

Executive Summary: Oregon's IV-E Waiver Demonstration Project

Relationship-Based Visitation & Parent Mentor Evaluations

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Executive Summary

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

This executive summary provides a brief description of the program services, research questions, methodology, and findings from the comprehensive 4-year evaluations of both program models. For more details, please see the full report, available at www.pdx.ccf/research.

Relationship Based Visitation Evaluation

Program Description

The Relationship Based Visitation program (RBV) was designed to support improved child welfare outcomes for children in foster care by providing a parent coaching intervention delivered during parent-child visitation. RBV services provided additional parent-child visits in a family-friendly setting, and incorporated parent education using an evidence-based parenting program called Nurturing Skills (NS, adapted from the Nurturing Parent Program, NPP, Bavolet, McLaughlin, & Comstock, 1983; See also: www.nurturingparenting.com). RBV represented an innovative approach to using the NPP/NS curriculum within the child welfare visitation context. The NS curriculum uses a parent-directed approach in which parents and coaches plan a series of parenting education lessons and activities that address individual parents' specific needs. RBV visits included a pre-visit parenting education session, a 90-minute, facilitated parent-child visit, and a debriefing/coaching session following the visit. RBV visits. A minimum of 16 weekly RBV sessions were provided (often many more), as well as post-reunification supports after children were returned home.

Study Eligibility, Design, & Data Collection Overview

Parents with new DHS cases were eligible for RBV services if they had at least one child under the age of 13 who had been placed out-of-home in the last 30 days. All DHS clients eligible for RBV were randomly assigned to either visitation as usual, or to referral to RBV services (intent-to-treat design). Data for the outcome study were collected on all randomized participants from the DHS administrative database, OR-Kids, as well as from standardized pre and post assessments administered by contracted providers for the treatment sample. Additional outcome data were collected from a subsample of participants in the intervention and control groups through telephone interviews conducted by the research team. Telephone interviews occurred at baseline (within 30 days of enrolling in the RBV program) and 9 months after enrollment. Process study data included information collected by RBV providers to document the services delivered, as well as qualitative interviews with RBV managers and staff, DHS managers and caseworkers, and other key stakeholders involved in the program implementation. Site visits were conducted by research team members twice during the study to monitor fidelity through case file reviews and to conduct observations of RBV sessions.

The evaluation of the RBV program used both qualitative and quantitative methods to address process and outcome questions. Process evaluation questions focused on key areas of the RBV programs thought to be most important to program success, such as: (1) Fidelity to the planned model; (2) Quality of RBV-DHS collaboration; (3) Adherence to principles of Visitation Best Practice; (4) Level of parent involvement in service planning and delivery; (5) Extent of foster parent involvement in service. Outcome evaluation questions addressed both shorter-term (intermediate) outcomes focused on changes in parental attitude, behavior, knowledge and experiences, as well as longer-term child welfare outcomes, including: (1) length of time in foster care; (2) likelihood of reunification; and (3) rates of re-report and re-entry into placement.

Results

Process evaluation findings suggested that implementation of the RBV model as planned proved challenging. In particular, early engagement of families in RBV services was a significant barrier to service delivery. Of families who were referred by DHS, only 69% successfully completed an intake. Reasons for this included a variety of factors; most often, families could not be contacted or located by RBV providers to set up an initial appointment. However, once an intake was completed, the large majority (94%) of families did engage in at least some RBV sessions. While RBV providers did a good job implementing RBV visits using the 3-component (lesson, visit, debrief) structure, visits tended to be shorter than intended and less frequent (only 18% receiving weekly visits).

