UNIVERSITY OF NEBRASKA AT OMAHA
SUPPORT AND TRAINING FOR THE EVALUATION OF PROGRAMS

College of Public Administration and Community Service
The Grace Abbott School of Social Work

Better Together: Final Evaluation Report

June 30, 2017

Heartland Family Service Team:

- Heather Bird, LICSW, LADC, MPA
- Mary O'Neill, MPA
- Monica Meier, LICSW, LADC
- Stephanie Sorum, LIMHP, LADC

STEPs Team:

- Jeanette Harder, Ph.D.
- Jodi McQuillen, Ph.D.
- Jieru Bai, Ph.D.
- Pamela Ashley, M.Ed.
- Joseph Forrest, MSW
- Natalie Scarpa, MSW/MPA student

Earlier:

- Christopher Goodman, Ph.D.
- Jessica VanVuren Groeneweg, MSW
- Carl Jackson, MSW
- Samantha Weiss, MSW

Acronyms	
BT	*Better Together*
DBT	Dialectical Behavior Therapy
GPRA	Government Performance and Results Act
HFS	Heartland Family Service
HMR	Helping Men Recover
HWR	Helping Women Recover
IRB	Institutional Review Board
MRT	Moral Reconation Therapy
NFC	Nebraska Families Collaborative
PSI	Parenting Stress Index/Short Form
TSC	Trauma Symptom Checklist-40
NDHHS	Nebraska Department of Health and Human Services
STEPs	Support and Training for the Evaluation of Programs

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Executive Summary

Program Description

Heartland Family Service (HFS) partnered with Nebraska Families Collaborative (NFC) and the Nebraska Department of Health and Human Services (NDHHS) to begin *Better Together*, a comprehensive support service program for families affected by substance abuse in Omaha, Nebraska. *Better Together* seeks to prevent infant abandonment by increasing well-being, improving permanency, and enhancing the safety of infants and young children who have been exposed to dangerous drugs.

Utilizing a community-based treatment setting, *Better Together* provides intensive outpatient and outpatient substance abuse treatment to families impacted by substance abuse. NDHHS and NFC identify families as being at risk for out-of-home placement of their children and recommend the appropriate services. The target population is families in which the mother is pregnant and using drugs and/or alcohol, families where infants screen positive for illegal substances, or families with young children who are at risk for placement due to parental substance abuse. HFS treats each family as a unit, providing comprehensive treatment and support services for the parents, infants, young children, older children, and any self-identified family members.

Better Together services include the following:

- Intensive outpatient and outpatient substance abuse treatment.
- Mental health treatment.
- Case management.
- Parenting education.
- Peer support.
- Family therapy.
- Housing assistance.
- Infant and child developmental screening and intervention.
- Physical health care coordination and support.
- Transportation assistance.

Families live in a community-based treatment setting, in individually-leased apartments, for up to two years. As they move through the program, their treatment becomes progressively less intensive. *Better Together* outcomes include improved child well-being, sustained parental recovery from substance abuse, and reunification of families.

Process Evaluation

Better Together's systems map and collaboration research acknowledge the challenges clients face when trying to regain stability after substance abuse recovery and child welfare involvement. **Findings confirm the complexity of clients' problems, as well as the importance of working closely with other providers and funding organizations to address them.**

Along with case management, *Better Together* offers its clients a deliberate screening and intake process which leads to a combination of services that are phased to target their needs regarding recovery, mental health, parenting, and self-sufficiency. The program's structure, service mix, phasing, and client support are vital.

Clients acknowledged the importance of their personal readiness for and commitment to the program and **confirmed high levels of satisfaction with the program services they received**. They also identified a few areas of potential program improvements, including community awareness and understanding of the program, substance abuse support groups, community services referrals, family therapy, and peer support. Process evaluation results showed three important factors in the *Better Together* program:

1. Client readiness for recovery,
2. High quality of services, and
3. Strong connections with the surrounding community.

Outcome Evaluation

Many *Better Together* clients demonstrated positive outcomes in all five areas:

1. Sustained recovery from substance abuse,
2. Increased parenting skills,
3. Increased mental health,
4. Children had permanency and stability, and
5. Children were safe from abuse and neglect.

Over an average of 15 months, one third of clients successfully discharged from the *Better Together* program. While not discounting their own readiness for and commitment to recovery, **clients expressed gratitude for the *Better Together* program**. In interviews and focus groups, clients expressed many ways they had gained knowledge and skills, as well as how meeting their basic needs and further services assisted in their sobriety and family reunification. They appreciated how the program allowed for individualized and client-centered treatment.

Over half of clients did not have a positive drug test while in the program. Most clients who were unsuccessful in the program had a positive drug test in the first three months, with further positive drug tests in subsequent months, and received significant services during their 7 months in the program.

Overall, **clients increased their parenting skills**, as measured through a self-reported reduction in parental stress. Parental stress improved the most between the program's 6th and 12th months, especially in the area of parental distress. However, clients also reported increased stress at 6 months due to parent-child interactions and raising a difficult child, which is about when clients' children had been returned for 3 months and services had begun to diminish.

Overall, *Better Together* **clients improved their mental health,** as measured through a self-reported decrease in their trauma symptoms at each point in time, both overall and in

each of six categories. Although they reported difficulty with sleep, it was also an area in which they improved the most, along with lower levels of depression.

Female and Black clients reported the highest levels of parental stress and trauma symptoms at both intake and at 12 months. Clients who had experienced fewer types of adverse childhood experiences (ACEs), entered the program with lower parental stress, and exhibited fewer trauma symptoms were somewhat more likely to finish the program successfully.

The *Better Together* program allowed children to have permanency and stability in their living situations. Two thirds of children reunified with their parents at the 3rd month of the program. Most *Better Together* clients who remained active in the program regained custody of their children. Clients' median monthly income increased at each measurement point, reflecting a steady increase in their financial sustainability. Also, fewer children needed developmental services as they progressed in the program.

While nearly all *Better Together* clients' children had been removed because of parental drug use, most children reunified with their parents and there were no reports or removals for abuse during the evaluation period.

> Whether it be advocating for me in court, or teaching me skills to handle situations … They've always been there.
>
> I think my children feel more safe and more secure now.

The benefit-cost analysis found that for every $1 invested in *Better Together*, there is an immediate return of $1.50 to individuals and to the community. Short-term benefits included increased client income, decreased foster care costs, and decreased community costs from supportive housing and treatment. Other likely benefits are decreased crime and emergency care, and improvements in clients' productivity, income, and physical and mental health.

Overview

Overview of the Community, Organization, and Target Population and Problem

The Community

The greater Omaha metropolitan area in which *Better Together* operates has a higher percentage of minority residents than Nebraska's outlying rural areas in Nebraska. Furthermore, three Indian reservations are located completely within the state, with three others crossing Nebraskan borders into neighboring states. The eastern neighborhoods of Omaha typically represent Native Americans from eastern Nebraskan reservations. The population of focus reflects the racial and ethnic demographics of the surrounding community, and exhibits many instances of other demographic indicators, such as poverty status, educational attainment, and mental health disorders.

The Organization

HFS is the oldest and largest nonsectarian human services agency in the Omaha metropolitan area dedicated to building the capacity of individuals. They offer 40 programs from 16 locations in east central Nebraska and southwestern Iowa that address the wide array of issues threatening the well-being of children, adults, and families, including addictions, child abuse and neglect, domestic violence, early childhood education, homelessness, poverty, juvenile delinquency, mental health, and neighborhood enrichment.

The agency pioneered the provision of mental health services in the community as early as 1940 and continues to be a leader in the field of mental health services. Since 1981, HFS has offered outpatient substance abuse services serving adults and adolescents. The agency has an established working relationship with Region 6 Behavioral Healthcare, the local entity which distributes federal, state, and county funds for mental health and substance abuse treatment. The agency possesses a broad geographical presence in the community, is knowledgeable about the range of community services, and has long-standing cooperative working relationships with other human service providers. HFS has proven its ability to develop and sustain diverse community-based programs, including home-based, outreach, and crisis intervention services with varied populations, including adults with substance abuse and/or mental health needs, children and adolescents, families in the child welfare system, homeless adults, and youth in the juvenile intervention system.

HFS has been offering family-based recovery programming like *Better Together* since the agency was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) Pregnant and HFS Postpartum Women (PPW) grant in 2006. The agency connects with and refers clients to key stakeholders and partners in the community, including the local courts, probation, child welfare entities, continuum of care for the homeless, and other substance abuse treatment providers. The agency has 6 years of

experience serving the population of focus in this capacity, but over 135 years of experience serving families in the Omaha metropolitan area, including those facing substance abuse issues and child welfare involvement.

The Target Population and Problem

In 2011, the Nebraska Court Improvement Project (NCIP) convened a group of stakeholders, in conjunction with the National Center on Substance Abuse and Child Welfare (NCSACW) In-Depth Technical Assistance (IDTA), to review data from all Nebraska child welfare cases opened in 2009, to understand and improve the current system. The results showed that over half (56%) of child welfare cases had substance abuse-related problems. While this percentage may not be as high as the national standard, the children in these cases were removed from the home a staggering 84% of the time (Court Improvement Project, 2011).

Despite recent efforts to reform child welfare services through privatization, the state of Nebraska has one of the highest out-of-home placements for children and families involved in the system. In 2010, 5,358 children in Nebraska lived apart from their families for out-of-home care, representing 41% of all children involved in the child welfare system (Child Welfare League of America, 2013). The national average for the number of children in foster care per 1,000 children as of September 30, 2010 was 29.1. Nebraska was at 89.8 children out of a 1,000 (National Coalition for Child Protection Reform, 2012).

The 2011 IDTA study also revealed that 85% of parents with substance abuse issues also had a diagnosed mental health problem. Substance abuse and child maltreatment often co-occur with other problems, including mental illness, domestic violence, poverty, health problems, and prior child maltreatment. The problems facing these families require comprehensive, individualized support services.

The population of focus also faces disproportionate health disparities compared to the general Omaha metro area population. According to SAMHSA, mothers who are drug-addicted are generally victims of serious physical and sexual abuse. Between 41% and 74% of women in drug treatment reported being victims of sexual abuse. In a cross-evaluation of family treatment programs funded by SAMHSA's Center for Substance Abuse, 76% of mothers reported a history of abuse, trauma, and/or neglect (The Rebecca Project for Human Rights, 2010).

Better Together helps participants deal with their trauma histories during and after their addiction treatments. *Better Together* assists clients in implementing appropriate coping skills to manage their trauma symptoms. The project also factors in the target population's needs and meets them through comprehensive ancillary services such as housing assistance, job training, and on-site mental health and psychiatric services.

Overview of the Program Model

Goals, Activities, and Outcomes

Better Together is a comprehensive housing, substance abuse, mental health, and parenting program providing enhanced intensive outpatient services, as well as outpatient services for families involved with child protective services. This program seeks to prevent the abandonment of drug-exposed infants. Additional benefits include avoidance of foster care expenses, timely and permanent family reunification, and stable parental sobriety. *Better Together* allows entire families to live in adjacent but independent apartments and receive daily on-site enhanced intensive outpatient substance abuse treatment, mental health treatment, and other services to facilitate and improve family well-being.

The overarching goal of *Better Together* is to prevent infant abandonment. The *Better Together* logic model, shown in Appendix A, includes the program's inputs, activities, outputs, short- and long-term outcomes, a statement of the problem, and collaborating partners. The long-term outcomes for the *Better Together* program are:

1. **Improved child well-being.** Infants and children receive developmental screenings to ensure they are on-track for developmental milestones. Early therapeutic, trauma-informed interventions help children increase their effective coping strategies and build protective factors that enable them to lead healthy lives.
2. **Sustained parental recovery from substance abuse.** Treatment coupled with stable housing improves the likelihood of sustained recovery, due to the assistance in balancing the costs and benefits of work, support programs and regular meetings, childcare, and transportation.
3. **Reunification of families.** High-risk families live in a safe, natural, and healing environment while receiving supervision and therapeutic services including behavioral health treatment, trauma treatment, and parenting services.

In conjunction with *Better Together* staff, STEPs prepared a service utilization path to help explain the complex program to potential and current clients, collaborating partners, and potential funders (see Appendix B). The service utilization path displays the journey clients take through the *Better Together* program, beginning on the left and progressing toward completion of the program on the right. Clients begin their journey with a referral, followed by a screening, a determination of acceptance into the program, and lastly their admission into the program and move into their apartment. *Better Together* utilizes this form and provides specific dates to provide clarity and accountability during the intake process, both in response to client feedback received through evaluation.

