the County's array of services, increasing effective collaboration, and improving effective social work practice.

Table C8: Riverside Performance Indicators

Indicator	Grantee Performance[108]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	90.5% Of those who were at home at time of enrollment[109]	Not Available
C2. Recurrence of maltreatment	4.0% Within 6 months of CAM entry	4.8% *Disposed Oct 1, 2012 to Mar 31, 2013 – Victims Re-victimized within 6 Months (California Child Welfare Indicators Project)*
C3. Median Length of Stay in Foster Care	266.0 days	243.0 days *Median Length of Stay in Foster Care Oct 1, 2012 to Mar 31, 2013 (California Child Welfare Indicators Project)*
C4. Re-entries to Foster Care within 12-months of reunification	3.2%	13.2% *Riverside County Children Removed to Foster Care During Oct 1, 2011 to Sep 30, 2012 – Re-entries to Foster Care within 12 months of Previous Discharge (California Child Welfare Indicators Project)*
C5. Timeliness of reunification	72.8% Reunified within 12 months of removal	45.4% *Riverside County Children Discharged During April 1, 2012 to Sep 30, 2012—*

[108] **Grantee performance through September 30, 2014.**

[109] **For Riverside, 61.5% of the children were in-home at time of CAM enrollment.**

Indicator	Grantee Performance[108]	Other Contextual Performance Information (specify)
		Discharged to Reunification within 12 Months (California Child Welfare Indicators Project)
C6. Timeliness of permanency	54.9% Exited to adoption or guardianship within 24 months of removal	20.5% *Riverside County Children Exited to Permanency During Oct 1, 2011 to Sep 30, 2012 – Exits to Permanency, less than24 months in care (California Child Welfare Indicators Project)*
C7. Prevention of SEN	The eighteen births subsequent to CAM enrollment did not test positive for substance exposure	Not available
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Educational: 93.6% Primary Pediatric Care: 99.4% Mental Health: 97.5% Developmental: 94.2% Substance Abuse Prevention: 98.6% Substance Abuse Treatment: 80.0% Neurological: 90.4% Dental: 99.4%	Not available
A1. Access to Treatment[110]	Mean: 2.2 days Median: 0.0 days	Mean: 6.0 days Median: 0.0 days *Days Waiting to Enter Treatment within Riverside County During 2010 (TEDS-A111)*

[110] **The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Riverside this was 99.5% of the adults who entered substance abuse treatment services.**

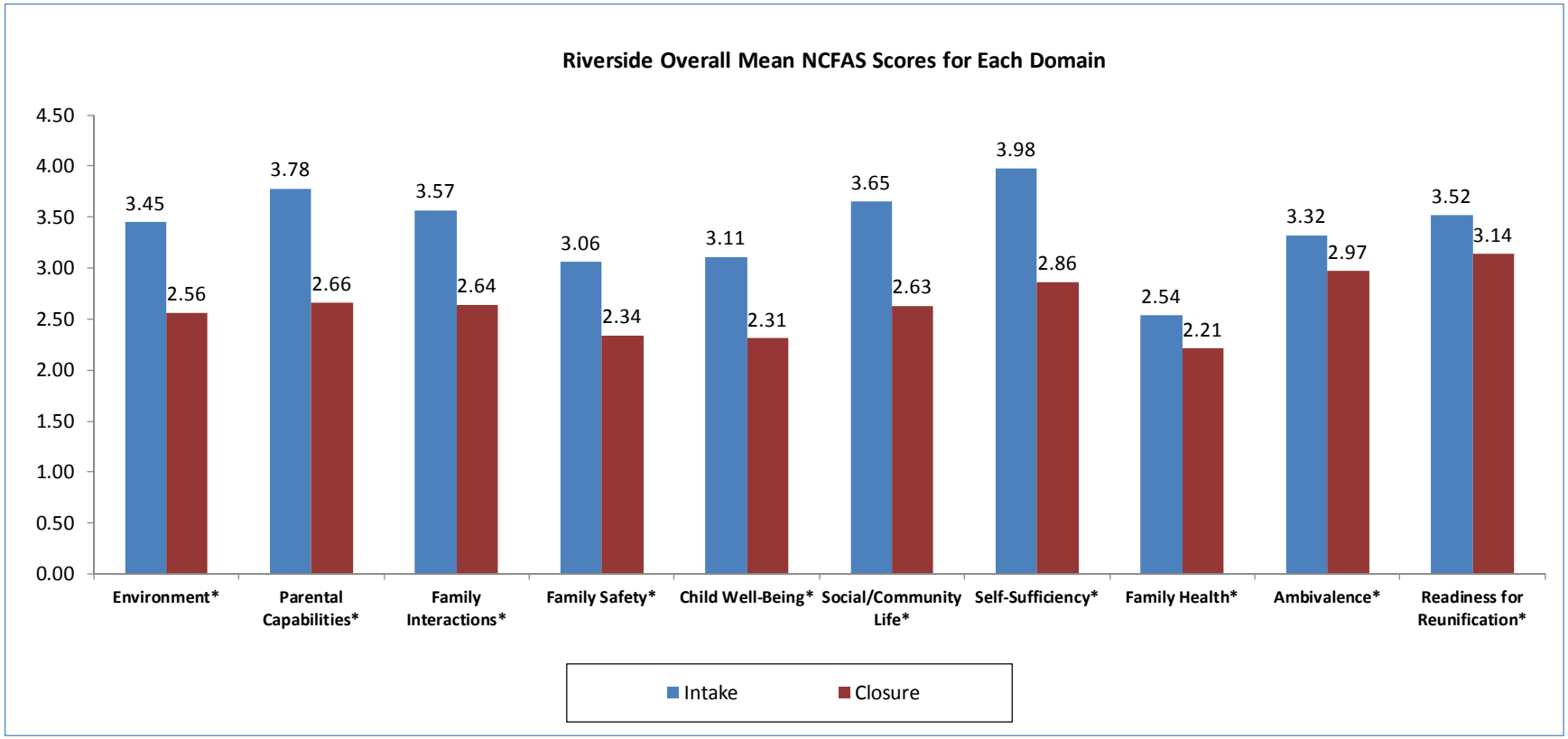
[111] **Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions (TEDS-A) and discharges (TEDS-D) through the Substance Abuse and Mental Health Services Administration (SAMHSA).**

Indicator	Grantee Performance[108]	Other Contextual Performance Information (specify)
A2. Retention in Substance Abuse Treatment	22.1% Completed 8.0% Transferred Completed Median length: 380.0 days Transferred Median length: 46.0 days	37.7% Completed *Reasons for Discharge within Riverside County During 2010 (TEDS-D)*
A3. Substance Use (reduction)	Alcohol: 60.4% Marijuana: 70.2% Heroin/Other Opiates: 33.3% Methamphetamine: 64.4%	Not available
A4. Connected to Supportive Services	Of those assessed, percentage who received services: Primary Medical Care: 90.0% Dental: 83.5% Mental Health: 87.1% Child Care: 78.6% Transportation: 96.2% Housing: 92.3% Parenting: 83.5% Domestic Violence: 86.3% Employment: 92.0% Continuing Care: 97.0% Trauma: 87.1% Family Planning: 91.3% Legal: 80.9%	Not Available
A5. Employment Status	Employed F/T or P/T Admission: 29.3% Discharge: 44.2% Enrolled in education or vocational training Admission: 5.8%	Admission: 14.7% Discharge: 14.4% *Employed F/T or P/T within Riverside County During 2010 (TEDS-A, TEDS-D)*

Indicator	Grantee Performance[108]	Other Contextual Performance Information (specify)
	Discharge: 11.0%	
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 94.1% Discharge: 100.0%	Admission: 89.0% Discharge: 89.4% *Arrests within Riverside County During 2010 (TEDS-A, TEDS-D)*
Average Length of Services for Closed CAM Cases[112] Median number of days (months)	121.0 days (4.0 months) Based on 789 of 869 families	Not available

[112] **See Table 1 in Appendix B for more details.**

Figure C8: Riverside Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$. Lower scores indicate improvement.

Sacramento Site Summary

The Sacramento County Children Affected by Methamphetamine (CAM) Project (also known as Children in Focus or CIF) served children and families participating in the Dependency Drug Court (DDC) or the Early Intervention Family Drug Court (EIFDC). The County of Sacramento Child Protective Services implemented CAM to enhance services provided to children aged 0-17. CAM supported services that included Celebrating Families (CF) and the use of Recovery Resource Specialists (RRS). CAM also linked participants to County Birth and Beyond Family Resource Centers (BBFRC) and other community resources that provided recovery support during CF participation and beyond commencement.

Sacramento CAM proposed to serve 420 children and 280 adults throughout the four year grant program. Through August 2014, Sacramento CAM has served 712 adults and 1,017 children and has exceeded their projected client numbers by over 200% for adults and children.

What did the site set out to accomplish?

The Sacramento CAM Project set forth to help children affected by parental substance use by addressing their needs as an explicit component of their parents' recovery process and with the goal of breaking the cycle of intergenerational addiction. Key planned service elements included the following:

- *Celebrating Families* – a 16-week evidence-based program that helped families recover from the effects of substance abuse and child neglect. Every family member beginning at age 4 participated in structured educational groups and activities. Meals were enjoyed together and families learned to communicate about the difficult issues that make recovery and healing possible.
- *Recovery Resource Specialists* – linked families to both community and faith-based services. The three RRS positions that were funded by CAM increased effective linkages by means of referring families to BBFRCs and provide an underpinning support system beyond participation in formal treatment services.