Administrative outcomes were analyzed using both an intent to intent-to-treat (ITT) approach that included all children who were randomized (RBV, $n=1,751$ vs. Control, $n=1,887$) and a treatment-on-the-treated (TOT) approach that separated the RBV group into two smaller groups: those who had an RBV intake (Intake, $n=957$) and those who did not (No Intake, $n=794$). Outcomes were examined at both 1-year and 2-years post-random assignment. Results were similar across all models. Generally, while RBV children tended to spend more time in foster care compared to controls, these differences were not statistically significant. In the ITT models, for children with at least one year of follow-up data, RBV children spent an average of 417 days in an out of home placement, compared to only 384 days for control children; however this difference was not statistically significant. For children with two years of follow up data, the magnitude of the difference was similar, (476 days vs. 443 days), and also not significantly different. For the TOT analyses, RBV children whose parents had an intake stayed in care for significantly more days (448 days in 1 year sample; 501 days in 2 year sample) than either randomized controls (386 and 443 days); or the RBV/unserved families (373 days and 442 days).

While child welfare outcomes did not favor the RBV group, results from both the parent interview subsample ($n=227$), as well as a subsample of RBV participants compared to interviewed controls ($n=396$) did show significant improvements in a variety of parenting-related domains. Results from the Adult-Adolescent Parenting Inventory and Nurturing Competencies Scales indicated that RBV participants showed significantly more improvement over time (compared to controls) on: (1) having appropriate expectations for children; (2) avoiding corporal punishment; (3) empathy; (4) appropriate parent-child roles; and (5) supporting children's power and independence. RBV participants also showed significantly more improvement on: (1) behavioral management skills; and (2) self-care skills. Control parents generally stayed the same or worsened slightly worse in all these areas over time. RBV parents also improved more on two domains of the Protective Factors Survey: Perceived Social Support and Nurturing skills

Despite these encouraging results in the parenting domain, there were few corresponding benefits in terms of child welfare outcomes. In fact, contrary to expectations, children who participated (at least through intake) in RBV remained in out of home care longer, compared to controls, were no more or less likely to be reunified, and were no more or less likely to be re-

reported to the child welfare system or to re-enter foster care. These results generally did not vary for families with different characteristics at entry into the child welfare system, although RBV families with inadequate housing, were somewhat less likely to be reunified, compared to controls. Results of the cost analysis, which focused on foster care costs, not surprisingly showed that these costs were higher for children in the RBV group.

Program fidelity data supported the finding that receiving RBV services was associated with spending more time in out of home placements, as families who received more RBV services tended to have children who remained in care longer periods of time. However, these families were also more likely to be reunified, an effect not seen in the overall RBV sample. It may be that judges and/or caseworkers are more willing to continue to give parents opportunities to address their case plans and safety concerns if the parent is engaged with, and supported by, the RBV program. This might have the unintended effect of increasing the time spent by children in out-of-home care, but eventually lead to more positive outcomes in terms of family reunification. Further, it appeared that families whose child was placed in relative care tended to receive *fewer* RBV services, and were rated as making less progress during visits. Placement in relative care was also related to longer lengths of stay in out-of-home placements and to lower reunification rates. To the extent that parents are less motivated to engage in services and/or to complete the RBV program because their children are placed with a family member, this could also lead to lower reunification rates and longer lengths of stay in out of home care.

Finally, it should be noted that parents who had either substance abuse or domestic violence issues in the home were generally less involved with the RBV program (less likely to receive an intake, received fewer visits, less likely to complete the program). These findings were consistent with initial concerns that engaging these families in the RBV model would be especially challenging.

Discussion

Process evaluation results suggest that implementing RBV with fidelity to the planned model was quite challenging, especially in terms of both initial engagement of referred parents and in terms of the frequency of sessions and visits. In particular, data suggest that initial and sustained involvement in RBV services was challenging for a variety of reasons. First, it appeared that in a number of DHS offices, there was little initial communication with DHS staff about the RBV program and its potential benefits. DHS workers often had concerns and/or misconceptions about the service, which contributed to reluctance to make needed referrals. More effective communication with DHS staff about the RBV program, which families were eligible, and what the service model looked like, may have helped to improve initial referral rates as well as information sharing. Building relationships between DHS and RBV providers played a significant role, either positively or negatively, in the ability of RBV providers to be able to engage families, especially initially.