After *Better Together* admits clients to the program and the clients move into their apartment, they begin Phase 1, which lasts approximately 6 weeks. Depending on the client's individualized treatment plan, clinicians identify which combination of the listed services clients will utilize. Clients needing the highest-intensity services will access all

listed services. Services fall into three primary categories: substance abuse and mental health recovery, children and families, and wellness and economic sufficiency. The "substance abuse and mental health recovery" grouping consists of the on-site substance abuse, mental health, and trauma treatments in both group and individual formats (individual therapy, DBT, Matrix, etc.). The "children and families" grouping consists of activities related to the reunification of children and strengthening of parenting capacity, including parenting classes like Common Sense Parenting or Circle of Security, family therapy, and more. Finally, the "wellness and economic sufficiency" grouping includes services designed to produce wellness and stability in the family unit, including on-site case management services.

Clients progress through the phases, completing many services (e.g. group therapy) while others remain throughout the program (e.g. 12-step groups or individual therapy). The intensity of programming decreases over time, while activities to promote independence intensify, with the greatest shift occurring around approximately 6 months as clients enter Phase 3. Clients have completed the program after working through all five phases. Program completion is celebrated in the "Bridging Ceremony," where clients, staff, family, and other supporters help the clients celebrate their move from recovery in a treatment setting to an independent recovery lifestyle. Since the recovery journey continues after leaving *Better Together*, clients "bridge" rather than "graduate."

Through completing services in all three programming areas, clients will have accomplished the five primary short-term outcomes of the program. Parents will have:

1. Sustained recovery from substance abuse,
2. Increased mental health,
3. Increased parenting skills.

Children will have:

4. Permanency and be safe from abuse and neglect and
5. Stability in their living situations.

Collaborative Partners

Better Together has e support from the community's key stakeholders. The two main stakeholders who have committed to sustaining the project past the grant period include:

Nebraska Families Collaborative (NFC)–a private child welfare agency contracted by NDHHS to serve families in the Eastern Service Area of Nebraska, which includes the Omaha metropolitan area. NFC refers all families to *Better Together*, participates in Family Team meetings, and helps to move families quickly toward permanency when reunification is not possible.

Nebraska Department of Health and Human Services (NDHHS), the Division of Children and Family Services and the Division of Behavioral Health (including

Region 6 Behavioral Healthcare, the Omaha-based entity that administers the state's behavioral health block grants)–helps fund treatment services through Medicaid and Medicaid Waiver funding, including individual and group substance abuse and mental health treatment and other mainstream resources such as Food Stamps, Assistance to Dependent Children, etc.

Other program partners included:

Program Partner	Services Provided
Douglas County Housing Authority	Section 8 Family Reunification Vouchers
Omaha Public Schools, Early Development Network	Developmental screening for children 0-3
Visiting Nurse Association	On-site health screening and education
OneWorld Health Center	Health care home
Nebraska AIDS Project	HIV/AIDS education and services
Goodwill	Job readiness and employment programming
Douglas County Family Drug Court	Judicial oversight and recommendations
Region 6 Behavioral Healthcare	Financial support, mental health
University of Nebraska at Omaha	Evaluation

Overview of the Evaluation

The three-year mixed-methods evaluation of *Better Together* assessed the program's processes and outcomes utilizing a time series/follow-up design along with focus groups, interviews, collaborator surveys, and a benefit-cost analysis.

The process evaluation included a demographic analysis of the clients served and systematic client satisfaction surveys. It also included service utilization components with an analysis of clients' received services and completed phases completed.

The outcome evaluation included a battery of standardized measurement tools administered by STEPs at five points in time: intake, 3, 6, 12, and 24 months. Both active and inactive clients were invited to complete the tools, and clients remained in the study as long as they participated in the program for at least 30 days and had not missed two consecutive measurement points. The measurement tools administered were:

1. Parenting Stress Index/Short Form (PSI).
2. Government Performance and Results Act (GPRA) (includes items from the Addiction Severity Index and the Treatment Services Review).
3. Trauma Screening Checklist (TSC).
4. Ages and Stages Questionnaire (ASQ).
5. Service Utilization Form.

STEPs administered these tools in clients' apartments or in the *Better Together* office, without *Better Together* staff present. Clients were given $12.50 Walmart gift cards to compensate for the approximately 30 minutes it took for them to complete the tools.

In addition, *Better Together* staff administered urinalysis or breathalyzer tests and the Adverse Childhood Experiences (ACE) tool to clients and shared the data with STEPs. Children's caseworkers with Nebraska Families Collaborative (NFC) administered the Structured Decision Making Model (SDM) tools and submitted the data to STEPs.

STEPs secured and maintained IRB approval throughout the evaluation. *Better Together* staff administered and documented the consent of clients, and STEPs administered the tools to clients, and analyzed and reported on the data. To protect confidentiality, identifying information was stripped from the data prior to analysis, and data was presented in aggregate form.

Clients were referred to the program by NFC, and *Better Together* staff determined their eligibility. Eligibility criteria were:

1. Parent had a substance dependence diagnosis (may also have had a concurrent mental health diagnosis) which could be treated at the level of intensive outpatient therapy.
2. Parent was not able to, or was not likely to be able to, attain recovery at the outpatient level.
3. Parent behavior was not an immediate threat to the safety of others.
4. Family had been referred by a Family Permanency Specialist of NFC or the State of Nebraska Division of Child Welfare.

Consistent with STEPs's participatory, utilization-focused approach to evaluation, in-depth results were presented to *Better Together* and HFS staff every 6 months. STEPs worked collaboratively with HFS to prepare cross-site data and reports for the funder.

Problems encountered in the implementation of the evaluation plan.
Overall, the evaluation went very well. The program staff and evaluation team members collaborated well in communicating about clients, sharing office space for data collection, confirming data and results, and meeting reporting deadlines. Semi-annually, STEPs provided the program and advisory board with both verbal and written in-depth reports on process and outcome evaluation results. Dialogue was facilitated through in-person presentations, which allowed the program to make adjustments based on results and helped the evaluation team to clarify data collection processes and interpret results.

Institutional Review Board approval was secured and adjusted, as needed, throughout the evaluation to reflect data needs and personnel changes.

The most significant problem encountered in the implementation of the evaluation plan was the difficulty in formulating a comparison group. The plan had been for NFC to provide referrals to both *Better Together* and the comparison group. However, since NFC is focused on child data, they did not have a systematic way to track parents' needs for substance abuse treatment. Although many meetings were held and emails exchanged over the span of a year, at all levels of both NFC and HFS, the quasi-experimental evaluation design was changed to a one-group time series design. This change was approved by the grant project officer since the evaluation plan included quantitative and qualitative components, a benefit-cost analysis, and a collaboration study.

Better Together received somewhat fewer referrals than expected as a lower number of NFC clients qualified for IOP treatment than anticipated. Also, the housing complex had fewer apartment units available than expected, and the number of housing vouchers was limited. Many efforts were made by HFS and *Better Together* staff to increase referrals, including broadening eligibility criteria to include those qualifying for outpatient level of treatment. Nevertheless, the overall sample size was smaller than expected which in turn decreased the generalizability of results and diminished the power of multivariate statistical models.

With only a few exceptions, the STEPs evaluation team was able to administer the battery of quantitative measurement tools to clients at intake, 3, 6, 12, and 24 months, as expected. However, once clients went inactive in *Better Together*, STEPs was only able to be contact and administer the tools to a few clients. Therefore, the intent-to-treat data is very limited.

In addition to these challenges to the evaluation plan's implementation, these limitations should be noted:

1. All quantitative and qualitative client data was based on self-report. Only one quantitative tool, the Parenting Stress Index-Short Form, had a mechanism for detecting inflated responses. This mechanism was utilized for interpreting the parental stress findings, but the other quantitative tools did not have this capacity.
2. During multi-year projects such as this one, personnel changes are inevitable. Both the program and the evaluation team encountered such changes. Hand-offs and training were completed carefully to maximize consistency and communication, and subsequent problems were minimal.
3. Since *Better Together* began with the award of this grant and the project is highly collaborative, it took some time to launch implementation and communicate with referral sources. In addition, some key data items were not well-defined or gathered until midway or near the end of the grant period. For example, the program began collecting ACEs data about midway through the grant period. Given the nature of this data, this did not affect the usefulness of the data other than the inability to collect this data on clients who had already gone inactive. Tracking of close reasons, child data,

service delivery, and phase completion was somewhat fluid and STEPs's evaluation team did not receive it until the end of the grant period.

4. Overall, the battery of quantitative measurement tools worked well. However, the Trauma Symptom Checklist-40 was designed for research purposes only and could not be used for the benefit-cost analysis. Also, results from the Ages and Stages Questionnaire were somewhat limited as parents who did not have custody or frequent visitation with their children were unable to reliably answer many of the questions. The GPRA tool had many items, and in the end, much of the data was not used for analysis and reporting.
5. The small sample size was a substantial barrier for multivariate analysis making statistical significance hard to achieve. For a new and small program like *Better Together*, statistical significance is not as important as practical significance. Statistical significance means generalizability and predictive ability.
6. STEPs collected the Structured Decision-Making data from NFC, however, due to its method of administration and the nature of the tool, this data was not useful to the evaluation of *Better Together.*

Project Implementation and Process Evaluation

Description of Clients Served

Funding for *Better Together* began in October 2013, and clients first enrolled in March 2014. **Overall, 47 clients enrolled, with a total of 111 children between them.** Of these children, 54 lived at *Better Together*, including three children born after intake into the program. Of the 47 clients enrolled, 18 (38%) enrolled in 2014, 15 (32%) enrolled in 2015, and 14 (30%) enrolled in 2016 and January 2017.

Demographics

The grant proposal estimated most clients would fall between ages 25 and 44 and be pregnant or parenting a child under 5 years of age. The table below outlines the description of clients accepted by *Better Together.* As shown, 70% of clients were female, and 30% were male. The average client was 31 years old, with most being between the ages of 25 and 44 years. Three fourths of clients were White, and two thirds were single. Nearly three in four clients had attained education at the high school level or beyond, with 55% achieving a high school diploma or GED, and 19% attaining one or two years of college education. Just over a quarter of clients had not completed high school at the time they enrolled in *Better Together.* Most clients were parenting a child age 5 or under at intake, and no clients were pregnant at intake (to our knowledge).

Client Demographics at Intake (n=47)			
Gender		**Marital Status**	
Female	33 (70%)	Single	30 (67%)
Male	14 (30%)	Married	13 (29%)
Age Mean=31 years old (SD=5.91; range=22-56)		Divorced/separated	2 (4%)
		Highest Level of Education	
20-24 years	6 (13%)	Less than high school	12 (26%)
25-29 years	15 (33%)	High school/GED	26 (55%)
30-34 years	18 (39%)	1st year of college	6 (13%)
35-44 years	6 (13%)	2nd year of college/Associates	3 (6%)
45 years and over	1 (2%)	**Number of Children** Mean=2.6 (SD=1.5; range=0-9)	
Race			
White	33 (75%)	1 child	11 (23%)
Black	9 (21%)	2 children	14 (30%)
American Indian	1 (2%)	3 children	13 (28%)
Multiracial	1 (2%)	4 children	6 (13%)
Ethnicity		5 children	1 (2%)
Hispanic	4 (9%)	6 children	1 (2%)
Not Hispanic	43 (91%)	9 children	1 (2%)

Other Client Characteristics

Prior to enrolling in *Better Together*, about one fourth of clients were in each of these living situations: in his/her own apartment, with a family member or friend, or in residential

treatment. Smaller numbers were living in a halfway house or three-quarter-way house, or in a shelter. One was incarcerated.

Nearly three in four clients were unemployed at intake. Of those who were unemployed, over half were not looking for work, and a small number were looking for work. (Note: Given the number of treatment hours, IOP clients were not able to work during the first phases of the program.) Clients' average monthly income at intake was $698/month (median $450), with $159 from public assistance, $45 from family and friends, and $294 from other sources of income including food stamps, and $314 from wages. The average income from wages was $315 per month, the median and mode income from wages were $0, and the range was $0 to $2,500 per month. Therefore, most participants had no wages at intake.