The CAM Project also set out to improve the collaborative capacity of county systems and staff to enhance the service array, increase access to services and retention in treatment and increase child safety, permanency, and well-being.

How did that plan change and why?

Throughout implementation, the grantee made refinements to the role of RRS to improve service delivery to participant families. Those included:

- RRS contacted Child Welfare Services (CWS) social workers to help initiate referrals to CF;
- Early engagement of the parents via the RRS through introductions at the first or second CF sessions;
- The completion of the initial NCFAS interview within the first few weeks; and,
- Initiating the warm hand-off to local BBFRCs earlier in the program (beginning as early as week 3) to allow for early and gradual transition to community support.

Early engagement of RRS promoted trust and support between the parent and the RRS which resulted in increased willingness to accept the connections to valuable community resources. The Grantee also learned of the critical importance of RRS regular attendance in FRC meetings to remain up to date on the services available at each of the eight sites. In addition, the Grantee focused on continued professional development and training for the RRSs. Information gained, particularly related to trauma and trauma-informed practice, was readily integrated into practice.

What was unique about this effort?

In Sacramento, participation in CAM services was defined by the 16-week participation in CF as an enhancement to the family treatment drug courts. This approach was a departure from other CAM projects where funding was used to initiate a family drug court. The administration of screening and assessments, data collection, and service provision were all conducted during the CF participation period. Another unique feature of Sacramento CAM was how it assists families from both DDC and EIFDC programs. EIFDC was a voluntary court program which enhances CWS interventions with families before the removal of children is necessary while DDC served families with open dependency cases with CWS. The eligibility or admission criteria to participate in CF were that the client must be involved in either DDC or EIFDC and that the client had physical custody or had unsupervised visitation on Saturdays.

Additionally, the parenting program was unique in itself as it offered an interactive program for every family member age four through adulthood; teaching all family members that they have a voice in recovery.

The unique features of the Sacramento CAM project design were important to consider, particularly when analyzing outcome data. The specific performance indicators for Access to Treatment (A1) needed to be viewed in light of the project design, since all of the parent participants were required to be in treatment prior to entering in CAM.

What did this Project accomplish?

The Grantee's wide implementation of CF was one of its most significant accomplishments and was recognized both locally and nationwide for its success. The CAM grant provided the grantee with the opportunity for full implementation of the CF curriculum. Also, the grantee committed to continuous improvement and refinement in its implementation of CF when barriers and challenges were encountered. A CAM Policy and Procedures workgroup convened every other month to review CF implementation leading to continuous improvement efforts and modifications to policies and procedures as needed.

The grantee also enhanced CF based on its implementation experiences. One of the enhancements was the inclusion of a licensed clinical social worker (LCSW) to provide therapeutic support onsite to any children struggling during session. Other enhancements to CF included: changing terminology by using "commencement" instead of "graduation" to reflect the ongoing nature of recovery; expanded and improved recruitment efforts in partnership with CWS social workers; and modification of CF sessions to accommodate children's ages and developmental stages.

Another highlighted accomplishment was the utilization of RRSs to provide critical recovery support. Upon enrollment into CAM, families were assigned an RRS also through a local non-profit substance abuse treatment provider. The RRSs linked families to Birth and Beyond Family Resource Centers

(BBFRCs) which provided comprehensive primary prevention and early intervention programs and supported services in eight community locations.

Sacramento CAM engaged with budget discussions within CWS as a part of their plans to sustain the key service components of CAM. The Grantee expected the Board of Supervisors funding and implementation of CF and RRS to remain the same when the grant funding expired.

Select results from the locally conducted evaluation for Sacramento were extracted from their final report and are included below.

Comparison Group Outcomes

The Grantee utilized a historical comparison group to examine the effectiveness of the implementation of CAM (also known as Children in Focus or CIF) in their local evaluation report (a summary of outcomes follows). All the cases were tracked through September 2014. Analyses found significant differences in child safety and permanency outcomes and adult outcomes due to the CIF enhancement to both of the FDC programs (DDC and EIFDC).

- Children of families that received the CIF enhancement in addition to EIFDC services were significantly more likely to stay in their home than those who received EIFDC services alone (95.1% and 88.1%, respectively).
- Among children who were removed, children of parents in DDC who also received the CIF enhancement were significantly more likely to be reunified with their families than children of families that only received DDC (97.0% versus 84.0%, respectively).
- Among children of parents in EIFDC who entered into foster care, children of parents who also received the CIF enhancement had higher reunification rates (60.0%) than children of parents who only received EIFDC (42.2%), but this difference was not statistically significant.
- Children of parents in DDC who received the CIF enhancement spend significantly less time in out of home care compared to children only provided DDC (median of 268 days versus 287 days, respectively).
- Participation in the CIF enhancement significantly increased successful completion of treatment for both DDC and EIFDC.
- Among parents in DDC and EIFDC, those who also received the CIF enhancement were more likely to experience a positive dismissal (dependency terminated) or graduate from their drug court program.

Table C9: Sacramento Performance Indicators

Indicator	Grantee Performance[113]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	97.6% Of those who were at home at time of enrollment[114]	Not Available
C2. Recurrence of maltreatment	1.3% Within 6 months of CAM entry	6.3% *Disposed Oct 1, 2012 to Mar 31, 2013 – Victims Re-victimized within 6 Months (California Child Welfare Indicators Project)*
C3. Median Length of Stay in Foster Care	140.0 days	159.0 days *Median Length of Stay in Foster Care Oct 1, 2012 to Mar 31, 2013 (California Child Welfare Indicators Project)*
C4. Re-entries to Foster Care within 12-months of reunification	9.0%	17.7% *Sacramento County Children Removed to Foster Care During Oct 1, 2011 to Sep 30, 2012 –* *Re-entries to Foster Care within 12 months of Previous Discharge (California Child Welfare Indicators Project)*
C5. Timeliness of reunification	82.6% Reunified within 12 months of removal	53.1% *Sacramento County Children Discharged During April 1, 2012 to Sep 30, 2012 – Discharged to Reunification within 12 Months (California Child Welfare Indicators Project)*
C6. Timeliness of permanency	75.0% Exited to adoption or guardianship within 24 months of removal	23.3% *Sacramento County Children Exited to Permanency During Oct 1, 2011 to Sep 30, 2012 –* *Exits to Permanency, less than24 months in care (California Child Welfare Indicators Project)*

[113] **Grantee performance through September 30, 2014.**

[114] **For Sacramento, 77.8% of the children were in-home at time of CAM enrollment.**

Indicator	Grantee Performance[113]	Other Contextual Performance Information (specify)
C7. Prevention of SEN	The one birth subsequent to CAM enrollment did not test positive for substance exposure	Not available
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Educational: 40.1% Primary Pediatric Care: 58.1% Mental Health: 11.7% Developmental: 15.0% Substance Abuse Prevention: 100.0% Substance Abuse Treatment: 1.0% Dental: 45.4%	Not available
A1. Access to Treatment[115]	Mean: 108.7 days Median: 50.0 days	Mean: 1.98 days Median: 0.0 days *Days Waiting to Enter Treatment within Sacramento County During 2010 (TEDS-A116)*
A2. Retention in Substance Abuse Treatment	50.8% Completed 4.8% Transferred Completed Median length: 185.0 days Transferred Median length: 68.0 days	35.5% Completed *Reasons for Discharge within Sacramento County During 2010 (TEDS-D)*
A3. Substance Use (reduction)	Alcohol: 95.8% Cocaine: 100.0% Marijuana: 83.9% Heroin/Other Opiates: 81.8%	Not available