Further, a number of families who began services did not complete them. In particular, it appears that families with substance abuse and domestic violence issues were more difficult to engage. Although this is not uncommon especially among child welfare-involved families with

multiple challenges, additional training and support for RBV staff may have helped to improve program services in this area. There was a clear and documented need for additional, ongoing support both in the NSP curriculum and in other aspects of coaching that, if they could have been provided, might have given coaches additional tools for sustaining families in services.

The goal of providing one RBV session per week was not met for the large majority of families. Additional logistical supports (e.g., transportation for parents and children) as well as enhanced engagement strategies on the part of RBV providers, may have strengthened this component. Given the finding that fidelity was more challenging for families with specific risk factors (especially domestic violence and substance abuse) incorporating supports specifically related to those issues into the RBV framework, perhaps through partnering directly with service providers or using a wrap-around type model to connect families with auxiliary resources, might be important.

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

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

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

Conclusions

Overall, results suggest that while RBV may be an effective model to improve parenting-related skills and behaviors among parents involved with the child welfare system, the program did not have its intended effect on shortening children's time in out of home care. If the RBV model

were to be adapted and implemented in other settings, it would be important to consider ways in which the program might be improved, and specifically, how the somewhat unintended consequence of keeping children in care for longer periods of time could be addressed. Further, the implementation and fidelity data make it clear that more field support for implementation, training, and communication with/between RBV and DHS would be beneficial to model implementation, and likely to model effectiveness. That said, results do support the benefits of enhancing the quality of parent-child visits and specifically, of providing research-based parenting interventions in a visitation context. Exploring methods for providing this type of parenting service in a timely way with reduced costs, and/or which also included strategies for addressing other family issues, could benefit the field.

Parent Mentor Program Evaluation

Program Description

The Parent Mentor (PM) program was designed to serve parents involved with child welfare services that have been identified as in need of substance abuse treatment. The primary goals of the program were to prevent foster care placement, expedite reunification and timely permanency, and prevent repeat maltreatment by motivating, facilitating, and supporting recovery. To do this, parents were paired with peer mentors who worked to develop and maintain transformational relationships with parents in order to inspire and support the parent's own, self-directed change process.

Services provided by mentors included:

- Outreach and engagement, including telephone calls, home visits or writing letters.
- A minimum of three face-to-face contacts with the parent during their enrollment in the program.
- “Relationship work”: provision of nonjudgmental, empathic support and encouragement throughout. Use of self-disclosure, informality & “straight talk” to build rapport, increase credibility, create trust, and foster an authentic relationship.
- Elicitation of hope by modeling recovery, sharing aspects of one's own experience, expressing belief in the parent. Focus on parent strengths and right to self-determination.
- Modeling of a sober lifestyle & providing assistance in developing the parent's own support networks, providing information about drug and alcohol-free activities and resources, and accompanying parents to 12 Step or other culturally appropriate groups.
- Elicitation & privileging of parent's own theory of change and culturally congruent approaches to making change. Active support throughout of parent's change plan.
- Assistance accessing concrete and immediate resources based on individual needs.
- Information regarding culturally-responsive services and assistance accessing additional information, all informed by a mentor's first-hand knowledge of community resources.
- Providing referrals and linkages to identified services providers, using “warm hand-offs” whenever possible.
- Assistance in navigating the child welfare system by providing information regarding system requirements, transportation, modeling of organizational skills, and coaching regarding self-advocacy and interaction with professionals.

- Encouraging honesty and accountability on the part of parents in their relationship with their DHS caseworker. Fostering perspective-taking regarding the child welfare agency's point of view, while simultaneously acknowledging the parent's right to self-determination.

Study Design & Data Collection Overview

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

The outcome evaluation was designed to assess the impact of the program on a range of short and longer term indicators focused on both child welfare and substance abuse treatment and recovery. Short term outcomes included participation in substance abuse treatment; engagement with the recovery community; development of formal and informal support; and parent attitudes and beliefs related to personal hope, self-efficacy, empowerment, and positive self-regard. Longer term child welfare outcomes were also examined, including the frequency of out-of-home cases (of those initially served in-home); the rates of reunification or other permanent placement; the length of time to permanent placement, and rates of re-report or re-entry into foster care.