Other Characteristics of Clients at Intake (n=47)	
Living Situation Prior to Intake	
Residential treatment	11 (24%)
Someone else's home	11 (24%)
Own home	10 (22%)
Shelter	5 (11%)
Halfway house	5 (11%)
Three-quarter-way house	2 (4%)
Incarceration	1 (2%)
Employment	
Full-time	9 (%)
Part-time	3 (6%)
Unemployed, looking for work	6 (13%)
Unemployed, not looking for work	27 (57%)
Volunteer work	1 (2%)
Disabled	1 (2%)
Annual Income (any source) Mean=$7,612 (SD=6,736.12; range=$0-$30,000)	
No income	4 (9%)
$1-$5,000	19 (40%)
$5,001-$10,000	7 (15%)
$10,001-$15,000	9 (19%)
$15,001-$30,000	6 (13%)
More than $30,000	2 (4%)

Clients' Substance Abuse History

The primary drug of choice for most clients was methamphetamine, followed by alcohol and marijuana. On average, clients had used drugs for 12 years but ranged from 1 to 40 years of use. Clients' average age of first use was 16 years, with a range of 8 to 26 years.

Substance Abuse History of Clients (n=47)	
Drug of Choice (most recent)	
Methamphetamine	32 (68%)
Alcohol	6 (13%)
Marijuana	6 (13%)
PCP	2 (4%)
Opiates	1 (2%)
Age When Began Drug Use (mean)	
16 years old (SD=4.22; range=8-26)	
Number of Years Using Drugs (mean)	
12 years (SD=7.18; range=1-40)	

Description of Clients' Children at Intake

The 47 clients served had a total of 111 children, 73 of whom lived or intended to live with their parent at *Better Together*, with 58 who did live on-site with their parent. A few more were male than female, and their average age was about 5 years. Nearly all children served by the program had an open NFC case at intake. As shown below, more than two thirds of children did not live with their parent at the time their parent was admitted into *Better Together.*

Description of Clients' Children at Intake			
	All Children	**Served by *Better Together*****	**Lived On-Site**
Total			
	111	73	58
Gender			
Female	52 (47%)	31 (42%)	27 (47%)
Male	59 (53%)	42 (58%)	31 (53%)
Age at Intake* (mean)			
	7.1 years SD=4.97; range=0.2-17	5.5 years SD=4.47; range=0.2-17	4.8 years SD=4.2; range=0.2-17
Placement at Intake			
With parent	17 (15%)	17 (23%)	17 (29%)
Not with parent	91 (82%)	54 (74%)	39 (67%)
Born after intake	3 (3%)	2 (3%)	2 (4%)
NFC Case at Intake*			
	80 (74%)	68 (93%)	52 (93%)

*Does not include children born after intake.
**Includes children who lived on-site and were intending to be placed at *Better Together.*

Adverse Childhood Experiences (ACEs) of Clients

The ACEs survey asks 10 questions about childhood trauma related to violence, abuse, neglect, and family environment. ACEs have been linked to risky health behaviors, chronic health conditions, low life potential, and early death. As the number of ACEs increases, so does the risk for these outcomes (CDC, 2016).

Clients completed the ACEs survey at intake, and the therapist interpreted the score. *Better Together* began using the ACEs survey about a year into the program, and went back to collect data from active clients, but did not get data from those who had discharged.

On average, *Better Together* clients experienced five types of ACEs (n=23). Three fourths of clients had experienced 4 to 7 ACEs, which puts them at risk for social, emotional, cognitive, and health impairment (Felitti et al., 1998). (See further analysis in Appendix C, Table 1.) Most clients had divorced or separated parents. Around two thirds of clients lived with an alcoholic or addict, and/or received emotional/physical abuse as a child. ACEs scores did not differ significantly by demographic characteristic or by client's most recent drug of choice.

Types of ACEs Reported by Clients	
Emotional abuse	15 (65%)
Physical abuse	14 (61%)
Sexual abuse	8 (35%)
Emotional neglect	5 (22%)
Physical neglect	4 (17%)
Divorced or separated parents	19 (83%)
Mother abused	13 (57%)
Live with alcoholic or addict	16 (70%)
Lived with someone with mental illness	10 (44%)
Lived with someone who became incarcerated	9 (39%)

Client Engagement

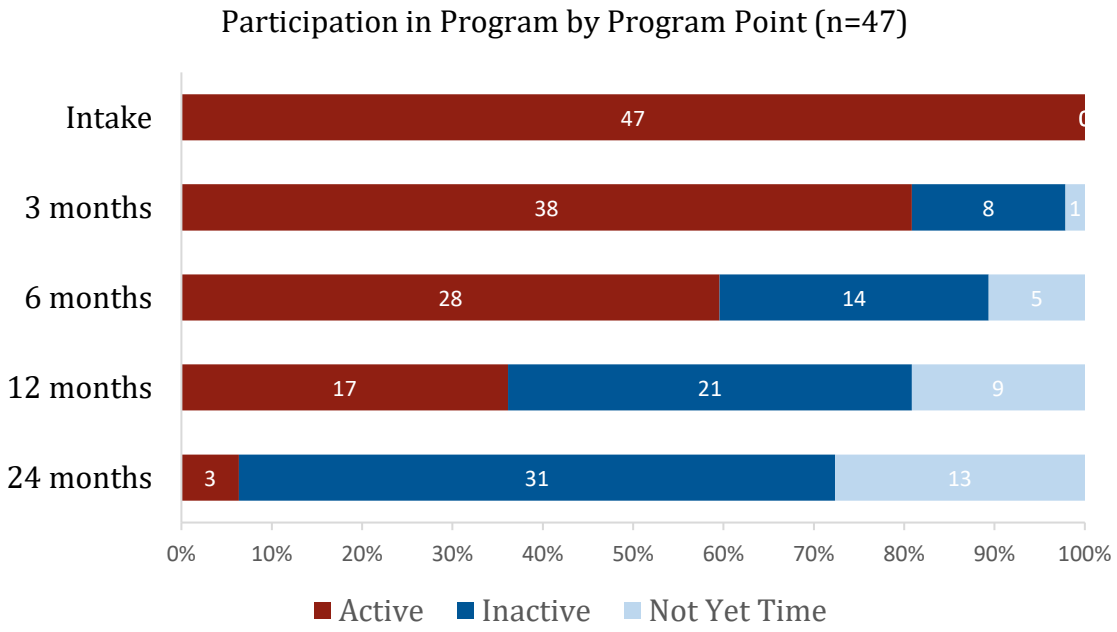
Length of Time

For those who had discharged as of January 31, 2017, the average length of stay was 278 days (9 months) (SD=216). Clients remained in the program from as few as 16 days to as many as 746 days (24 months). The table below shows the number of months clients remained in the program.

Months of Programming for Discharged Clients (n=32)	
0-3 months	8 (25%)
4-6 months	6 (19%)
7-12 months	7 (22%)
13-18 months	7 (22%)
18-24 months	3 (9%)
25 months and over	1 (3%)

The average length of stay for clients still in programming was 388 days (13 months) (SD=300), with some clients experiencing as few as 75 days (2 months) and others as many as 1,030 days (34 months) of programming. At the end of data collection (January 31, 2017), 15 clients remained active in the *Better Together* program (see Appendix C, Table 2).

Of the clients enrolled, 83% were active at the 3-month point, 67% were active at the 6-month point, 45% were active at the 12-month point, and 9% were active at the 24-month point.



Phases Completed

Clients' movement through the program was measured in phases. They did not move forward through treatment in a consistent manner, with some taking longer than others, some moving backward and then going inactive, or some moving backward and forward again. As shown below, most clients who did not complete the program, did complete at least Phase 1.

Clients' Completion of Program Phases - for 33 inactive clients	
Phase 1	26 (79%)
Phases 1 and 2	12 (36%)
Phases 1, 2, and 3	10 (30%)
Phases 1, 2, 3, and 4	6 (18%)
Phases 1, 2, 3, 4, and 5	6 (18%)

Services Received

Better Together offers a range of services to help clients achieve sustained recovery from substance abuse, increase their parenting capacity, and achieve good mental health. Services are selected on a case-by-case basis to meet the individual needs of clients, and therefore not all clients access all services offered. The tables below offer examples of key services most utilized by clients in their treatment. The services most frequently utilized by clients are DBT (87%), Circle of Security (79%), Helping Men/Women Recover (77%), and Matrix (70%). Nearly three in four clients accessed all of these services while participating in the program.

Key Client Services (based on billable hours) – All Clients			
Service	**# of Clients Who Participated**	**Mean # of Sessions Each Client Attended**	**Mean # of Hours Each Client Received**
Recovery			
HMR/HWR	36 (77%)	13.03 SD=8.55; range=1-40	25.58 SD=16.94; range 2-80
Matrix	33 (70%)	15.76 SD=8.86; range 1-38	29.68 SD=17.90; range=1.5-76
Parenting			
Family Therapy	27 (57%)	6.04 SD=5.14; range=1-22	5.9 SD=5.21; range=0.67-22
Circle of Security	37 (79%)	4.96 SD=2.89; range=1-15	9.47 SD=4.39; range=1.5-23
Mental Health			
DBT	41 (87%)	16.20 SD=7.90; range=3-31	29.0 SD=15.58; range=6-54
MRT	25 (53%)	18.36 SD=12.61; range=1-47	24.60 SD=18.38; range=1.5-65

The table below focuses on clients who remained in the program for more than 12 months. Nearly all clients in the program for more than 12 months utilized all six of the key programs highlighted. MRT was the only program that was utilized by less than three fourths of clients, potentially associated with its focus on reducing criminal recidivism.

Key Client Services (based on billable hours) – Clients in the program for >12 months			
Services	**# of Clients Who Participated**	**Mean # of Sessions Each Client Attended**	**Mean # of Hours Each Client Received**
Recovery			
HMR/HWR	18 (100%)	15.61 SD=9.38; range=2-40	31.00 SD=18.70; range=4-80
Matrix	16 (89%)	18.75 SD=9.81; range=3-38	36.66 SD=19.49; range=5.5-76
Parenting			
Family Therapy	16 (89%)	7.25 SD=5.93; range=1-22	7.09 SD=5.98; range=1-22
Circle of Security	18 (100%)	7.11 SD=2.72; range=3-15	10.75 SD=4.15; range=4.5-23
Mental Health			
DBT	18 (100%)	19.50 SD=6.60; range=6-27	38.77 SD=13.68; range=11.40-54
MRT	13 (72%)	24.46 SD=12.44; range=1-47	34.50 SD=18.49; range=1.5-65

Clients' reporting of the services they received provides an overview of the *Better Together* program journey. The highlighted cells in the table below identify at least 75% service participation at that particular measurement point. At intake, clients were engaged in substance abuse support groups, as well as group and individual therapy. By 3 months,

Better Together added parenting classes to the service mix in anticipation of clients' children returning home, which usually occurred soon after the 3-month mark. At 6 months, the focus remained on support groups and therapy, building their sense of community. By 12 months, the clients were either employed or engaged in training or education and remained primarily active in dealing with their personal issues through substance abuse support groups and individual therapy. At 24 months, individual therapy was the service most commonly still reported.

Service Received by Clients (based on client self-report)					
Service	**Intake** (n=47)	**3 months** (n=35)	**6 months** (n=29)	**12 months** (n=20)	**24 months** (n=5)
AA/substance abuse support group	42 (89%)	35 (100%)	27 (93%)	18 (90%)	3 (60%)
Group therapy	36 (77%)	33 (94%)	26 (90%)	13 (65%)	0 (0%)
Individual therapy	35 (75%)	34 (97%)	25 (86%)	18 (90%)	4 (80%)
Parenting classes	17 (36%)	33 (94%)	16 (55%)	8 (40%)	1 (20%)
Family therapy	9 (19%)	15 (43%)	12 (41%)	7 (35%)	3 (60%)
Vocational classes	7 (15%)	4 (11%)	7 (24%)	9 (45%)	2 (40%)

*n=# of clients who participated in the measurement point.

Client Engagement Summary

As program phases occurred and time passed, the number of clients remaining active in the *Better Together* program declined. According to billable service hours, utilization of overall offerings was higher among clients who stayed in the program for 12 months. Clients self-reported a combination of services that defined their progress through their recovery and to well-being.