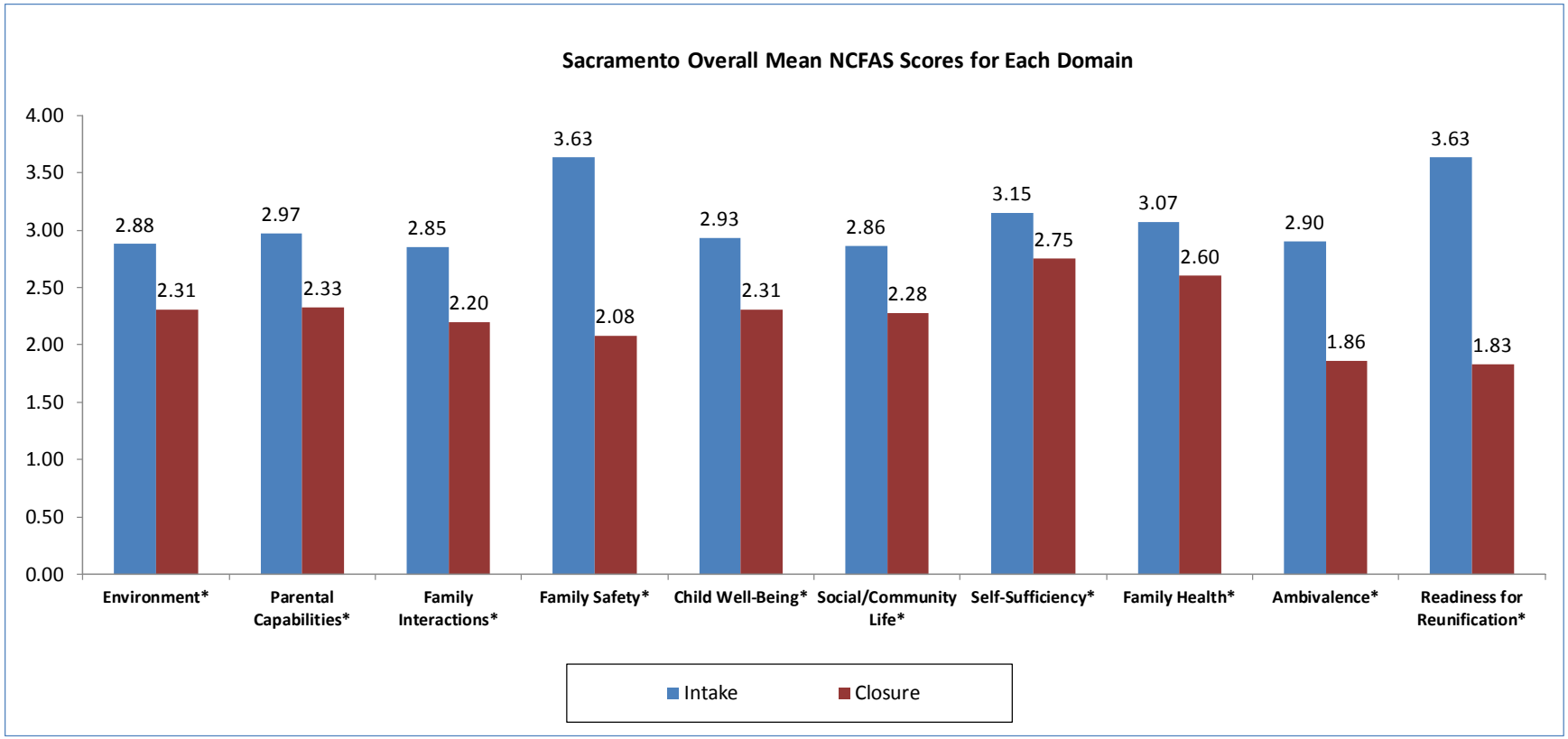
[115] The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Sacramento this was 24.8% of the adults who entered substance abuse treatment services.

[116]Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions (TEDS-A) and discharges (TEDS-D) through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Indicator	Grantee Performance[113]	Other Contextual Performance Information (specify)
	Methamphetamine: 93.2%	
A4. Connected to Supportive Services	Of those assessed, percentage who received services: Primary Medical Care: 41.3% Dental: 34.4% Mental Health: 18.8% Child Care: 9.7% Transportation: 51.4% Housing: 27.0% Parenting: 100.0% Domestic Violence: 6.1% Employment: 14.9% Continuing Care: 49.0%	Not Available
A5. Employment Status	Employed F/T or P/T Admission: 11.7% Discharge: 19.0% Enrolled in education or vocational training Admission: 0.5% Discharge: 0.5%	Admission: 12.8% Discharge: 13.7% *Employed F/T or P/T within Sacramento County During 2010 (TEDS-A, TEDS-D)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 90.9% Discharge: 99.5%	Admission: 88.4% Discharge: 88.7% *Arrests within Sacramento County During 2010 (TEDS-A, TEDS-D)*
Average Length of Services for Closed CAM Cases[117] Median number of days (months)	112.0 days (3.7 months) Based on 398 of 423 families	Not available

[117] **See Table 1 in Appendix B for more details.**

Figure C9: Sacramento Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$. Lower scores indicate improvement.

San Luis Obispo Site Summary

The San Luis Obispo County Children Affected by Methamphetamine (CAM) Project served children and families that participated in the Dependency Drug Court (DDC). The CAM Project focused on case management, in-home and outpatient behavioral health treatment services and parent education. Services were provided to children ages 0-17 and their families with a particular focus on school-aged children after determining that this population, particularly youth and teenagers, were under-served.

Key service elements included the following:

- *Celebrating Families! (CF)* – A 16-week evidence-based interactive parenting program that helped families recover from the effects of substance abuse and child neglect.
- *Court Appointed Special Advocates (CASAs)* – Provided children a mentor relationship, which could include tutoring supports, incentives and supportive activities.
- *Martha's Place Assessment Center* – Provided assessment and treatment strategies for children ages 0-5 at high risk for health and behavioral health problems.
- *Theraplay* – A trauma-informed therapy modality focused on building and enhancing attachment, self-esteem, trust in others and meaningful engagement.

The grantee experienced no significant problems in enrolling participants into the program. Through its collaborative efforts across systems, the grantee continued to meet their projected numbers for adults and children. Through August 2014, the Grantee served a cumulative total of 211 adults (102.4% of projected total of 206 adults) and 241 children (109.5% of projected total of 220 children).

What did the site set out to accomplish?

The Grantee planned to serve a cumulative total of 206 adults and 220 families over the course of the four-year grant program. In the initial proposal, the Grantee set out to expand services to children affected by parental methamphetamine use that were participating in DDC and provided the following new specialized services:

- Celebrating Families! (Cognitive Behavioral Support Group Curriculum for families affected by parental substance use disorders);
- Court Appointed Special Advocates (CASAs);
- Outpatient and In-home behavioral health counseling interventions;
- Services Coordination; and,
- Case management services to interface and coordinate with a variety of services including school services, developmental services, and primary care.

How did that plan change, and why?

In Year 1, the grantee requested an adjustment of its projected total of clients to be served from 60 children and 72 adults to 40 children and 40 adults due to delays in the start-up implementation phase. The Grantee also changed the number of adults in Y2 (32 to 60 adults) and Y3 (46 to 60 adults) from the initial proposal. The number of children remained the same for Y2-Y4 and the number remained the same for adults in Y4 (46 adults). Although the project aimed to primarily focus on

serving school-aged children (ages 6-17), the grantee realized the continued need to serve younger children with participating families. Therefore, the grantee partnered with Martha's Place, a community-based family services organization, and implemented Theraplay with younger children from families participating in the CAM project.

During the initial phase of implementation, the Project realized that coordination of all the programmatic components and viable delivery required more ancillary staff than what they had planned for and were funded by the grant. These components included transportation for families to sessions, grocery shopping, meal preparation and serving, site preparation, group facilitation and childcare. With time, the necessary logistics were stabilized with established systems now functioning strongly. The grantee now recognized the importance of early planning regarding recruitment and anticipation of staffing needs. The utilization of volunteers and student interns also allowed for stronger staff coverage as needed. The need and cost associated for transportation, however, continued to be a challenge for the Grantee and participant families. Given the labor intensity of CF!, the Project realized that it was no longer feasible to simultaneously run two tracks of CF! in separate locations in the County. The Project continued to serve the northern (Atascadero) and southern (Grover Beach) regions of the County but alternated and overlap delivery of the 16-week program between the two regions.

The complex needs of children and families also required the grantee to expand their partnerships to the community. One critical need identified during implementation was the need for occupational therapy (OT) services for children. Martha's Place offered OT but had a long waiting list for clients. The grantee identified Kid Motion as a service partner to provide OT services to CAM children in a more timely fashion. The Grantee has noted that gains achieved through OT services have a synergetic effect on children as it helped them prepare for success in other areas. Most recent, the grantee had begun connecting with school resources to address participating children's needs for academic and social-emotional supports.

What was unique about this effort?

A unique aspect of the San Luis Obispo CAM project was its strong focus on the parent-child relationship including services and clinical supports to strengthen that relationship. Specifically, the grantee expanded how the DDC served children and families by taking a holistic, family-centered approach to treatment. Programming such as CF! and attachment-based therapy provided families the support they needed to restore and strengthen family relationships. According to the grantee, this systems approach to working with families and the community represented a significant shift in services for children and families in their community. The CAM project also allowed the introduction of parent-child attachment services early in treatment rather than waiting until the child returned back home with the parent, which was standard practice prior to CAM. By focusing on attachment, both the child and parent benefitted, increased the quality of the visitation and provided greater motivation and confidence in the parent's recovery. Another innovation was the focus on providing early support and services especially to those participating in CF! This approach enhanced the degree to which the families were able to benefit from the CF! curriculum.

What did this project accomplish?

The results of pre-intervention and post-intervention scores on the North Carolina Family Assessment Scale (NCFAS) indicated significant improvement in family functioning. The Grantee planned to use those data as part of their plan to sustain key components of the CAM project such as CF!, Theraplay,

and other clinical supports. Furthermore, the grantee increased substantial capacity to implement CF!, refined recruitment and retention to successfully serve DDC participants.

Another significant accomplishment was the improved bridge-building and resource management among community partnerships such as Martha's Place and CASA. Both partnerships underwent an initial period of adjustment and negotiation but this collaboration improved over time. For the grantee, both partnerships participated in the health and well-being of children they were serving in common. Improvements included a streamlined referral process, reduced waiting list for referred CAM children, and a greater awareness and understanding of each other's service capacity. The depth of the partnership with Martha's Place was best exemplified by the agency's new practice of referring families to the CAM team for CF! and additional services, following completion of the assessment. Also, a designated CASA representative attended weekly case management meetings and the monthly Stakeholder Meeting. To date, CASA successfully matched a total of 29 CAM children with volunteers to provide mentoring support for CAM youth–a pattern only interrupted by a lack of volunteers.