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

Results

Process study outcomes

Parents and child welfare staff reported high levels of satisfaction with the PMP. During interviews, parents pointed to numerous specific ways in which the program was useful to them. Interviews with caseworkers were similarly positive. All reported that parents who were willing to engage with the PMP benefited from the program and many of the caseworkers identified ways in which partnering with the mentor improved child welfare practice more generally.

A number of mentoring activities surfaced as **key mentoring practices**- what mentors do that parents and others identify as making a difference.

- **Assertive outreach and frequent contact** -reaching out to parents and being accessible and responsive increases the likelihood that hard-to contact parents will connect with a mentor, and that reluctant parents will engage in services.
- **Give parents a voice**- parent-identified needs and goals largely drive the mentoring work and mentors share the parent’s perspective and experience with providers.
- **Warmth, kindness, connection**- mentors encourage parents, offer acceptance rather than judgment, argue for hope, and help parents feel worthy.
- **Information, transportation and accompaniment**- mentors help parents navigate complex systems and access needed supports.
- **Advocacy**- mentors work to ensure parents’ needs are heard, identify when providers are working at cross purposes, and model effective communication skills for parents.
- **Helping parents understand how systems work**- mentors translate jargon, use accessible language, anticipate questions and take the time to make sure parents understand.
- **Honesty and accountability**- mentors encourage rigorous honesty from parents, and “tell it like it is” if they believe parents are veering off track. They have time to check in frequently with parents and can track them down if need be.
- **Be there for parents**- mentors take the time to listen to parents, offer lots of support and are “on their side”. Many parents reported having few other positive people in their lives.
- **Build support networks**- mentors introduce parents to recovery, faith-based and cultural communities and promote parents’ interests in activities such as exercise, gardening, fishing and reading.

The study also identified some of the **mechanisms** by which these and other mentoring practices facilitate parents’ engagement with services and progress on their child welfare cases more generally.

- A **warm relationship** between parents and mentors helps parents **believe they are worthy of care and have faith enough in themselves to try**.
- Parents **engage earlier** because they are **not afraid of being misunderstood or judged** by their mentor.
- Peer mentors **inspire parents to have hope**- mentors work in positions that elicit respect by providers and parents alike and are **“living proof that success is possible”**.
- Mentors have the time, flexibility and know-how to **address many of the concrete needs** (such as transportation, food and housing) that serve as **barriers** to parents’ ability to engage.

- Peers have **credibility** with parents which increases the likelihood that they will **listen when mentors share information and advice**.
- Mentors often have **histories that are similar to parents**, which helps them anticipate parents' needs and creates **shortcuts in communication and understanding**.
- Mentors **coach** parents before/during meetings and court hearings and provide **emotional support, reducing parents' anxiety and increasing their confidence**.
- Parents may be more likely to **tell mentors about barriers to engagement**- mentors can then partner with parents, caseworkers and other providers to **develop solutions**.
- Mentors help parents **map out small steps** making **success more likely** and keeping parents from becoming overwhelmed and giving up.
- Because they are **peers** and "not child welfare", mentors can help parents **see "choices and possibilities"** rather than "mandated services and court orders".
- Mentors **celebrate parents' successes** which increases parents' **confidence and motivates them to take the next step**.