Client Voice

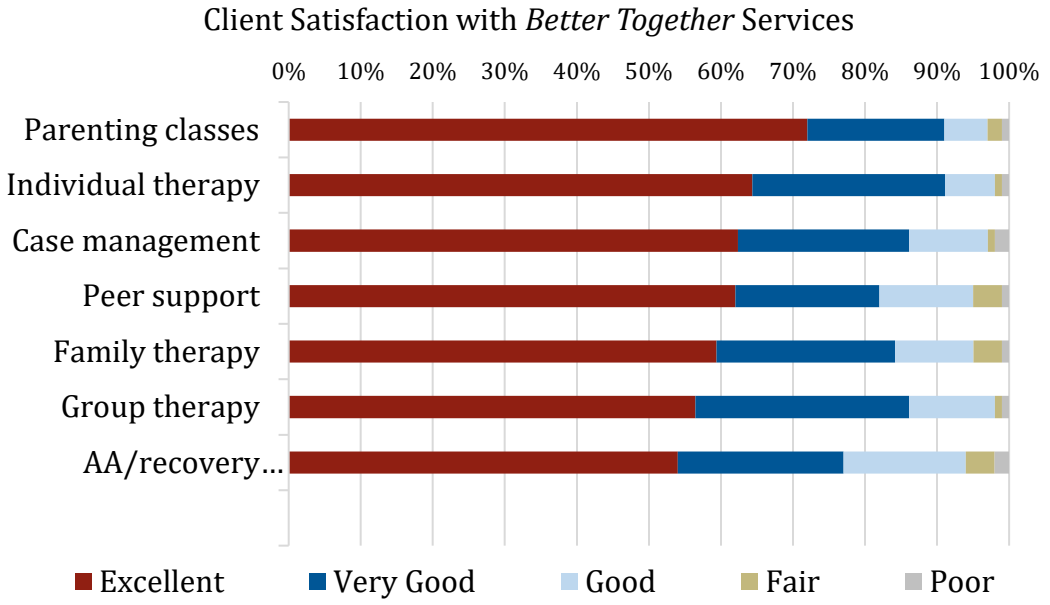
During the course of this evaluation, the *Better Together* client voice was heard. Every quarter, STEPs distributed a client satisfaction survey to active clients to record their assessment of the program's services and experience. As clients approached 6 months in the program, STEPs invited active clients to participate in a focus group to share their thoughts and suggestions about the program. And at 12 months, STEPs invited all clients to offer their perspective and feedback on their program experience.

Client Satisfaction

Methods. Each quarter during 2015 and 2016, active *Better Together* clients completed a two-page client satisfaction survey intended to monitor their experience in the program. The survey solicited ratings of the services clients received and the program's impact on their lives.

Results. While almost all of the program access and service ratings were positive, the substance abuse support groups, referrals to community services, family therapy, and peer support services that received at least 5% negative ("fair" + "poor") ratings. While each client's utilization of *Better Together*'s therapeutic and support services varied according to his/her family's needs, ratings of the services tended to remain positive.

Client Satisfaction Survey Results – Program Access and Services						
	# of Client Surveys	Excellent	Very Good	Good	Fair	Poor
Program Access						
Help with getting an apartment	126	78%	18%	1%	2%	2%
Admission process	126	58%	31%	8%	2%	2%
Explanation of *Better Together* services and schedules	126	61%	29%	9%	1%	1%
Referrals to community services	125	60%	26%	9%	4%	2%
Therapeutic Services						
Family therapy	85	60%	25%	11%	4%	1%
Individual therapy	124	65%	27%	7%	1%	1%
Group therapy	122	57%	30%	12%	1%	1%
Support Services						
Parenting classes	101	72%	19%	6%	2%	1%
Peer support	113	62%	20%	13%	4%	1%
Case management	113	63%	24%	11%	1%	2%
AA/substance abuse support groups	117	54%	23%	17%	4%	2%



Close to 90% of clients rated interactions with staff positively. "Having a say in how client and staff work together" did, however, receive the highest percentage of neutral or negative ratings. The lower ratings, "a little" and "not at all," were recorded by those with less than 3 months of service. However, the largest cluster of "somewhat" ratings were registered in the 6- to 12-month time period, which was potentially a time of transition to more control for these clients.

Client Satisfaction Survey Results – Client-Staff Interactions						
	# of Client Surveys	**A Great Deal**	**A Lot**	**Somewhat**	**A Little**	**Not At All**
Being listened to by staff	113	66%	26%	6%	2%	0%
Having a say in which goals client works on	126	62%	29%	7%	2%	0%
Feeling hopeful after talking with staff	126	69%	21%	8%	2%	0%
Discussion of client progress in program	126	63%	25%	7%	3%	2%
Having a say in how client and staff work together	126	51%	32%	14%	2%	2%

In addition to 90% of clients reporting satisfaction with the program recovery support of and agreeing their personal functioning had improved, a full 97% acknowledged they would recommend *Better Together* to others.

Client Satisfaction Survey Results – Program Impact						
Program improved personal functioning	**# of Client Surveys**	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
	125	71 (57%)	45 (36%)	7 (6%)	0 (0%)	2 (2%)
Satisfaction with program support in personal recovery	**# of Client Surveys**	**Extremely Satisfied**	**Very Satisfied**	**Somewhat Satisfied**	**Slightly Satisfied**	**Not At All Satisfied**
	126	81 (64%)	37 (29%)	6 (5%)	1 (1%)	1 (1%)
Willingness to recommend program to others seeking treatment	**# of Client Surveys**	**Yes**	**No**			
	116	113 (97%)	3 (3%)			

The comments clients shared while moving through the *Better Together* program also reflected the impact indicated by these responses. The focus of clients' comments shifted along with their tenure in the program:

- As they began their involvement with *Better Together*, clients mentioned feeling safe and having a sense of belonging. They acknowledged the staff's support through providing structure and meeting their needs.
- When they reached 3 months, clients' comments focused on the support they received from both the staff and their peer community. The clients also acknowledged their steps toward recovery and the program's trauma-informed approach.
- Sobriety and family reunification were prominent themes as clients moved past 6 months in the program. Both staff and peers were cited for their balancing of *advocacy for* and *accountability from* program clients.

- At 12 months, clients reflected on accomplishing their goals and becoming a better person. They acknowledged the support and help received as well as declared they "love it here."
- After 18 months, the clients described the *Better Together* program as "great sober support," "helpful for me and my family," and staff being there "every time I needed them."

Client Focus Groups

Methods. STEPs conducted four focus groups to gather clients' overall impressions of *Better Together*. All focus group participants were active when they participated in the focus groups. **In total, 21 individuals participated in the focus groups: 15 females (71%) and 6 males (29%).**

STEPs completed the analysis of the transcribed data using MAXQDA software and utilized a mix of inductive and *a priori* coding in the analysis of the focus group transcripts. Ultimately, four major themes emerged across all four focus groups.

Findings. This summary of the four focus groups is expanded in detail in Appendix D. The analysis of the focus group discussions revealed four overriding themes:

1. Program Access,
2. Program Services,
3. Client-Staff Interaction, and
4. Program Impact.

Program Access. This not only refers to participants' literal access to *Better Together* program, but also to what they needed to access within themselves in order to benefit from offered services. Participants stated that their own commitment to recovery allowed them to gain the most benefit from the program. As one participant stated, "I've been through treatment before, and I've held back. I'm at the point where I'm just sick and tired of being sick and tired so, why hold back?"

One concern regarding program access that participants repeatedly addressed was that the community was not aware of *Better Together*. Some participants expressed concern about key referral sources not knowing about the program or misunderstanding its admission criteria. As one participant stated, "My NFC worker was like, 'I've never even heard of it.'"

Program Services. All focus group participants expressed gratitude for the *Better Together* program. Many participants discussed the knowledge they and their families gained from the therapeutic treatment in their individual, family, and/or group therapy. All were able to communicate how these services benefited their sobriety and had led, or would lead, to their families reunifying.

The therapeutic benefits of a peer community were of particular value to participants. Living in close proximity to peers, living in close proximity to treatment, receiving respect

from staff, and receiving emotional support from one another created this sense of community.

Client-Staff Interaction. The vast majority of participants spoke positively of program staff and their interactions. As one participant stated, "The staff do have open minds. They do treat us as people instead of just clients or drug addicts or alcoholics. That's a good thing."

Program Impact. Nearly all focus group participants expressed appreciation for *Better Together's* positive impact in their lives. For some, the appreciation centered on their sobriety and learned skills. For others, the basic needs the program provided while they were in recovery was the biggest impact on their lives. Still others expressed appreciation for reunification with their children through participation in *Better Together*. The severity of participants' situations was not lost on most of them. As one participant stated, "I gotta get my kid out of the system … This is serious business for us."

Client Interviews

Methods. STEPs conducted 15 individual interviews with *Better Together* participants in or after their 12th month in the program. The purpose of these interviews was to gather information from the viewpoint of participants as they reached the program's halfway mark. 14 interview participants were active at the time of their interviews and one was inactive. **In total, 15 individuals participated in individual interviews: 11 females (73%) and 4 males (27%).**

STEPs completed the analysis of the transcribed data using MAXQDA software. Initially, STEPs analyzed each interview transcript on its own using inductive and *in vivo* coding, then completed multiple levels of analysis and thematic coding across all 15 transcriptions using constant comparison of themes and codes.

Findings. This summary of the 15 interviews is expanded in detail in Appendix E. The analysis of these interviews revealed three major themes:

1. Recovery,
2. Parenting, and
3. Family Reunification.

Recovery. When reflecting on what helped them achieve successful recovery, most participants identified both their own willingness to change and *Better Together* staff as key components in their recovery. As one participant stated, "Every treatment is different, and you gotta go in with an open mind … it is what *you* put into it." All participants shared positive comments when talking about *Better Together* staff. Many expressed gratitude: "Whether it be advocating for me in court, or teaching me skills to handle situations … They've always been there."

In addition to staff, participants mentioned benefitting from the various therapeutic and educational programs that *Better Together* offered. They most frequently referenced individual therapy, DBT classes, and peer support as being critical to their sobriety. The general consensus among interviewees was that *Better Together* is a "case-by-case

program" and that staff "take into consideration each individual situation." Thus, participants expressed appreciation that the program allowed for individualized and client-centered treatment.

Parenting. All participants identified improved relationships with their children as a result of participating in the *Better Together* program. As one stated, "I'd say the biggest change would probably be parenting. Like knowing how to be the right parent for my child." Most interviewees also noted their improved parenting skills, and credited individual therapy, family therapy, and Circle of Security for making the biggest impact on their parenting skills.

Finally, program participants frequently addressed the bonds and attachments that grew between them and their children as a result of being in *Better Together.* Some discussed how therapy and parenting classes helped them "get that bonding back" after months or years of separation from their children. One participant spoke on behalf of her children when she stated, "I think my children feel more safe and more secure now."

Family Reunification. While treatment initially focused on sobriety, clients' reunification with their child(ren) was the ultimate goal. All participants credited *Better Together* with allowing them to obtain, or maintain, reunification with their children. As one participant stated, "I really love the program … It was the hand up that I needed to be stable and get my son back. I know that being in this program had a huge part in getting custody back." While all interviewees were only halfway through the *Better Together* program at the time of their interviews, some were already able to say, "My case is closed," with pride.

Client Voice Summary

Better Together clients confirmed a high level of satisfaction with the services they received during the course of the program. While they acknowledged the importance of their personal readiness for and commitment to recovery, they also offered insight into their personal journeys and expressed particular gratitude for the knowledge they had gained through the therapeutic services, as well as both staff and peer supports. They reflected on their road to recovery but identified family reunification and improved relationships with their children as the ultimate success. Clients also identified a few areas of potential program improvement, including increasing community awareness and understanding of the program, substance abuse support groups, referrals to community services, family therapy, and peer support.

System Collaboration

Systems Map

Methods. Hargreaves (2010) emphasizes the importance of capturing system relationships and collaboration through a systems map to depict the networks and relationships involved in a program. A systems map depicts the boundaries, dynamics, and multiple perspectives for a program in a visual format. It can portray the overall program as well as subsystems that are affected by or impact the program (Cook, 2015).

A systems map was drafted in a meeting of *Better Together* staff and the STEPs's evaluation team. Sticky notes represented the program's core elements and collaborative partners, and much discussion ensued on the centrality of and relationships between various services and partners. STEPs then drafted a systems map and fine-tuned it through further communication with program staff and collaborative partners.