The grantee, along with the larger DDC continued strengthening its collaborative relationship with CWS, particularly as it related to progress of participant families and the needs of children and the coordination of various case plans. One remaining specific challenge included the need to improve communication between CWS social workers and DDC and CAM Teams regarding progress of participant families and how this information was used in a collaborative manner to inform important decisions such as unsupervised visitation and reunification. Also, occupational therapy (OT) and school support were identified as emerging critical needs among children in the CAM Project.

The grantee was also seeking to identify residential treatment resources for families. Through another SAMHSA grant awarded to the DDC, the grantee contracted with residential treatment facilities to establish extra beds for women with children. The grantee reported some initial challenges in the launching of this program due to the lengthy request for proposal and contracting process.

The grantee was confident in their abilities to sustain most of the key components of CAM by integrating many of the service components into their behavioral health system. This integration would enable the drug treatment system to maintain the family-centered and child-focused approach established through the CAM grant, with particular attention to the parent-child relationship as a part of recovery. Drawing from the outcome data analysis and overall success of the CAM project, the grantee made a compelling case for future funding during budget meetings with key stakeholders. Additionally, some of the child mental health services provided by CAM staff and Martha's Place could be billable under Mental Health Medi-Cal or EPSDT or under changes related to implementation of the Affordable Care Act. The grantee was successful in identifying additional funding for its case managers, allowing for an increase from 20 hours to 30 hours per week, per case manager.

Table C10: San Luis Obispo Performance Indicators

Indicator	Grantee Performance[118]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	88.3% Of those who were at home at time of enrollment[119]	Not Available
C2. Recurrence of maltreatment	1.9% Within 6 months of CAM entry	11.3% *Disposed Oct 1, 2012 to Mar 31, 2013 – Victims Re-victimized within 6 Months (California Child Welfare Indicators Project)*
C3. Median Length of Stay in Foster Care	304.0 days	279.0 days *Median Length of Stay in Foster Care Oct 1, 2012 to Mar 31, 2013 (California Child Welfare Indicators Project)*
C4. Re-entries to Foster Care within 12-months of reunification	1.8%	12.0% *San Luis Obispo County Children Removed to Foster Care During Oct 1, 2011 to Sep 30, 2012 –* *Re-entries to Foster Care within 12 months of Previous Discharge (California Child Welfare Indicators Project)*
C5. Timeliness of reunification	72.3% Reunified within 12 months of removal	44.9% *San Luis Obispo County Children Discharged During April 1, 2012 to Sep 30, 2012 —* *Discharged to Reunification within 12 Months (California Child Welfare Indicators Project)*
C6. Timeliness of permanency	93.3% Exited to adoption or guardianship within 24 months of removal	23.2% *San Luis Obispo County Children Exited to Permanency During Oct 1, 2011 to Sep 30, 2012—* *Exits to Permanency, less than24 months in care (California Child Welfare Indicators Project)*

[118] Grantee performance through September 30, 2014.

[119] For San Luis Obispo, 32.3% of the children were in-home at time of CAM enrollment.

Indicator	Grantee Performance[118]	Other Contextual Performance Information (specify)
C7. Prevention of SEN	The four births subsequent to CAM enrollment did not test positive for substance exposure	Not available
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Educational: 100.0% Primary Pediatric Care: 100.0% Mental Health: 100.0% Developmental: 100.0% Substance Abuse Prevention: 100.0%	Not available
A1. Access to Treatment[120]	Mean: 38.6 days Median: 44.0 days	Mean: 0.5 days Median: 0.0 days *Days Waiting to Enter Treatment within San Luis Obispo County During 2010 (TEDS-A121)*
A2. Retention in Substance Abuse Treatment	55.2% Completed 4.9% Transferred Completed Median length: 428.0 days Transferred Median length: 224.0 days	36.0% Completed *Reasons for Discharge within San Luis Obispo County During 2010 (TEDS-D)*
A3. Substance Use (reduction)	Alcohol: 75.6% Marijuana: 70.8% Heroin/Other Opiates: 73.3% Methamphetamine: 81.3%	Not available
A4. Connected to Supportive Services	Of those assessed, percentage who received services: Mental Health: 100.0%	Not Available

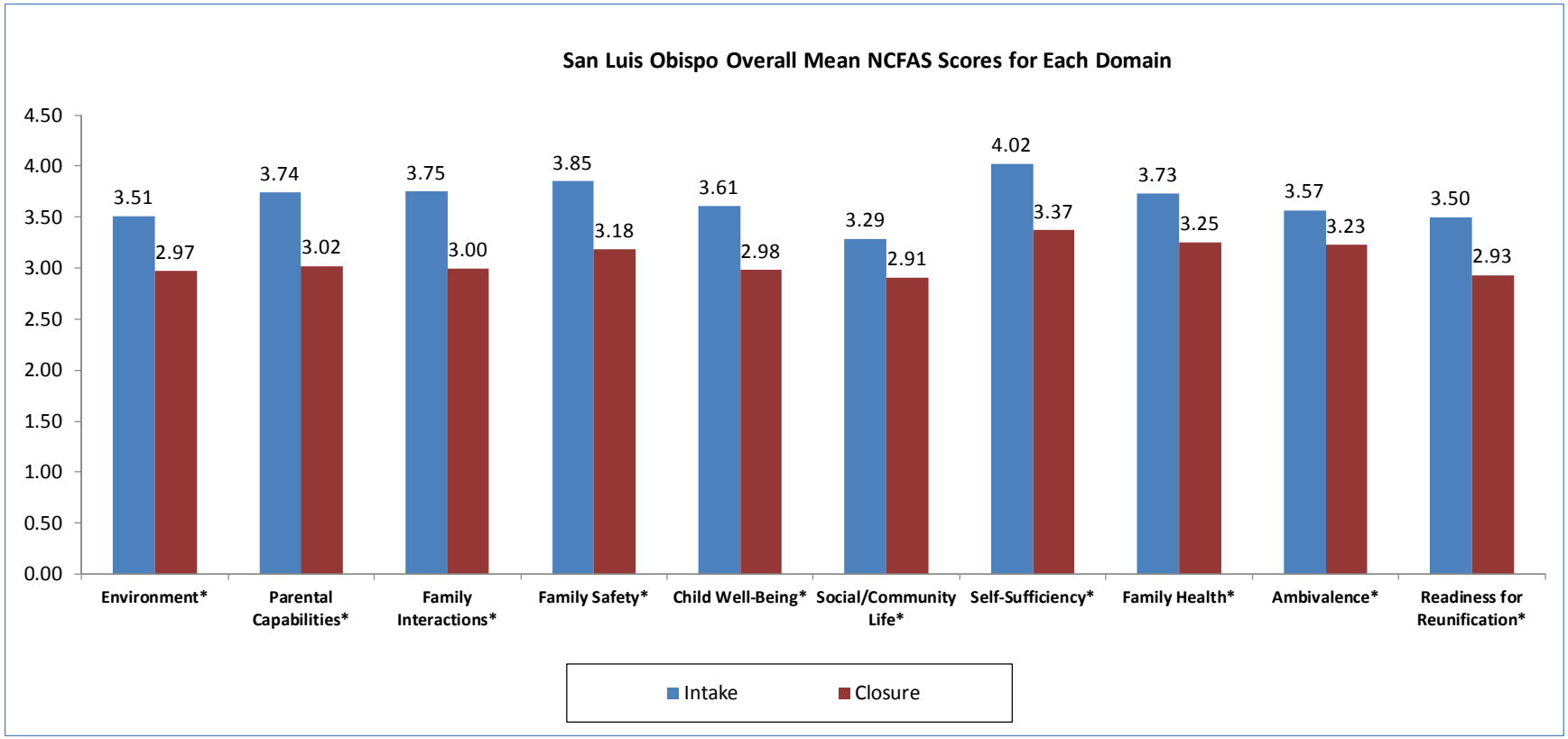
[120] The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For San Louis Obispo, this was 4.2% of the adults who entered substance abuse treatment services.

[121] Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions (TEDS-A) and discharges (TEDS-D) through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Indicator	Grantee Performance[118]	Other Contextual Performance Information (specify)
	Child Care: 100.0% Transportation: 100.0% Housing: 100.0% Parenting: 100.0% Employment: 100.0% Continuing Care: 100.0% Trauma: 100.0% Family Planning: 100.0%	
A5. Employment Status	Employed F/T or P/T Admission: 23.1% Discharge: 57.4% Enrolled in education or vocational training Admission: 3.3% Discharge: 9.8%	Admission: 29.3% Discharge: 32.1% *Employed F/T or P/T within San Luis Obispo County During 2010 (TEDS-A, TEDS-D)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 81.1% Discharge: 94.3%	Admission: 82.6% Discharge: 83.2% *Arrests within San Luis Obispo County During 2010 (TEDS-A, TEDS-D)*
Average Length of Services for Closed CAM Cases[122] Median number of days (months)	147.5 days (4.9 months) Based on 112 of 138 families	Not available

[122] **See Table 1 in Appendix B for more details.**

Figure C10: San Luis Obispo Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$. Lower scores indicate improvement.

Santa Barbara Site Summary

The Santa Barbara County Children Affected by Methamphetamine (CAM) Project served children and families participating in the Family Treatment Drug Court (FTDC). The CAM Project utilized a family-centered and trauma-focused approach to treatment by focusing on specific issues to parents, the parent-child dyad and reunification supports. The targeted areas of the Project were the communities of Santa Maria and Lompoc, both located in the northern part of the county.