The process evaluation and fidelity assessment suggest that the following are **important features of the PMP model**:

- **Parent-directed goal setting and planning**- privileging parents' interests and needs as defined by them is feasible, empowering for parents, and is often central to mentors' ability to build trusting relationships with parents.
- **Mentors and parents have similar life experiences** – most mentors have prior child welfare involvement and a history of addiction. Shared gender, race/ethnicity, drug of choice and even religion were valued by some parents, but were not universally seen as essential or even desirable.
- **Mentors' ability to meet in the community and outside regular work hours** – mentors' are reliable, responsive and able to travel to parents (rather than meeting them in the office). This built rapport and trust, and resulted in more than one crisis being averted.
- **Protecting parents' privacy**- mentors respect parents' privacy in that no information is shared with other providers (with the exception of child maltreatment, intent to harm themselves or a relapse) without a signed ROI. Parents appreciated the ability to be honest with mentors and this often meant issues were resolved more quickly.
- **Focus on recovery**- peer mentors support recovery by educating parents about addiction and recovery, sharing information about related services and events, modeling a sober lifestyle, helping jump start parents' own support networks, and inspiring hope.
- **Support and opportunities for professional development for mentors**- parents are often challenging to work with and mentors confront many possible triggers. Supervision and peer support are crucial to their ability to work constructively and avoid burn out or relapse. At the same time, mentors' status as professionals is inspiring to parents.

Peer mentoring is not without its **challenges**. A number of them are described below:

- **While very few parents actually declined services, a significant proportion of parents chose not to engage in the PMP even after accepting services.** Some of the parents interviewed described themselves as “not ready” to work with the mentors and said there was little a mentor could do under these circumstances to get them to participate; caseworkers and mentors largely echoed this assessment.
- **A small number of parents were unhappy with the PMP.** A few experienced their mentor as unreliable or not adequately available. Another parent described her mentor as focused solely on getting her to attend a specific recovery meeting and uninterested in what the parent perceived as more important issues or needs. A mentoring program that employs peers will likely need to provide on-going training and supervision in order to ensure consistent, high quality services.
- **Caseworkers’ most frequent complaint about the PMP was having to explain child welfare policies and practices to mentors.** Caseworkers were unhappy with the amount of time it took to educate mentors as well as the confusion their lack of understanding sometimes caused for mentors and parents alike.
- **On-going communication regarding the role of mentors and information sharing between mentors and other providers is time consuming but important.** While child welfare staff had few complaints, a lack of clarity regarding what mentors do resulted in confusion and some frustration especially in the early days of the program.

Short Term Outcomes

The study explored the impact of the PMP on a range of short term outcomes. Highlights are listed below.

Substance Abuse Treatment and Recovery-Related Activities

Results from Exit Forms indicate a high degree of participation in treatment and recovery related activities by parents.

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

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

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

Informal Supports/Culturally Congruent Services

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

Hope, expectation that change is possible for someone like me

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

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

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

"I thought I was too broken to be fixed before I met (M). She boost my confidence to where I am not shattered, I am just a little chipped on the edges." (parent)

Self-efficacy/ Empowerment

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

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

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

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

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

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

Interview data also suggests that parents felt empowered in their work with the mentors: *somebody telling you what to do—yeah it feels good when you accomplish that, but when you set the goal for yourself it feels so much better. For me personally, I feel so much more accomplished, and you are ready to set another goal a little bit higher goal, and I did it! It is like a rush, an adrenaline rush. Yeah, I did it. (parent)*

Positive self-regard/respect

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

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

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

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

Child Welfare Long Term Outcomes

To examine child welfare outcomes, we used two stratification schemes for children with two different follow-up periods (1 year and 2 years post randomization). The intent-to-treat (ITT) stratification included all children as they were randomized (PMP, $n=784$ vs. Control, $n=489$). The treatment-on-the-treated (TOT) stratification broke the PMP group into two smaller groups: those who accepted PMP services (Accept, $n=498$) and those who did not (No Accept, $n=286$).