Findings. *Better Together* chose the image of a ship to depict how clients must forge through treacherous waters to reach their end goal of economic and family self-sufficiency. (See Appendix F). The main cabin of the ship houses the core program elements, with collaborative partners in upper levels of the ship. Referring entities are shown as the tour guide, pointing passengers (clients) in the direction of the ship. The ship's propeller is identified as funding sources, and the steering mechanism as program values. Passengers (clients) are seen in three locations on the system map: sad parents and children in separate houses on the shoreline, happy families clustered on the ship's deck, and reunited and self-sufficient families at their destination.

Treacherous waters with sharp rocks and sharks are in the foreground of the ship, and a smaller boat with a lone passenger is attempting to navigate the rough waters in isolation. The sun and clouds in the sky illustrate the overall environmental impact of larger systems.

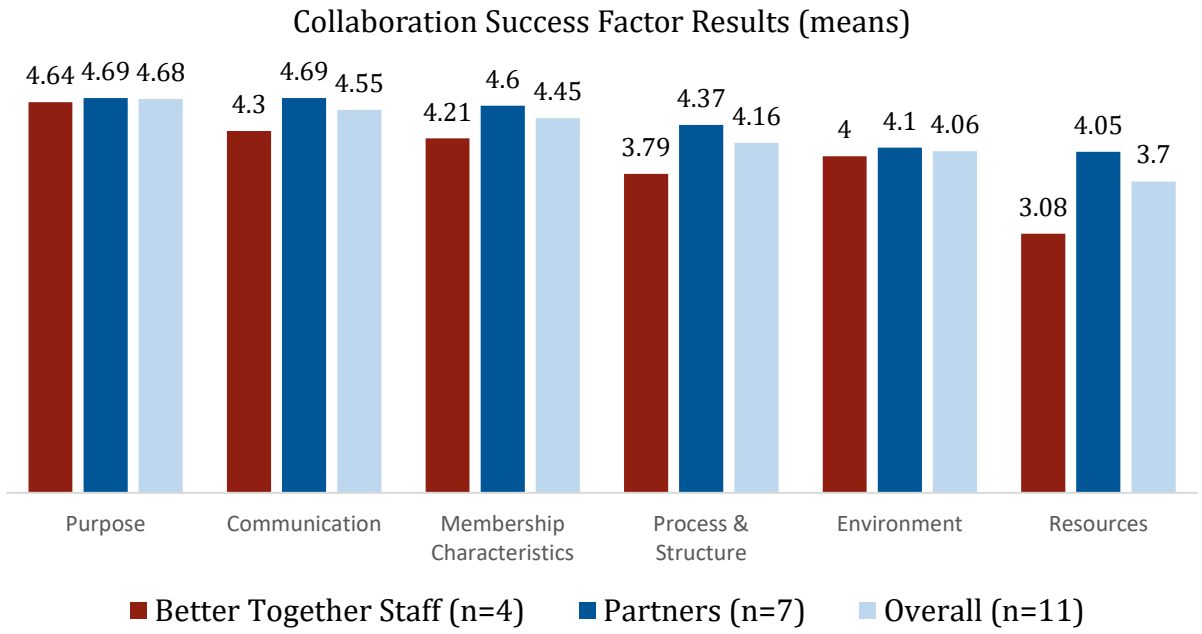
Collaboration Survey

Methods. STEPs asked collaborative partners to complete the Wilder Collaboration Factors (WCF) Inventory and followed up with a qualitative interview. The WCF Inventory consists of 20 factors that effective collaboration needs. A systematic review of empirical studies on collaboration produced inventory items grouped into six categories: environment, membership characteristics, process and structure, communication, purpose, and resources. Participants respond to 40 statements on a five-point Likert scale: strongly disagree (1), disagree (2), neutral or have no opinion (3), agree (4), or strongly agree (5).

Following the authors' guidelines, we averaged item ratings within a given factor and interpreted factor scores as follows: scores of 4.0 or higher show strength and probably do not need special attention; scores between 3.0 and 3.9 are borderline and may require attention; and scores of 2.9 or lower indicate concern and should be addressed (Mattesich, et al., 2001; Pitkin Derose et al., 2004; WCF Inventory, n.d.).

Findings. Community partners tended to rate the success factors more highly than *Better Together* staff. Two factors exemplified that difference in perceptions: process and structure, and resources. Staff thought both areas might need attention with average ratings below 3.9. The process and structure dimension includes commitment, decision making, roles and responsibilities, adaptability, and appropriate pace. The resources dimension covered leaders, people power, and funds.

Both groups gave most of the collaboration success factors an average rating over 4.0, thus identifying purpose, communication, membership, and environment as strengths of *Better Together's* collaboration.



Collaboration Interviews

Individual interviews with the collaborative partners revealed strengths and weaknesses of, opportunities for, and threats to collaboration with *Better Together*. Overall impressions of the effort included a focus on its mission, the program model, and its impact. Regarding mission, interviewees confirmed they valued being involved in helping people get their lives back on track. They confirmed that the family focus of the program acknowledges the impact of addiction on the entire family. They considered the program model unique for its service to both couples and single fathers, supportive environment in which families could reunite, and its on-site therapeutic treatment. Interviewees cited families reuniting and clients staying involved and graduating as impacts of *Better Together*.

The strengths of *Better Together* that collaborative partners identified centered around the program's staff. As supports and a safety net for their clients, collaborators shared how the staff understood each client's situation and facilitated close relationships. In their roles as system navigators and case managers, program staff coordinate a client's process from application, briefing, to program use. They are responsive to questions and are true to their word. With support from the juvenile court system, the staff use their training on how the system works to run the program smoothly, including thoughtfully referring clients for specific housing vouchers.

The weaknesses of *Better Together* that collaborative partners described fell into two realms: one, the initial support of clients, and two, coordination with service providers. Collaborators identified a need to streamline the program's screening and admissions process, and increasing the availability of housing vouchers, so as to intake more clients more quickly. Interviewees called for more initial support of clients and suggested creating a peer welcoming committee for new clients. Regarding coordination with service providers, collaborators suggested more communication, and, particularly, being more

open to partner feedback about process improvement. *Better Together* staffing changes and variability in programming schedules produced challenges for their service partners. There was also a call for more communication so providers could more deeply understand the program phases and better support client progress.

Opportunities for Better Together's future success included exploring additional sources for housing vouchers, such as:

- Dual-diagnosis (substance abuse/mental health diagnosis) Region 6 housing funds.
- Douglas County Housing Authority's available "project-specific" funding, a program designation that can be applied for through the Division of Behavioral Health.
- Omaha Housing Authority's housing vouchers other than "family reunification."
- Expand to other area housing authorities (e.g., Bellevue, Sarpy County).

Interviewees suggested providing more partner services on-site, including the Housing Authority's required "tenant education course" and a "resource closet" with basic-needs supplies such as personal hygiene items or kitchen utensils. They also including the expansion of collaboration with current partners, including personalized client consultations with Visiting Nurse Association (VNA) and utilizing women's intensive outpatient program (IOP) funding whenever possible.

Additionally, collaborators cited referrals and funding as two areas of opportunity. There was a call for more education and marketing to referral sources about the "ideal" program candidate and the niche of the *Better Together* program. Interviewees also noted that freedom from stringent grant restrictions would provide other program opportunities.

Interviewees identified threats to *Better Together*'s future success in the financial realm. They specifically mentioned the challenge of budgetary stability in the pending transition from a start-up grant to independent funding sources. In addition, potential changes in housing vouchers and leasing fees could be challenging. The apartment complex's balance of business priorities was a potential challenge in this collaboration. They included:

- Paying closer to market value of rental units.
- Broken leases when clients leave program early.
- Costly damages to rental units.
- Holding units for program clients can leave them empty and uncompensated.
- 3-bedroom units, desired by program clients, are in higher demand and cost more.

In addition, interviewees suggested diligently monitoring clients' behaviors and maintaining communication with the program's landlord, given the unpredictable nature of a recovering-addict population.

Another set of program challenges center around program quality. Collaborators identified the neighborhood surrounding the current apartment complex as being rough and suggested moving to a "healthier and safer" complex. Lastly, the *Better Together* program's increasing size could be a possible challenge to maintaining program strengths, such as closeness to clients and effective case management.

System Collaboration Summary

Better Together's systems map, collaboration surveys, and interviews acknowledge the challenges clients face when trying to get their lives back on track after substance abuse recovery and child welfare involvement. The research highlights the value of program staff closely supporting and guiding their clients. It also identifies the importance of ongoing communication and engagement between *Better Together* staff and collaborating service providers, including the program's apartment complex management team. Finally, the research recognized the challenge of establishing the program's budgetary stability with its pending transition from a start-up grant to independent funding sources.

Overall Process Evaluation Discussion

Better Together's systems map and collaboration research acknowledge the challenges clients faced when trying to get their lives back on track after substance abuse recovery and child welfare involvement. The program's collaborative partners revealed the strongest agreement in their shared purpose, and biggest differences in their assessment of available resources. **These findings confirm the complexity of clients' problems and the importance of working closely with other providers and funding organizations to address them.**

Along with the case management navigation and connections to other community resources, *Better Together* offers its clients a deliberate screening and intake process which leads to a combination of services that are phased to target their recovery, mental health, parenting, and self-sufficiency needs. According to both billable service hours and self-reported service utilization, the passing of time and program phases decreased the number of clients who remained active in *Better Together*. However, those who reached 12 months in the program utilized a wide variety of services. **The importance of the program's structure, service mix, phasing, and client support should not be underestimated.**

Both the collaboration research and client voice findings highlight the value of program staff closely supporting and guiding their clients. While clients acknowledged the importance of their personal readiness for and commitment to the program, they confirmed high levels of satisfaction with the program services they received. The clients also identified a few potential areas of program improvement, such as increasing the community's awareness and understanding of the program, substance abuse support groups, community services referrals, family therapy, and peer support. **STEPs approached *Better Together*'s process evaluation from the perspectives of clients, the program, and the community, and found three important factors: client readiness for recovery, high quality of services, and strong connections with the surrounding community.**

Project Outcome Evaluation

The 3-year outcome evaluation of *Better Together* utilized a time series/follow-up design along with focus groups and interviews. It included a battery of standardized measurement tools that STEPs administered at five points in time: intake, 3, 6, 12, and 24 months. Both active and inactive clients received invites to complete the tools, and clients remained in the study as long as they participated in the program for at least 30 days of services and had not missed two consecutive measurement points. Administrative data was gathered at the end of the project. The measurement tools and their associated short-term outcomes are shown in the table below.

Short-Term Outcome	Measurement Tools/Data Sources
Parents have sustained recovery from substance abuse	• Close reason • Drug screening results • Government Performance and Results Act (GPRA) (includes items from the Addiction Severity Index and the Treatment Services Review.)
Parents have increased parenting skills	• Parenting Stress Index-Short Form
Parents have increased mental health	• Trauma Symptoms Checklist-40 (TSC-40)
Children have permanency and stability in their living situations	• NFC administrative data • Income data (from the GPRA)
Children are safe from abuse and neglect	• NFC administrative data • Ages and Stages Questionnaire (ASQ)

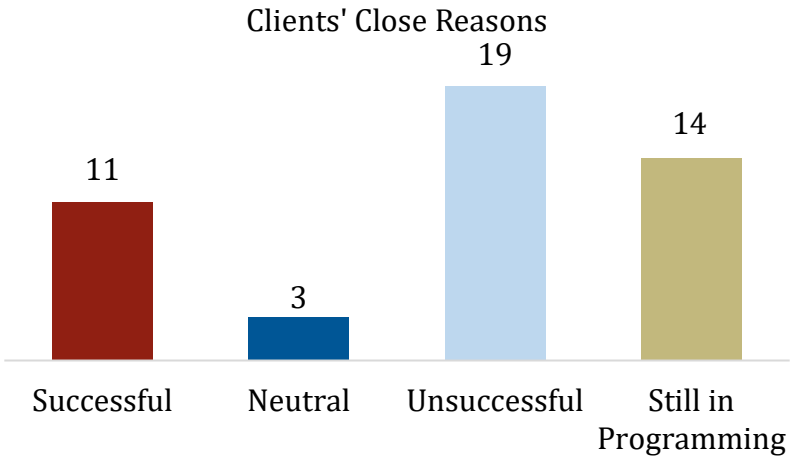
In addition to the quantitative findings discussed below, the qualitative findings summarized in the "Client Voice" section above evidence positive outcomes. Full reports are in Appendices D and E.

Outcome 1: Parents Have Sustained Recovery From Substance Abuse

Clients' sustained recovery from substance abuse was measured in two ways: close reason and drug screening results.