Santa Barbara CAM proposed to serve 177 children and 142 adults throughout the four-year grant program. Through August 2014, they had served a total of 90 adults (63.4% of projected) and 134 children (75.7% of projected).

What did the site set out to accomplish?

The Santa Barbara grantee recognized that integration of children and adult services was particularly important in the family engagement and reunification process. In pursuit of that effort, key elements of their project included:

- *Seeking Safety* – An evidence-based and present-focused therapy to help people attain safety from trauma/PTSD and substance abuse.
- *Nurturing Parenting Program* – A 16-week evidence-based parenting program which offered parenting information, parent modeling and coaching, and includes the child at the end of class sessions.
- *Great Beginnings* – Offered through a partnership with Child Abuse Listening and Meditation (CALM) and provides a continuum of services to promote the well-being, health, social-emotional and cognitive development of children ages 0-5 in the Project; services include home visitation and early childhood mental health services.

Santa Barbara's CAM project goals included:

- Provided rapid access and engagement in services for children with intensive supervision for families affected by methamphetamine and other drugs;
- Provided comprehensive, culturally competent and trauma-sensitive system of services for children and their families in treatment;
- Reduced substance use and related problems of parents;
- Strengthened the confidence and competence as parents/caregivers;
- Improved physical, developmental, and mental health of the children; and,
- Decreased time to reunification.

Throughout the grant program, the project struggled to enroll the projected numbers of families, particularly for adults, due in part to the formula they used for the initial proposal, which assumed two parents per family. The decreased number of detentions in Year 3 in the designated service delivery (North County communities of Santa Maria and Lompoc) also impacted the number of families eligible for FTC. The Grantee explored and implemented various strategies to identify additional parents and recruit families into the FTC program.

How did this plan change, and why?

The grantee explained that they "learned to adapt its services and programming to the specific needs of our clients while remaining true to the original grant plan." For example, the initial intention was to develop support groups for children, however this did not seem to work with the population being served due to the geographic and demographic dispersion of the CAM children.

In their efforts to engage more adults and fathers, the grantee also realized that gender specific and trauma-informed treatment for male participants was a gap in their services. In June 2012, the CAM staff decided to add the *Helping Men Recover* treatment curriculum specifically for those men and fathers who have experienced trauma and have struggled with substance use.

What did this project accomplish?

A unique focus of Santa Barbara FDTC and CAM Project was its trauma-informed services and trauma-informed system of care. Their service array included *Helping Women Recover* and *Seeking Safety*, which were evidence-based therapy programs to help women address trauma, Post-Traumatic Stress Syndrome and substance abuse. The grantee also initiated *Helping Men Recover*, which provided similar support for male participants. In addition, the grantee administered the Adverse Childhood Experiences (ACE) tool as a way to assess the level of trauma exposure by adult clients during their childhood. The Grantee reported that half of the CAM parents had an ACE Score of at least 10, which indicated exposure to all of the categories of trauma listed on the assessment tool.

The Grantee also provided clinical supervision for staff to address the issue of burnout and secondary trauma experienced by direct services staff. Those who have participated in clinical supervision have reported that they felt relieved and supported, as well as better equipped to work with CAM clients.

Nearly all of the assessment tools, individual and group therapy groups, and child-focused parenting were unavailable before the CAM grant. The grantee noted that their family-centered approach benefited CAM clients in all areas of FTDC, including a wide range of treatment strategies throughout the reunification and family engagement process. For example, the residential treatment options available through Good Samaritan allowed pregnant and parenting women to live with their children post-partum while undergoing substance abuse treatment. CAM clinicians provided an array of family-centered services, including parent-child counseling, family counseling, couples counseling, co-parenting support, Nurturing Parenting curriculum, parent-child guided parenting lessons and family reunification groups.

Given their strong work in trauma-informed care, Santa Barbara was highlighted in the FDC Learning Academy Webinar entitled, *Responding to Domestic Violence in Family Drug Courts*. Furthermore, the site presented at the National Association for Drug Court Professionals (NADCP) National Conference in July 2013 and May 2014 regarding their trauma-informed system of care. The grantee also presented findings from the CAM Project at the annual conference for the American Psychological Association in August 2013. With increased attention of addressing trauma in CWS and FDC practice, Santa Barbara FTDC and CAM is exemplary in this critical practice area.

The grantee secured budgetary commitments to fund the CAM service components beyond the grant program. The details of such plan were further discussed during the Year 4 Site Visit in April 2014. The grantee was able to use their local evaluation to provide valuable data and information to show the impact of the CAS services. The grantee planned to continue to exercise its collaborative strength by integrating areas of practice, administration, and planning efforts within the FPC as a new way of doing business.

The following table summarizes Santa Barbara's accomplishments in terms of the required performance measures.

Table C11: Santa Barbara Performance Indicators

Indicator	Grantee Performance[123]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	69.2% Of those who were at home at time of enrollment[124]	Not Available
C2. Recurrence of maltreatment	0.7% Within 6 months of CAM entry	3.4% *Disposed Oct 1, 2012 to Mar 31, 2013 – Victims Re-victimized within 6 Months (California Child Welfare Indicators Project)*
C3. Median Length of Stay in Foster Care	339.0 days	393.0 days *Median Length of Stay in Foster Care Oct 1, 2012 to Mar 31, 2013 (California Child Welfare Indicators Project)*
C4. Re-entries to Foster Care within 12-months of reunification	5.4%	11.9% *Santa Barbara County Children Removed to Foster Care During Oct 1, 2011 to Sep 30, 2012 – Re-entries to Foster Care within 12 months of Previous Discharge (California Child Welfare Indicators Project)*
C5. Timeliness of reunification	64.7% Reunified within 12 months of removal	39.4% *Santa Barbara County Children Discharged During April 1, 2012 to Sep 30, 2012 – Discharged to Reunification within 12 Months (California Child Welfare Indicators Project)*

[123] **Grantee performance through September 30, 2014.**

[124] **For Santa Barbara, 11.7% of the children were in-home at time of CAM enrollment.**

Indicator	Grantee Performance[123]	Other Contextual Performance Information (specify)
C6. Timeliness of permanency	61.9% Exited to adoption or guardianship within 24 months of removal	17.4% *Santa Barbara County Children Exited to Permanency During Oct 1, 2011 to Sep 30, 2012 – Exits to Permanency, less than24 months in care (California Child Welfare Indicators Project)*
C7. Prevention of SEN	No children were born subsequent to CAM enrollment	Not available
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Educational: 100.0% Primary Pediatric Care: 100.0% Mental Health: 97.4% Developmental: 96.8% Substance Abuse Prevention: 100.0% Substance Abuse Treatment: 100.0% Neurological: 85.7% Dental: 100.0%	Not available
A1. Access to Treatment[125]	Mean: 7.6 days Median: 0.0 days	Mean: 1.4 days Median: 0.0 days *Days Waiting to Enter Treatment within Santa Barbara County During 2010 (TEDS-A126)*

[125] The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Santa Barbara, this was 41.5% of the adults who entered substance abuse treatment services.