Findings

- The analyses for the sample of children with at least one year of post-randomization follow-up time suggest no statistical differences between children with parents in the PMP group vs. control children. Children were in foster care for an average of approximately 1.1 years, and it took them an average of 1.1 years to exit foster care. Four out of every five children who exited foster care within this time frame were returned home. Of the children who exited foster care, one out of every seven were re-placed in foster care. Of the children who were not in foster care at the time their parents were randomized for the program, 20% went into foster care later in the case. Finally, 18% of the children had a founded post-randomization maltreatment report.
- Analyses for the sample of children with at least one year of post-randomization follow-up time indicated no statistical differences between children with parents involved in the PMP who accepted the program vs. control children (TOT analyses).
- The ITT analyses for the sample of children with at least two years of post-randomization follow-up time produced nearly identical results to those reported for the children with at least one year of follow-up time. With a longer follow-up period, children were generally in care for longer periods of time (1.3 years), and there were slightly higher rates of subsequent maltreatment reports and re-placements in foster care, but this occurred uniformly in both the PMP and Control groups.
- The TOT analyses for the sample of children with at least two years of post-randomization follow-up time also indicated no statistically significant differences between the PMP Accept, PMP No Accept, and the Control group children.

Covariates as Potential Moderators

A number of significant ($p \leq .05$) interactions were found for previous in-home services, previous foster care placement, and child age. Child race was also a statistically significant moderator for a number of variables. These interactions suggest that the relationship between these variables and a number of outcomes (days in foster care, time to permanency, likelihood of re-removal, entering foster care post-randomization but not in foster care at time of randomization) differed based on group assignment. Unfortunately, all of the interaction effects were based on a small number of children (in many cases <20), which limits generalizability. Moreover, the pattern of findings was not consistent in terms of the effects of the PM program, making the overall findings difficult to interpret.

Limitations

It should be noted that these results are based on data available for about one-third of the total child sample. Foster care placement was not an eligibility criterion, so it is not surprising that many children associated with the PM program were not in foster care at any time during the study window. Conversely, a number of children were still in foster care at the end of the study window (i.e., had not yet reached a permanency) and were not included in the calculations of days in foster care. With larger samples and longer follow-up periods, there would be increased power to detect statistically significant differences. Given the lack of baseline equivalence between the groups (and interaction effects found for covariates), it is likely that the

significance tests were not fully adjusted for all of the differences (measured and unmeasured) between the groups. We also did not find strong evidence of moderated program effects that would allow us to confidently make statements about parenting mentoring services working better for certain groups of children and their families.

Conclusion and Next Steps

This evaluation of Oregon's Parent-Directed Parent Mentoring Program makes a significant contribution to the peer mentoring knowledge base. Findings from the project include a detailed picture of what mentors do, a comprehensive list of important mentoring practices, rich reporting from both parents and caseworkers of the impact of the PMP, and identification of some of the mechanisms by which mentoring facilitates parents' engagement and progress on their case plans. We also identified the organizational and other supports that facilitate implementation and sustain the program over time. Building on the program model and other relevant research, a Fidelity Framework was constructed that captures key program features, and results suggest the PMP was delivered largely in accordance with the original design. Both quantitative and qualitative data indicate that the PMP had a positive impact on a range of short-term outcomes. Unfortunately we were unable to include an analysis of substance abuse treatment administrative data, however, other data sources suggest the PMP is particularly well suited to facilitate parents' recovery-related efforts.

Results from the analyses of the child welfare administrative data are inconclusive at best- the evaluation suffered from many of the pitfalls common to RCTs in applied settings- and next steps should include a rigorous outcomes study. Also important will be further development of the fidelity framework, especially efforts to account for the individualized (parent-directed) nature of the supports that are provided. We are also very excited to build on our preliminary work regarding the application of Self Determination Theory to peer mentoring, and motivation and engagement among child welfare involved parents more generally.

Cost Analysis Discussion

The general pattern of findings suggests that children in the PM and RBV groups, especially if their parents accepted services, had higher foster care placement costs over an average period of 1.3 years (within the Waiver study window, randomization date through June 30, 2015). Placement costs ranged widely and distributions were highly positively skewed (e.g., 90% of the children had costs under \$17,000), which implies that costs were driven by a smaller group of children. Indeed, 10% of the children (with costs over \$17,000) accounted for 30% of the total placement costs for all children included in the analysis. By definition, RBV children accounted for a larger proportion of the placement costs overall, as program eligibility relied on at least one child being in foster care, whereas most children whose parents were identified for the PM program did not have foster care placement costs.