Close Reason

Findings. Of the 47 clients enrolled, 33 discharged from the program. **Of those who discharged, one third (n=11) finished successfully and just over one half (n=19) did not finish successfully, either because of actual or suspected drug abuse.** As of January 31, 2017, 14 clients were still in the program, which, due to the long-term nature of the program and the relatively short time the program has been open, is a significant success. A small number of clients (n=3) exited for neutral reasons, which means they were making progress toward their goals, but chose to leave voluntarily.



When comparing close reason by gender, 7 of the 33 females' cases (21%) closed successfully, as compared to 4 of the 14 males' cases (29%). All 3 of the clients who left for neutral reasons were female. When comparing close reason by ethnicity, 7 of the 32 White clients' cases (22%) closed successfully, as compared to 2 of the 8 Black clients' (25%), and 2 of the 4 Hispanic clients' (50%). Neither the relationship between gender nor ethnicity and close reason is statistically significant.

On average, clients who exited the program successfully were in the program for 15 months, with a minimum of 8 and maximum of 25 months. Clients were in the program an average of 7 months before exiting the program because of drug use, with a minimum of 0.5 and a maximum of 21 months (two clients left the program within the first month and were not included in the evaluation data). The three clients who left the program on their own accord after meeting some goals were in the program between 1 and 8 months, with an average of 5 months.

Of those who had discharged prior to the 3-month point, 12% (n=1) were neutral (neither successful nor unsuccessful) and 88% (n=7) were unsuccessful. Of clients who discharged by the 6-month point, 14% (n=2) were neutrally discharged and 86% (n=86) were unsuccessfully discharged. Of those who discharged by the 12-month point, 19% (n=4) had successfully discharged, 14% (n=3) had neutrally discharged, and 67% (n=14) had unsuccessfully discharged. Of those who discharged by the 24-month point, 29% (n=9) had discharged successfully, 14% (n=3) had discharged neutrally, and 61% (n=19) had discharged unsuccessfully. **Clients who were successful in completing the program had lower ACEs scores than other clients who were not.**

ACEs Scores by Close Reason (means)		
Close Reason	**n**	**Mean**
Successful	6	3.2
Unsuccessful	5	5.0
Still in program	12	5.8
Overall	23	4.9

p=.076; df=2; F=2.936

Drug Screenings

Methods. Clients took drug and alcohol tests routinely throughout their time in *Better Together,* typically with higher frequency in the beginning of programming and diminishing frequency over time. *Better Together* staff recorded the results, indicating whether the positive results were "explained" or "unexplained," "explained" positive results being those accounted for by a doctor's prescription. *Better Together* sent the log to STEPs monthly, who tabulated the results in a spreadsheet. STEPs treated the "explained" positives as negatives for the purposes of data analysis.

Findings. Over half of the clients (n=25, 53%) in the program never had a positive urinalysis or blood alcohol test while in the program. In each period of programming, clients who had positive UAs went inactive at a higher rate. Clients with positive drug tests left the program at a more rapid rate than those who did not.

Of the clients who had a positive drug test in the program, 17 were female (77%) and 5 were male (23%), and most were White (n=14, 64%) and the rest were African American (n=6, 27%) or Hispanic (n=2, 9%). The average age of those who tested positive was 30 years (SD=4; range=22-39), and over one in four (n=6, 29%) were married. Of those who had been discharged, almost two thirds (n=13, 59%) had been discharged for drug use or suspicion of use, while three (14%) were still in programming, two (9%) for breaking rules or laws, two (9%) were discharged with maximum benefits, one (5%) chose to leave with goals unfinished, and one (5%) graduated.

The table below indicates the period of programming during which positive drug tests occurred, further distinguished by clients' discharge status. As few as 10% of clients who discharged successfully had a positive drug test in the first 3 months of programming, compared to 63% of clients who discharged unsuccessfully. Clients who were still in programming, who had a neutral discharge or who had graduated successfully tended to have no positive drug tests after 6 months in the program. On the contrary, those who discharged unsuccessfully were the only clients who tended to have a positive drug test in more than one period in the program (e.g. during the 0- to 3-month period and the 4- to 6-month periods). (See Appendix C, Table 3 for more detailed analysis).

Positive Drug Tests				
Close Reason	**0-3 months**	**4-6 months**	**7-12 months**	**Over 12 months**
Still in Programming	13% (n=2)	7% (n=1)	0	0
Successful	10% (n=1)	0	0	17% (n=1)
Unsuccessful	63% (n=12)	33% (n=4)	67% (n=4)	40% (n=2)
Neutral	33% (n=1)	0	0	n/a
Total	34% (n=16)	13% (n=5)	15% (n=4)	17% (n=3)

*Data may be duplicated; clients may have had a positive UA in more than one period.

Summary

Many *Better Together* clients sustained recovery from substance abuse as evidenced through successful completion of the program and drug test results. One third of clients discharged from the *Better Together* program successfully, and just over half did not. On

average, it took 15 months for clients to complete the program successfully. Clients who exited the program after possible or actual drug use received an average of 7 months of services. Clients who experienced fewer types of ACEs were somewhat more likely to finish the program successfully than were those clients who had experienced more types of ACEs. Over half of clients did not have a positive drug test while in the program. Most clients who were unsuccessful in the program had a positive drug test in the first three months and further positive drug tests in subsequent months.

Outcome 2: Parents Have Increased Parenting Skills

Parenting Stress Index-Short Form

Methods. Parenting capacity is approximated through the Parenting Stress Index-Short Form (PSI), 4th edition. Scores, shown in percentiles, can range from 0 to 100. "Total Stress" signifies the overall level of parenting stress an individual is experiencing, and individuals with scores ≥90 are experiencing "clinically significant levels of stress" (Abidin, 2012, p. 60). The three subscales are briefly described below:

1. Parental Distress (PD): "Level of distress that an individual is experiencing in his or her role as a parent" (ibid., p. 60).
2. Parent-Child Dysfunctional Interaction (P-CDI): Parent's perception that "the child does not meet his or her expectations and that his or her interactions with the child are not reinforcing to him or her as a parent" (ibid., p. 60).
3. Difficult Child (DC): Focuses on "basic behavioral characteristics of children that make them either easy or difficult to manage" (ibid., p. 60).

The Defensive Responding score in the PSI "assesses the extent to which the [individual] approaches the questionnaire with a strong bias to present the most favorable impression of him- or herself or to minimize indications of problems or stress in the parent-child relationship" (Abidin, 2012, p. 59). A score ≤10 is notable.

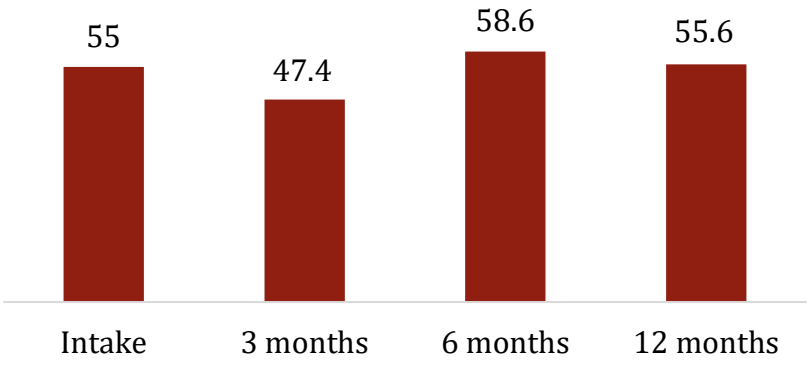
Findings. Total parental stress was similar at intake, 3, and 6 months; it decreased at 12 months, and increased at 24 months. However, the sample size diminishes considerably over time. Interestingly, Parental Distress scores decreased at each point in time, with the exception of the small number of clients at 24 months. Both Parent-Child Dysfunctional Interaction and Difficult Child increased at the 6-month point, which is typically when children had been returned to their parents for 3 months and services decreased.

The table below shows PSI scores for all clients assessed at these points of time, regardless of their active/inactive status in the program or their Defensive Responding score. (See Appendix C, Table 4 for only clients active at that point in time.)

PSI Total and Subscale Scores (means) – For All Clients					
Point in Time	**n**	**Parental Distress**	**Parent-Child Dysfunctional Interaction**	**Difficult Child**	**Total Stress**
Intake	45	56.0 SD=20.7 range=2-96	52.9 SD=23.1 range=4-98	54.7 SD=23.1 range=2-94	53.3 SD=20.9 range=12-94
3 months	33	47.6 SD=22.6 range=2-78	52.5 SD=25.1 range=4-86	50.6 SD=28.9 range=4-92	49.7 SD=25.1 range=1-84
6 months	27	45.0 SD=25.2 range=2-82	56.2 SD=25.3 range=10-94	56.0 SD=23.1 range=10-90	52.2 SD=24.1 range=4-82
12 months	20	34.7 SD=24.5 range=2-70	39.2 SD=25.6 range=4-90	45.8 SD=25.5 range=4-90	36.3 SD=25.0 range=4-82
24 months	4	54.0 SD=25.1 range=22-76	72.0 SD=26.2 range=42-94	78.8 SD=32.9 range=30-99	72.0 SD=19.1 range=44-86

Of all clients, 16 were active after 12 months in the program. When including those 16 clients and looking at those who had a Defensive Responding score over 10 at the corresponding point in time, parental Total Stress decreased at 3 months, but went back up at 6 and 12 months. Parental Distress decreased at 3 months and stayed at a lower level. Both Parent-Child Dysfunctional Interaction and Difficult Child increased at the 6-month point, which is typically when children have been returned to their parents for about 3 months and programming is decreasing. Parental stress levels moderated somewhat at 12 months. The chart below shows that Total Stress scores for the 16 clients still active at 12 months remained relatively stable. (The sample size was too small to test for statistical significance. See Appendix C, Table 5 for additional analyses.)

Mean Total Stress Scores
for the 16 Clients Still Active at 12 Months

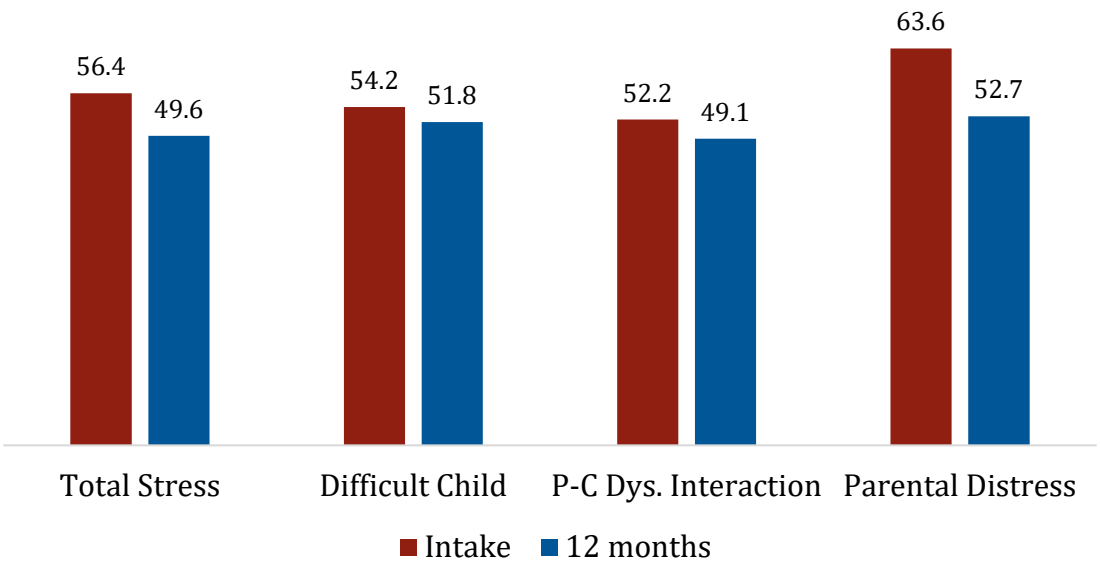


When looking at PSI total scores for all clients with Defensive Responding over 10 at the corresponding point in time, the only statistically significant difference was a decrease in stress in the span from 6 to 12 months (63.2 to 51.2 points; p=.058; df=11; t=2.111).