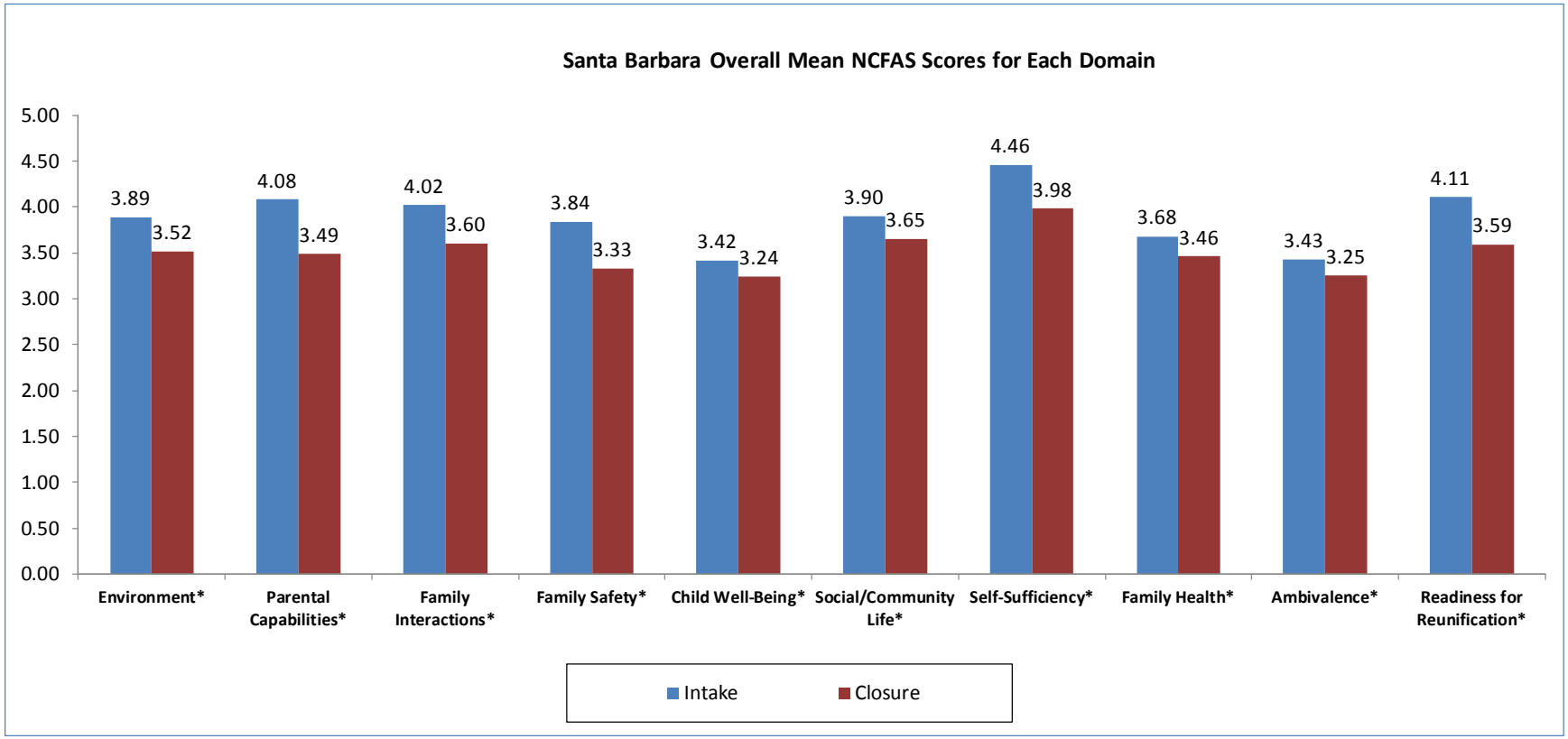
[126] Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions (TEDS-A) and discharges (TEDS-D) through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Indicator	Grantee Performance[123]	Other Contextual Performance Information (specify)
A2. Retention in Substance Abuse Treatment	68.4% Completed 2.6% Transferred Completed Median length: 301.0 days Transferred Median length: 177.0 days	46.7% Completed *Reasons for Discharge within Santa Barbara County During 2010 (TEDS-D)*
A3. Substance Use (reduction)	Alcohol: 100.0% Marijuana: 100.0% Heroin/Other Opiates: 100.0% Methamphetamine: 95.5%	Not available
A4. Connected to Supportive Services	Of those assessed, percentage who received services: Mental Health: 100.0% Transportation: 86.8% Housing: 92.3% Parenting: 100.0% Domestic Violence: 94.6% Continuing Care: 100.0% Trauma: 97.7% Family Planning: 88.7% Legal: 100.0%	Not Available
A5. Employment Status	Employed F/T or P/T Admission: 28.9% Discharge: 37.8% Enrolled in education or vocational training Admission: 1.6% Discharge: 11.5%	Admission: 22.6% Discharge: 23.0% *Employed F/T or P/T within Santa Barbara County During 2010 (TEDS-A, TEDS-D)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 67.6% Discharge: 87.8%	Admission: 83.3% Discharge: 81.2%

Indicator	Grantee Performance[123]	Other Contextual Performance Information (specify)
		Arrests within Santa Barbara County During 2010 (TEDS-A, TEDS-D)
Average Length of Services for Closed CAM Cases[127] Median number of days (months)	247.0 days (8.1 months) Based on 63 of 74 families	Not available

[127] **See Table 1 in Appendix B for more details.**

Figure C11: Santa Barbara Overall NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$. Lower scores indicate improvement.

Santa Cruz Site Summary

The Santa Cruz County Children Affected by Methamphetamine (CAM) Project served children and families participating in the Family Preservation Court (FPC). Also known as Leaps and Bounds, the CAM Project focused on the developmental and socio-emotional needs of children. The grantee employed two full-time Children's Services Coordinators (CSCs) to deliver or coordinate the following key service elements:

- *Promoting First Relationships (PFR)* – A 10-week training curriculum used during home visits for families with children ages 0-3. PFR was also a prevention program dedicated to promoting attachment and positive and responsive parent-child relationships.
- *Ages and Stages Questionnaires* (ASQ) – Assessed developmental areas of communication, gross motor, fine motor, problem-solving, personal-social and social-emotional behavior. The Project also offered ASQ learning activities to help the child progress in areas of identified delays.
- *Parent-Child Interaction Therapy (PCIT* – An evidence-based parent-child treatment program aimed at promoting positive parent-child relationships and interactions while teaching parents effective child management skills for children ages 2-7.
- *Home Visits* – CSCs provided home visits with all CAM children and conducted assessments, including the Child Behavior Checklist (CBCL) and ASQs. They worked with parents using ASQ Learning Activities and the PFR curriculum.
- *Dominican Child Development Clinic* – Offered comprehensive neuro-developmental and psycho-social assessments conducted by a multi-disciplinary team.

Overall, outcome findings indicated that CAM participation improved child well-being, social and emotional health as well as development and reduction in behavioral problems.

What did the site intend to accomplish?

The Santa Cruz CAM service model set forth to deliver enhanced and targeted services which addressed and supported healthy child development for infants and young children ages 0-7 through early assessment and intervention. By focusing particular attention to the developmental expectations and enhancing the parent-child attachment, the model was able to promote the sensitive, consistent and development-informed parenting that CAM children need. This focus, which started at the time of the out-of-home placement and continued through reunification, reflected the comprehensive and thoughtful approach of CAM service delivery.

Santa Cruz CAM proposed to serve 177 children and 142 adults throughout the four-year grant program.

The goals and objectives of the CAM Project included:

- Provided age-appropriate screening and assessment to FPC children ages 0-7 whose parents are recovering from methamphetamine use;
- Increased children's connection to services;
- Provided evidence-based therapy to children and their parents;
- Aligned service delivery to service and treatment plan recommendations;

- Improved parents' ability to care for their children safely;
- Improved child well-being and healthy development; and,
- Reviewed service needs of program participants annually and on an on-going basis.

How did that plan change and why?

Through August 2014, Santa Cruz CAM served a total of 120 adults (104.3% of projected) and 128 children (84.2% of projected). Throughout the grant program, the Project struggled to meet its projected numbers. In May 2012, the grantee was placed on a Corrective Action Plan (CAP) by SAMHSA after they were significantly behind in meeting projected client numbers served in Year 2. Consequently, the Grantee expanded its efforts to increase client flow, including raising the age limit for eligibility to age 7 and ensuring that all eligible participants were approached for recruitment.

In August 2012, the FPC temporarily shut down new admissions after treatment funding through their RPG grant expired, which in turn impacted admission into CAM. The grantee recovered from the temporary shutdown and reached out to all child welfare staff, the court and attorneys for parents and children in the CWS system and re-engaged all eligible adult clients to engage in CAM services.

What was unique about this effort?

A highlighted feature of the CAM project was the intentional and integrated promotion of healthy development of children participating in the FPC. Santa Cruz CAM's strong focus on the parent-child attachment and relationship was based on the belief that child well-being and healthy development occurs in the context of parent-child relationship. CAM staff worked closely with the family to increase opportunities for parents to engage with their child and strengthen the relationship. The successful implementation of PFR and PCIT was particularly helpful in supporting this focus. Santa Cruz CAM also placed a high value on quality visitation, which provided valuable opportunities to strengthen the parent-child bond and for parents to utilize newly learned parenting skills. The CAM Project also recognized that parent-child visits were one of the determining factors in reunification and that incorporation of family-based/attachment based interventions such as PFR and PCIT offered opportunities for both quality and positive interactions.

Another highlighted feature of the CAM project was its response to the need for social and community support to maintain long-term recovery. FPC and CAM families have complex and multiple needs with long histories, but with few extended family and social supports. In Year 2 and Year 3, the grantee held Sober Family Fun events which provided opportunities for FPC and CAM families to enjoy the outdoor activities with other sobriety-focused families. In Year 1, a significant need for housing support was identified for CAM families. In response, the grantee provided a staff person to assist CAM families with their housing needs through a local housing organization called Families in Transition (FIT).

What were the key accomplishments?

The grantee shared how the CAM grant changed the way they served children ages 0-7 and their families in FPC. Prior to CAM funding, the FPC and general child welfare population received Positive Parenting Program (aka Triple P), which was an evidence-based parenting program focused on helping parents to develop parenting skills. With CAM funding, the grantee was able to purchase the necessary equipment, curriculum and training materials and securing required staffing to facilitate PFR and PCIT. CAM also helped move FPC from a program focused primarily on adults in recovery, to

families in recovery with a stronger emphasis on strengthening the parent-child relationship and the needs of the children. Each of the CAM service elements, such as PCIT, PFR, home visits by the CSCs and developmental assessments supported families in achieving their goals of successful reunification, improved parenting skills and child well-being.

The grantee confirmed that CWS has committed the necessary funds to sustain the staff and service components of CAM in their 2014-2015 budget recommendations. This allowed them to continue to hire two full-time Children's Services Coordinators through the Parents Center and provided all of the key CAM services.

The Grantee also recognized opportunities to build upon their accomplishments under CAM and moved to the "next level" in terms of service array and systems change. These included:

- Expanded service array by adding an evidence-based parenting programs into their menu of parenting programs and improve coordination to match families to the most appropriate parenting program;
- Supported father-involvement and co-parenting;
- Trauma-informed system of care; and,
- Internal evaluation to support efficient data collection, entry, extraction, and analyses.

The following table summarizes Santa Cruz's accomplishments in terms of the required performance measures.

Table C12: Santa Cruz Performance Indicators

Indicator	Grantee Performance[128]	Other Contextual Performance Information (specify)
C1. Children Remain at Home throughout CAM participation	89.5% Of those who were at home at time of enrollment[129]	Not Available
C2. Recurrence of maltreatment	2.8% Within 6 months of CAM entry	5.9% *Disposed Oct 1, 2012 to Mar 31, 2013 – Victims Re-victimized within 6 Months (California Child Welfare Indicators Project)*
C3. Median Length of Stay in Foster Care	395.0 days	237.0 days *Median Length of Stay in Foster Care Children Previous Placement (California Child Welfare Indicators Project)*

[128] **Grantee performance through September 30, 2014.**

[129] **For Santa Cruz, 18.6% of the children were in-home at time of CAM enrollment.**

Indicator	Grantee Performance[128]	Other Contextual Performance Information (specify)
C4. Re-entries to Foster Care within 12-months of reunification	6.8%	14.1% *Santa Cruz County Children Removed to Foster Care During Oct 1, 2011 to Sep 30, 2012 – Re-entries to Foster Care within 12 months of Previous Discharge (California Child Welfare Indicators Project)*
C5. Timeliness of reunification	52.5% Reunified within 12 months of removal	16.7% *Santa Cruz County Children Discharged During April 1, 2012 to Sep 30, 2012 – Discharged to Reunification within 12 Months (California Child Welfare Indicators Project)*
C6. Timeliness of permanency	54.5% Exited to adoption or guardianship within 24 months of removal	25.9% *Santa Cruz County Children Exited to Permanency During Oct 1, 2011 to Sep 30, 2012 – Exits to Permanency, less than24 months in care (California Child Welfare Indicators Project)*
C7. Prevention of SEN	One of the three births subsequent to CAM enrollment tested positive for substance exposure	Not available
C8. Children Connected to Supportive Services	Of those assessed, percentage who received services: Educational: 97.6% Primary Pediatric Care: 94.4% Mental Health: 96.1% Developmental: 97.8% Neurological: 82.2% Dental: 75.0%	Not available
A1. Access to Treatment[130]	Mean: 189.7 days	Mean: 5.6 days

[130] **The mean and median for A1 is calculated for adults who enter substance abuse treatment on or after enrollment in CAM services. For Santa Cruz this was 16.0% of the adults who entered substance abuse treatment services.**

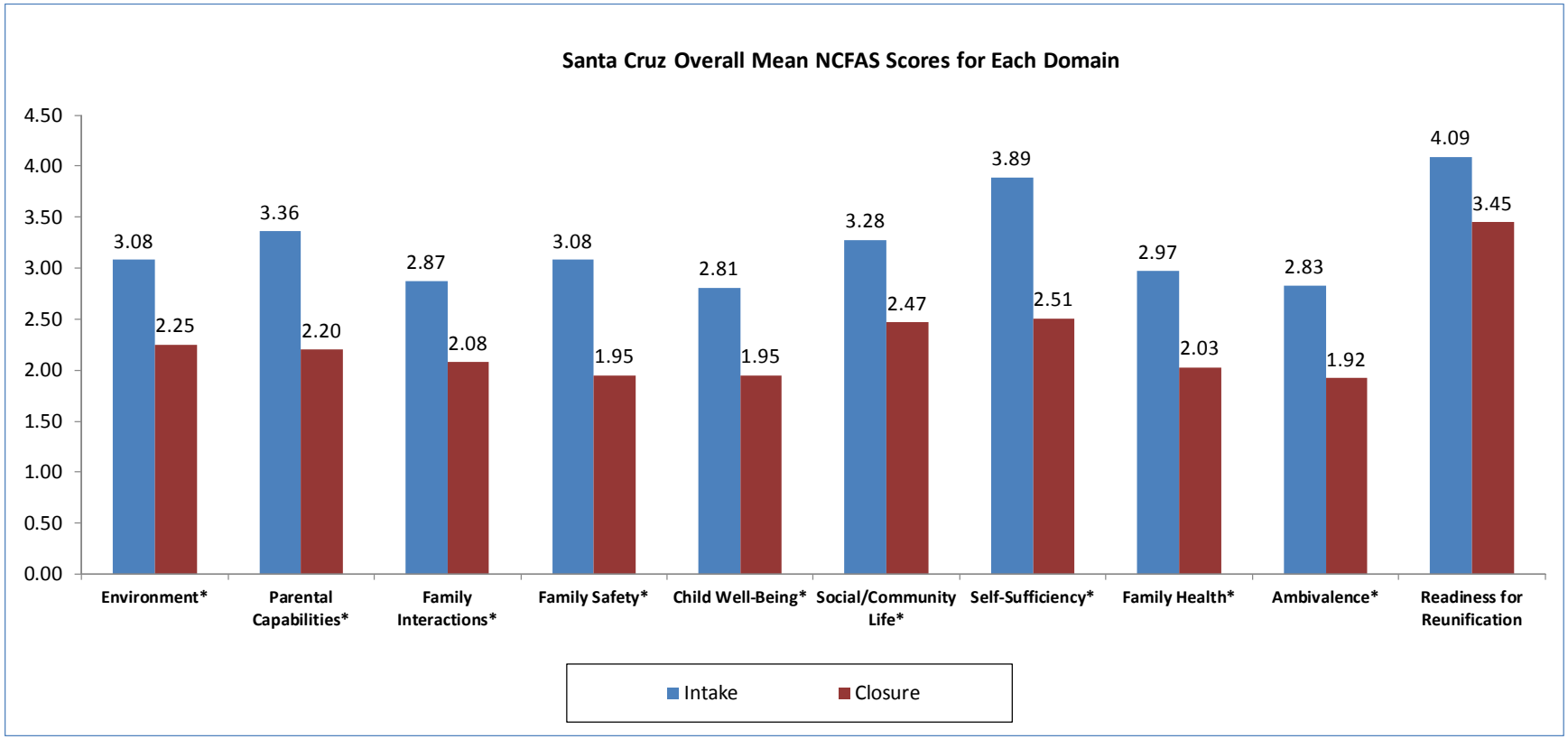
Indicator	Grantee Performance[128]	Other Contextual Performance Information (specify)
	Median: 52.0 days	Median: 0.0 days *Days Waiting to Enter Treatment within Santa Cruz County During 2010 (TEDS-A131)*
A2. Retention in Substance Abuse Treatment	39.0% Completed 1.4% Transferred Completed Median length: 364.0 days Transferred Median length: 324.0 days	42.0% Completed *Reasons for Discharge within Santa Cruz County During 2010 (TEDS-D)*
A3. Substance Use (reduction)	Alcohol: 100.0% Cocaine: 100.0% Marijuana: 100.0% Heroin/Other Opiates: 100.0% Methamphetamine: 84.6%	Not available
A4. Connected to Supportive Services	Of those assessed, percentage who received services: Primary Medical Care: 92.3% Dental: 72.7% Mental Health: 86.8% Child Care: 68.8% Transportation: 93.7% Housing: 85.1% Parenting: 98.9% Domestic Violence: 62.5% Employment: 72.7% Continuing Care: 97.8%	Not Available
A5. Employment Status	Employed F/T or P/T Admission: 27.8% Discharge: 50.0%	Admission: 16.5% Discharge: 16.8%

[131] **Treatment Episode Data Sets (TEDS) are provided for substance abuse admissions (TEDS-A) and discharges (TEDS-D) through the Substance Abuse and Mental Health Services Administration (SAMHSA).**

Indicator	Grantee Performance[128]	Other Contextual Performance Information (specify)
	Enrolled in education or vocational training Admission: 6.8% Discharge: 12.3%	*Employed F/T or P/T within Santa Cruz County During 2010 (TEDS-A, TEDS-D)*
A6. Criminal Behavior **No arrests in past 30 days**	Admission: 78.3% Discharge: 98.3%	Admission: 85.9% Discharge: 84.8% *Arrests within Santa Cruz County During 2010 (TEDS-A, TEDS-D)*
Average Length of Services for Closed CAM Cases[132] Median number of days (months)	366.0 days (12.0 months) Based on 73 of 104 families	Not available

[132] **See Table 1 in Appendix B for more details.**

Figure C12: Santa Cruz Overall Mean NCFAS Scores



Note. * signifies significant differences between intake and closure at $p < .05$.

Appendix D: Performance Measure Definitions

Child/Youth Indicators

C1. Children Remain at Home: Percentage of Children Identified as At Risk of Removal from the Home Who are Able to Remain in the Custody of a Parent/Caregiver through CAM Case Closure.

This indicator is primarily influenced by the grantees' program model which determines whether a child is allowed to remain in the home while participating in CAM services. The calculation is based on those children "at risk" of removal from the home who remained in the custody of parent/caregiver through CAM case closure compared to those who were in the home at time of enrollment and who were "at risk" of removal whose case is now closed.

C2. Occurrence of Child Maltreatment: Percentage of Children Who Had an Initial Occurrence and/or Recurrence of Substantiated/Indicated Child Maltreatment Within 6, 12, 18 and 24 Months After Enrolling in the CAM Program.