PSI Total Scores for All Clients with DR>10 At Those Points in Time				
Points in Time	**n**	**Means**	**Difference**	**Statistics**
Intake ⟶ 3 months	27	58.6 (SD=18.1) 55.3 (SD=20.8)	3.3 (SD=21.0)	p=.427; df=26; t=.806
3 months ⟶ 6 months	21	57.1 (SD=18.0) 60.7 (SD=15.6)	-3.6 (SD=20.8)	p=.435; df=20; t=.797
6 months ⟶ 12 months	12	63.2 (SD=15.0) 51.2 (SD=20.8)	12.0 (SD=19.7)	p=.058; df=11; t=2.111
Intake ⟶ 12 months	11	56.4 (SD=19.1) 49.6 (SD=21.1)	6.7 (SD=22.3)	p=.341; df=10; t=1.001

When including only those clients who were active in the program at 12 months and had Defensive Responding over 10 at intake and 12 months, the only statistically significant difference in subscales was a decrease in Parental Distress (63.6 to 52.7 points; p=.018; df=10; t=2.823). Scores also decreased slightly in the other two subscales: Parent-Child Dysfunctional Interaction and Difficult Child. (See Appendix C, Table 6.)

Parental Stress in the Four Subscales from Intake to 12 Months



At the end of data collection, 10 clients had completed the program successfully and had PSI scores at both intake and discharge. On average, these 10 clients decreased their scores in Total Stress as well as in Parental Distress and Difficult Child; however, they did not decrease their scores in Parent-Child Dysfunctional Interaction. The only statistically significant decrease in scores was in Parental Distress (from 49.4 to 33.8, p=.009; df=9; t=3.297).

(Of these 10 clients, two had too low of Defensive Responding at intake and close, and another 2 clients had too low of Defensive Responding at close. Nevertheless, to achieve a reasonable sample size, all 10 clients were included in this analysis. It is also important to note that the time in the program varied considerably between these clients, from 6 to 24

months. So, this analysis includes all 10 clients who completed the program successfully, regardless of their Defensive Responding scores at either intake or discharge. See additional analysis in Appendix C, Table 7.)

Female clients reported statistically significantly higher levels of stress than male clients at both intake and 12 months. Additionally, Black clients reported statistically significantly higher levels of stress at intake, and their scores at 12 months were much higher as well. Clients who were single (including two who were separated from their spouses) had higher levels of parental stress at intake than those who were married. (The frequency for the married group dropped to 2 at 12 months, so STEPs did not run that comparison.) Clients' reported levels of stress was about the same at intake, regardless of total number of children; however, at 12 months, parents with 3 to 9 children had higher parental stress than those with 1 to 2 children. Although not statistically significant, clients whose last drug of choice was methamphetamine had lower parental stress at intake and much lower at 12 months. Across the demographics, male clients decreased their reported stress the most from intake to 12 months. (See Appendix C, Table 8.)

Those who were later successful in completing the program had lower PSI Total Stress scores at intake, as well as lower scores in most of the subscales. The difference, however, was not statistically significant.

PSI Total Stress at Intake by Close Reason (means)
For All Clients With DR>10 at Intake

Close Reason	n	Parental Distress	Parent-Child Dysfunctional Interaction	Difficult Child	Total Stress
Successful	8	60.3	43.5	49.8	50.0
Neutral	3	58.7	59.3	57.3	58.7
Unsuccessful	18	60.3	60.4	54.9	58.4
Still in Program	12	62.3	51.3	60.0	56.2
Overall	41	60.8	54.4	55.5	56.2

We were only able to capture PSI scores from nine clients after they went inactive in the program. Of these clients, 6 increased and 3 decreased their PSI total stress scores after going inactive. (See Appendix C, Table 9.)

Summary

Overall, clients increased their parenting skills, as measured through a self-reported reduction in parental stress. Client stress levels were well below clinically significant at all points in time, both in Total Stress and all subscales. For clients who stayed in the program for at least 12 months, their PSI Total Stress scores improved, especially between 6 and 12 months. The most significant changes in parental stress scores were in the Parental Distress subscale, and these scores improved steadily throughout clients' time in the program from intake through 12 months. At the same time, clients reported increased stress due to parent-child interactions and having a difficult child at 6 months, which is

about when clients' children had been returned for 3 months and services began to diminish.

Looking at demographic characteristics, female and Black clients reported the highest levels of stress at both intake and 12 months. While males did not enter the program with parental stress scores as high, their reported levels of stress improved the most of all demographic groups from intake to 12 months.

Clients who were later successful had entered the program with lower parental stress scores in all areas except Parental Distress. In absence of a comparison group, we cannot tell from comparing inactive to active clients whether changes in parental stress were related to program participation.

Outcome 3: Parents Have Increased Mental Health

Trauma Symptoms Checklist-40

Methods. *Better Together* measured clients' mental health through the Trauma Symptom Checklist-40. According to Briere and Runtz (n.d.), "The TSC-40 is a research measure that evaluates symptomatology in adults associated with childhood or adult traumatic experiences. It measures aspects of posttraumatic stress and other symptom clusters found in some traumatized individuals. It does not measure all 17 criteria of PTSD, and should not be used as a complete measure of that construct."

The TSC-40 is a 40-item self-report instrument consisting of six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual Problems, and Sleep Disturbance, as well as a total score. Each symptom item is rated according to its frequency of occurrence over the prior two months, using a four-point scale ranging from 0 ("never") to 3 ("often") (Briere & Runtz, n.d.).

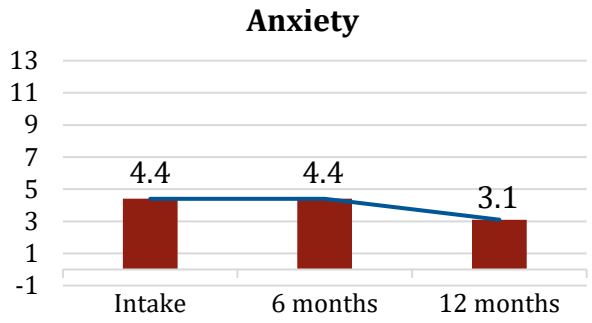
Since subscales have different numbers of items, the means can only be compared within each subscale over time, and subscales should not be compared to each other. Some trauma symptoms are included in more than one subscale; for example, insomnia is included in both the Depression and the Sleep Disturbance subscales.

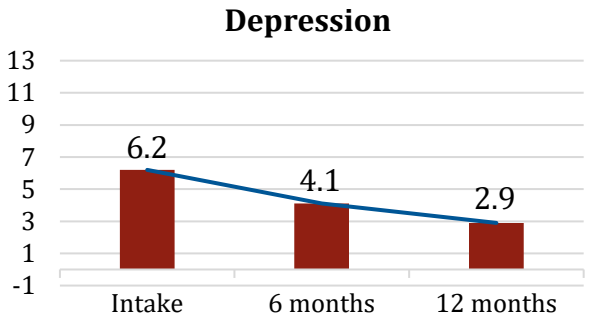
Findings. Total trauma symptoms self-reported by clients decreased at each point in time. Trauma scores in each of the subscales also decreased at each point in time with only one exception: anxiety increased at 6 months but decreased at all the other points in time. Similar results were found when only looking at those clients who were active in the program at 12 months (see Appendix C, Table 9).

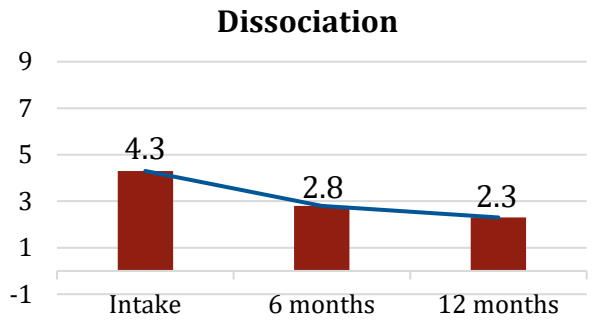
On average, clients reported 20% of the highest possible score of overall trauma symptoms measured by the TSC-40 at intake. Among the subscales, clients reported the highest proportion of symptoms in the trauma subscales of Sleep Disturbance, followed by Dissociation and Depression. Their lowest reported level of trauma symptoms was in

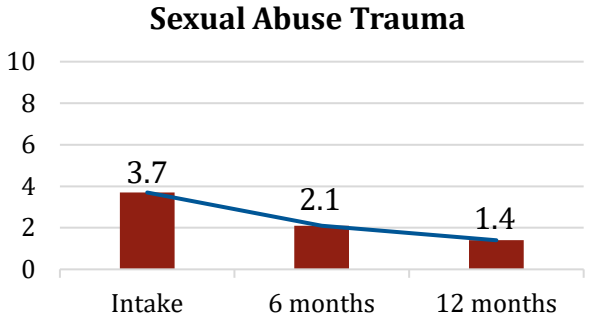
Sexual Problems, followed by Sexual Abuse Trauma. The table and corresponding graphs below demonstrate two things: 1) Trauma symptoms in all six areas measured by the TSC-40 decreased from intake, to 6 months, to 12 months; and 2) The proportion of symptoms self-reported varied relative to the scale in the tool. The y axis is one half of the highest possible score in each subscale.

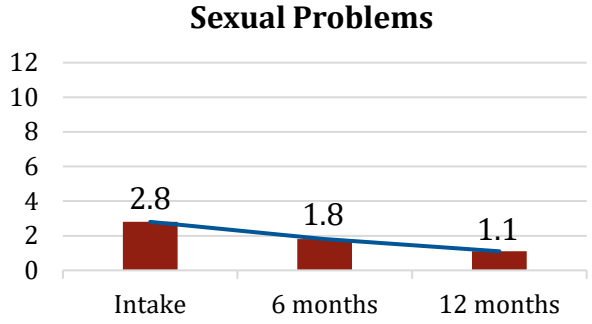
TSC Total and Subscale Scores (means) – For All Clients						
Subscales	**Maximum Possible**	**Intake (n=44)**	**3 months (n=33)**	**6 months (n=28)**	**12 months (n=20)**	**24 months (n=6)**
Anxiety	27	4.41 (16%)	4.21	4.36	3.10	1.69
Depression	27	6.20 (23%)	5.39	4.14	2.85	1.17
Dissociation	18	4.32 (24%)	3.64	2.75	2.30	0.67
Sexual Abuse Trauma	21	3.68 (18%)	3.00	2.07	1.35	0.50
Sexual Problems	24	2.84 (12%)	2.58	1.82	1.05	0.35
Sleep Disturbance	18	6.39 (36%)	6.30	4.46	3.60	1.50
Total	120	23.66 (20%)	21.24	17.04	12.80	5.51

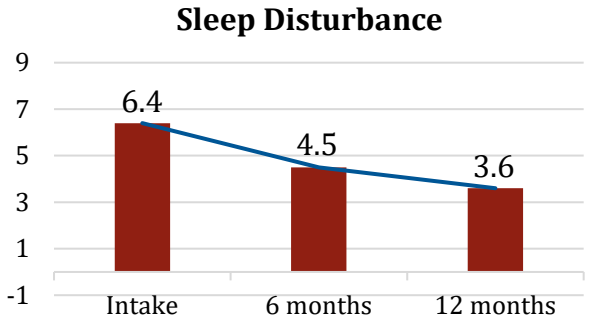












When looking at all clients, the decrease in trauma scores was statistically significant at each span of measurement points, except for the span from 6 to 12 months.

Differences in TSC Total Scores (means) – For All Clients				
Points in Time	**n**	**Means**	**Difference**	**Statistics**
Intake ⟶3 months	32	24.66 (SD=17.065) 20.56 (SD=14.960)	4.09 (SD=9.573)	p=.022; df=31; t=2.419
3 months ⟶6 months	25	21.16 (SD=16.540) 17.04 (SD=15.941)	4.12 (SD=9.688)	p=.044; df=24; t=2.126
6 months ⟶12 months	19	15.37 (SD=16.820) 13.42 (SD=14.342)	1.95 (SD=10.469)	p=.428; df=18; t=.811
Intake ⟶12 months	19	19.63 (SD=15.283) 11.79 (SD=13.616)	7.84 (SD=9.662)	p=.002; df=18; t=3.538

For the 15 clients still active in the program at 12 months, trauma scores decreased significantly from intake to 12 months. The difference was statistically significant, both overall and for each subscale, with the exception of Sexual Problems. Depression and Sleep Disturbance saw the biggest decrease in self-reported trauma symptoms (see Appendix C, Table 12).