This indicator is intended to capture maltreatment that occurs *after* CAM enrollment; it does not reflect maltreatment that may have led to the family's referral or entry into CAM program. This indicator is designed to measure the effectiveness of the CAM program in preventing maltreatment by the parent or caregiver receiving CAM services. Because data are not collected on the perpetrator, it is possible that any maltreatment that occurred while the child was in out-of-home care during the CAM program may have been perpetrated by someone who is not the focus of the CAM intervention.

C3. Average Length of Stay in Foster Care: For Children Discharged from Foster Care, Their Average Length of Stay (in Days) from Date of Most Recent Entry into Such Care Until Date of Discharge.

This indicator applies to children who have been removed from the home and placed in out-of-home care. The calculation is based on the removal and reunification dates and foster care disposition. To be consistent with the way the CFSR outcomes are reported, the key findings highlight the median – rather than the mean – length of stay in foster care. Further, the median is considered a better measure of the typical length of time in foster care for the children in the CAM treatment sample, especially since the sample sizes for foster care discharges for many of the individual grantees is small.

C4. Re-entries to Foster Care: Percentage of Children Returned Home from Foster Care that Re-entered Foster Care in Less Than 6, 12, 18 and 24 Months.

This indicator applies to children who have been removed from the home and reunified with their parent/caregiver and then re-entered foster care. The calculation is based on the removal and reunification dates and foster care disposition.

C5. Timeliness of Reunification: Percentage of Children Who Were Reunified in Less than 12 Months from the Date of the Most Recent Entry into Foster Care.

This indicator applies to children who have been removed from the home and reunified with their parent/caregiver. The calculation is based on the removal and reunification dates and foster care disposition. Per CFSR definition, valid reunification includes children returned home to principal caregiver's care or living with other relative.

C6. Timeliness of Permanency: Percentage of Children Placed in Foster Care Who, in Less than 24 Months from the Date of the Most Recent Entry Into Foster Care Placement, Achieved a) Finalized Adoption or b) Legal Guardianship.

This indicator applies to children who have been removed from the home and placed in finalized adoption or legal guardianship. The calculation is based on the removal and reunification dates and foster care disposition.

C7. Prevention of Substance-Exposed Newborns: Percentage of Pregnant Women Who Had a Substance-Exposed Newborn (First or Subsequent), as Detected at Birth.

This indicator is defined as substance exposure, as detected at birth. While identification of a substance-exposed newborn is to come from a doctor or other health care professional assessing the newborn's health, it is not limited to a positive toxicology test. Substance exposure also may be determined by other clinical indicators, including maternal and newborn presentation, history of mother's substance use or abuse or other medical history.

C8. Children Connected to Supportive Services: Percentage of Children Who Were Assessed for and Received the Following Supportive Services: Developmental Services, Mental Health or Counseling, Primary Pediatric Care, Substance Abuse Prevention and Education, Substance Abuse Treatment, Educational Services, Neurological Services, Dental Services and Other Supportive Services.

This indicator applies to children who are assessed and received the outlined supportive services. The supportive services assessed for and received are determined by the grantee's program model.

C9. Improved child well-being: Percentage of children who show an increase in socio-emotional, behavioral, developmental and/or cognitive functioning.

The purpose of this performance measure is to measure improvement in the areas of child socio-emotional, behavioral, developmental and/or cognitive functioning.

Adult Indicators

A1. Access to Treatment: Percentage of Parents or Caregivers Who Were Able to Access Timely and Appropriate Substance Abuse Treatment; Number of Days between Program Entry and Treatment Entry.

The intent of this indicator is to measure how long it takes a parent or caregiver to access treatment once they have entered the child welfare systems (or the CAM program if the grantee is focused on preventing child welfare involvement). Because there is variability among grantees in how a family enters the CAM program and is admitted to substance abuse treatment depending on the target population, lead agency, local procedures and other factors, time to treatment is assessed from three different time points: 1) from when the family enters the child welfare system; 2) from when the family enters the CAM program; and, 3) from when a client receives a substance abuse assessment. This calculation is based on entry into the CAM program, entry into child welfare, substance abuse assessment/intake date, substance abuse treatment admission date and substance abuse treatment setting.

A2. Retention in Substance Abuse Treatment: a) Percentage of Parents or Caregivers Referred to Substance Abuse Treatment Who Remained Until Treatment Completion; and, b) Average Length of Stay in Treatment for Referred Parents or Caregivers.

This indicator is intended to capture substance abuse treatment completion and the average length of stay in substance abuse treatment. The length of stay calculation examines the length of stay for the entire treatment episode and not the transition or length of stay based on the level of care (or treatment modality). Treatment completion is defined in alignment with the TEDS Discharge Reports, (completed treatment and transferred to another treatment program/facility for further treatment and known to report is also considered a positive treatment outcome per Federal TEDS treatment discharge reporting).

A3. Substance Use: Percentage of Parents or Caregivers Who Report a Reduction in Substance Use, as Measured by Number of Days of Use in Past 30 Days at Treatment Intake and Discharge.

This indicator is intended to capture a reduction in substance use as measured by the number days used in the past 30 days at treatment admission and discharge. The analyses focus on the five major substances used by CAM adults: 1) alcohol; 2) cocaine/crack; 3) marijuana; 4) heroin/other opiates; and, 5) methamphetamine.

A4. Parents or Caregivers Connected to Supportive Services: Percentage of Parents or Caregivers Who Were Assessed for and Received Supportive Services that Include: a) Primary Medical Care; b) Dental Care; c) Mental Health; d) Child Care; e) Transportation; f) Housing Assistance; g) Parenting Training/ Child Development Education; h) Domestic Violence Services; I) Employment or Vocational Training/Education; j) Continuing Care/Recovery Support Services; k) Trauma Services; l) Family Planning Services; and, m) Legal Services.

This indicator applies to adults who are assessed and received the outlined supportive services. The supportive services assessed for and received are determined by the grantee's program model.

A5. Employment: Percentage of Parents or Caregivers Participating in Substance Abuse Treatment Who Are: a) Employed Full Time; b) Employed Part Time; c) Employed Full or Part Time; and, d) Currently Enrolled in an Educational or Vocational Training Program.

This indictor is intended to examine whether substance abuse treatment participation has a positive influence on employment or educational status. This performance measure applies to those in substance abuse treatment and is measured by the number days used in the past 30 days at treatment intake/entry and discharge. Employment definitions are derived from TEDS and educational/vocational training program enrollment status is derived from GPRA.

A6. Criminal Behavior: Percentage of Parents or Caregivers Participating in Substance Abuse Treatment Who Show a Decrease in Criminal Behavior.

This indicator applies to those in substance abuse treatment and is measured the number of arrests in the past 30 days at treatment intake/entry and discharge.

Family/Relationship Indicators

F1. Improved Parenting.

For the purposes of this grant program, parenting capacity is thought of as the ability of parents/caregivers to understand and give priority to their child's basic needs (e.g., health,

educational, developmental, safety, social and housing), to adapt to the child's changing needs over time and to address any challenges posed by their child's temperament and development. Baseline and exit instrument/test scores will be submitted without client identifying information using the NCFAS-G+R.

F2. Family Relationships and Functioning.

For purposes of this grant program, family functioning refers to how family members communicate, relate to one another and maintain relationships, as well as how they make decisions and solve problems. Baseline and exit instrument/test scores will be submitted without client identifying information using the NCFAS-G+R.

F3. Risk/Protective Factors.

For purposes of this grant program, risk factors may include things such as acute life stress or everyday stress, physical and mental health crisis, acute school problems, family relationship conflict, social isolation, child behavior/mental health/physical health problems, caregiver mental health/physical health problems, impaired caregiver-child relationship, poverty, violence in community and caregiver childhood adversity. Protective factors may include things such as family systems strengths, coping strategies, social support, spirituality, community connections, housing stability and safe neighborhood. Baseline and exit instrument/test scores will be submitted without client identifying information using the NCFAS-G+R.

NCFAS-G+R.

The NCFAS-G+R is a family functioning assessment tool used to inform case management and family treatment options. The NCFAS-G+R measures ten domains of family functioning including the environment, parental capabilities, family interactions, family safety, child well-being, social/community life, self-sufficiency, family health, caregiver/child ambivalence and readiness for reunification. Grantees assess each family at program intake and closure.

Scoring

Each item represents the rater's best judgment of the child or family's overall level of functioning in that domain. The NCFAS-G+R is scored on a six-point scale: +2 (clear strength), +1 (mild strength), 0 (baseline/adequate), -1 (mild problem), -2 (moderate problem) and -3 (serious problem).

This scale includes three strength and three problem ratings. Workers must assess if a family is in either the strength or problem range and to what degree. There is no midpoint rating, rather the "baseline/adequate" level of functioning is "that level above which there is no legal, moral or ethical reason for exercising an intervention mandate."[133]

[133](Kirk, R. & Griffith, D. (2007). *An Examination of Intensive Family Preservation Services.* Durham, NC: Independent Living Resources, Inc.

The data from the forms are entered into a database that recodes the scores into the following:

Clear strength = 1	Mild problem = 4	Not applicable = 0
Mild strength = 2	Moderate problem = 5	Unknown = 9
Baseline/adequate = 3	Serious problem = 6	Missing = 99

As a result of this coding, the higher the score, the more serious of a problem that domain is for the family; the lower the score the more of a strength that domain is for the family. Also, in the analysis of this data, the values of "not applicable," "unknown" and "missing" are removed the analysis.