Again, at the end of data collection, 10 clients had completed the program successfully and had TSC scores at both intake and discharge. It is important to note that the length of time in the program varied considerably between these clients, from 6 to 24 months. On average, clients who completed the program successfully decreased their trauma symptoms as measured by the TSC-40, both overall and in each of the subscales. The decrease in trauma symptoms was statistically significant, both overall and in the Depression and Sleep Disturbance subscales (see Appendix C, Table 13).

Female clients reported statistically significantly higher levels of trauma at intake than male clients. Female clients also reported higher levels of trauma at 12 months. Nevertheless, on average, both male and female clients reduced their trauma from intake to 12 months. Additionally, Black clients reported statistically significantly more trauma at intake than White or Hispanic clients, with much higher scores at 12 months as well (while the difference is not statistically significant). The clients who were single (including two who were separated from their spouses) reported statistically significantly more trauma at both intake and 12 months than those who were married. While those who had fewer children reported higher levels of trauma at both intake and 12 months, the differences were not statistically significant. Similarly, clients who reported their last drug of choice as marijuana, alcohol, or other drugs reported higher trauma than those who had used methamphetamine, but the difference was not statistically significant. (See Appendix C, Table 14.)

Looking at intake scores for clients, those who were later successful in completing the program had only slightly lower TSC scores than other clients. Those who later closed unsuccessfully had more depression, and those still in the program had more dissociation.

The three clients who closed for a neutral reason had lower TSC scores, both overall and in each subscale. None of these differences, however, were statistically significant.

TSC Total Scores at Intake by Close Reason (means)					
Subscales	**Successful (n=11)**	**Neutral (n=3)**	**Unsuccessful (n=16)**	**Still in program (n=14)**	**Overall (n=44)**
Anxiety	4.82	2.67	4.63	4.21	4.41
Depression	5.64	3.67	7.06	6.21	6.20
Dissociation	4.09	2.67	4.00	5.21	4.32
Sexual Abuse Trauma	3.36	2.00	3.69	4.29	3.68
Sexual Problems	2.82	.00	3.06	3.21	2.84
Sleep Disturbance	5.73	5.67	6.56	6.86	6.39
Total	22.09	14.00	24.81	25.64	23.66

STEPs was only able to capture TSC scores from nine clients after they went inactive in the program. Of those clients, most reported similar or decreased TSC scores after going inactive. These results are uncertain as the sample size is small. (See Appendix C, Table 15.)

Summary

Overall, *Better Together* clients improved their mental health as evidenced by a decrease in self-reported trauma symptoms at each point in time, both overall and in each of the subscales. Among the subscales, clients reported the highest proportion of symptoms in the Sleep Disturbance subscale, followed by Dissociation and Depression. They also reported the biggest decrease in Depression and Sleep Disturbance. The lowest level of trauma symptoms reported was in Sexual Problems, followed by Sexual Abuse Trauma. Clients who were female and those who were Black reported statistically significantly higher levels of trauma at both intake and 12 months. Looking at intake scores for clients, those who were later successful in completing the program had only slightly lower TSC scores than other clients.

Outcome 4: Children Have Permanency and Stability in Their Living Situations

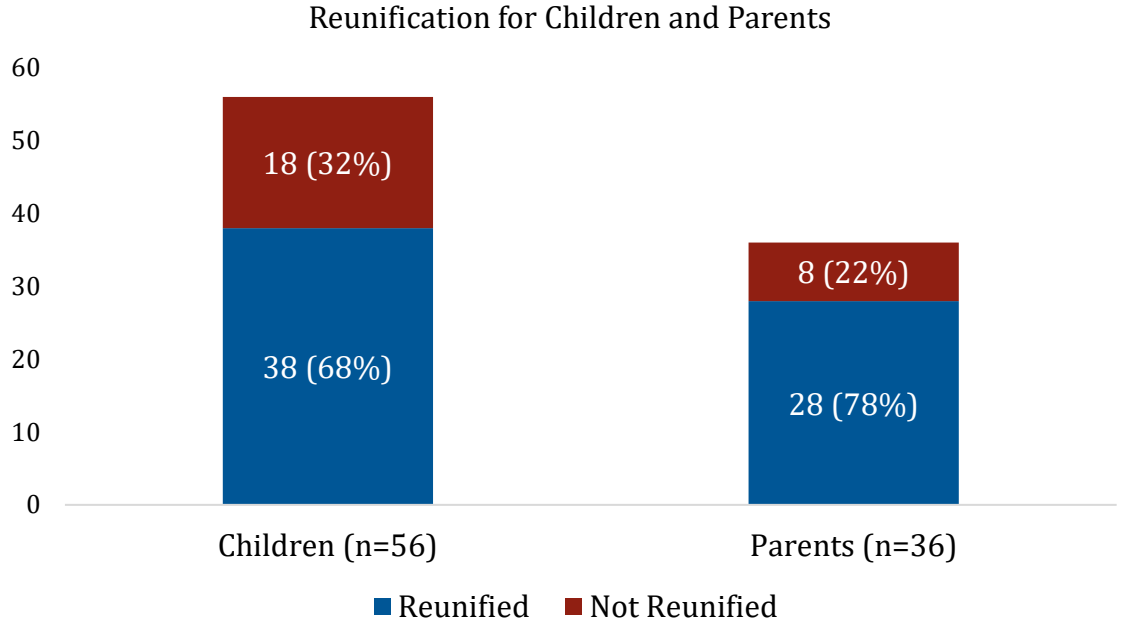
Better Together and STEPs measured child permanency and stability in multiple ways: reunification rates from Nebraska Families Collaborative (NFC) data, changes in household income from Government Performance and Results Act (GPRA) data, and level of need for referrals to developmental services in the Ages and Stages Questionnaire (ASQ).

NFC Data

Findings. According to NFC and HFS data, *Better Together* anticipated half of clients' children (n=56, 50%) to reunify with their parents while active in the program. Program staff anticipated a third (n=34, 31%) to not reunify, typically due to the child having another permanent living placement. Furthermore, 16% (n=18) of children were already placed with their parent at time of admission, and 3% (n=3) were born to parents after they were admitted into the program.

Child Placement Intentions at Intake	
	# of children
Anticipated to reunify	56 (50%)
Not anticipated to reunify	34 (31%)
Arrived with parent	18 (16%)
Born after intake	3 (3%)
Total	111 (100%)

The 56 children anticipated to reunify with their parents belonged to 36 clients. **Over two in three of the children (68%) anticipated to reunify with their parents did so,** leaving 18 children (32%) from eight clients who did not successfully reunify. On average, children were reunified with their parents at 86 days of programming (SD=40; range=14-181), or at just under three months. Two of the eight clients who did not achieve successful reunification received one month or less of programming, and therefore STEPs did not consider them as receiving a measurable dosage of *Better Together* programming. Of the remaining six, the average length of stay was 108 days (SD=31; range=50-191).

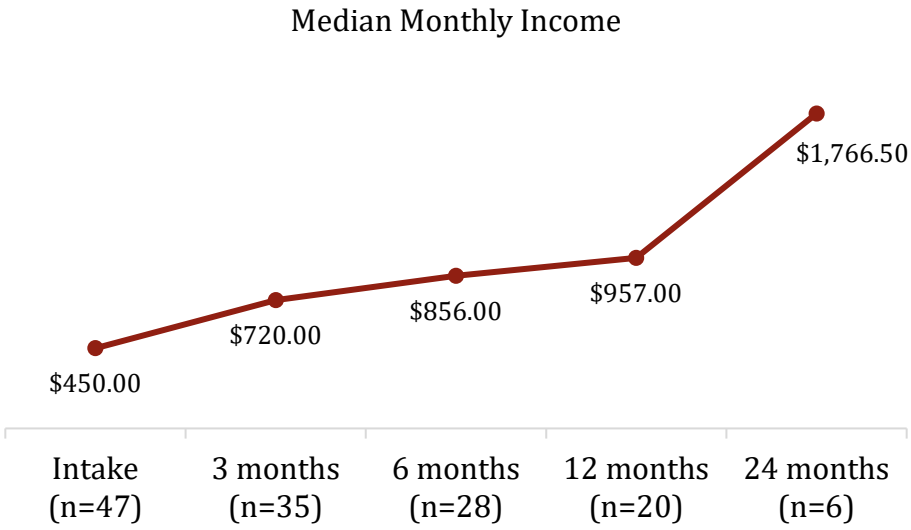


Most *Better Together* clients who remained active in the program regained custody of their children. The percentage of children living with an active client increased at each measurement point.

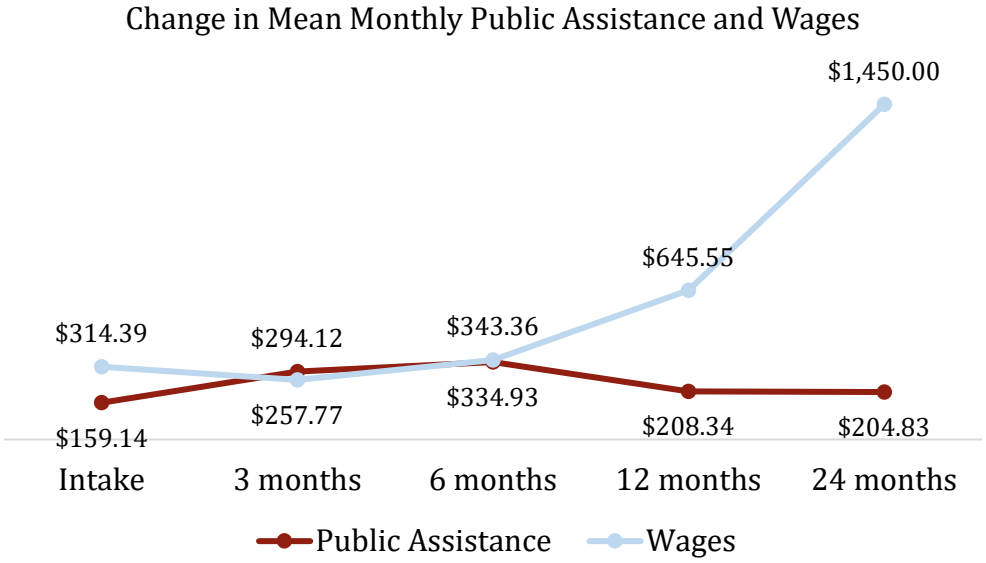
Of the 18 children anticipated to reunify with their parent but did not, 8 (44%) were adopted, 5 (28%) were living in a relative/kinship placement, and 1 (6%) was placed in a youth correctional facility at the end of data collection. The remaining 4 (22%) were returned to their parent after discharge from *Better Together* in a joint custody arrangement. So, although not all *Better Together* parents achieved reunification, nearly all children achieved some form of permanency.

GPRA Data

Findings. Self-reported median monthly income increased at every measurement point, from a median of $450 (mean=$689) at intake to $1,766 (mean=$1,722) at 24 months.



Wages decreased by an average of $57 between intake and 3 months but increased between intake and all other measurement points. Wages increased, on average, by $85 per month between 3 and 6 months, $302 between 6 and 12 months, and by $1,135 between 12 and 24 months. Average income from public assistance increased $135 between intake and 3 months and $41 between 3 and 6 months, significantly decreased by $127 between 6 and 12 months, and slightly increased again by $46 between 12 and 24 months.



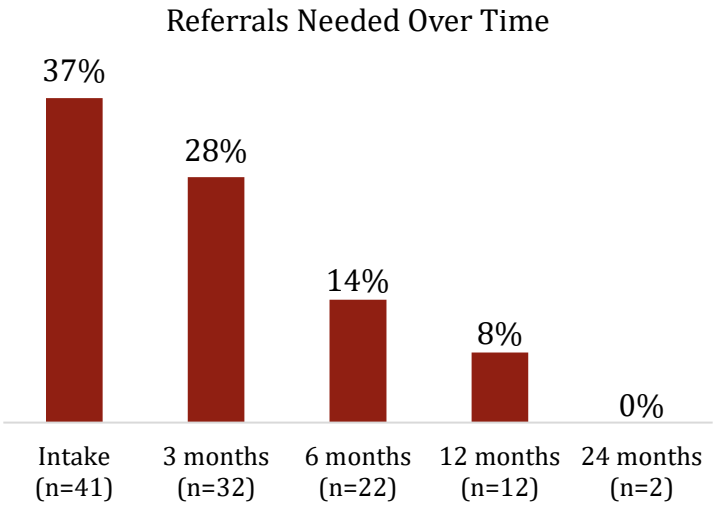
Average income from family and friends decreased at every measurement point. Overall, average monthly income from all sources increased from $689 at intake, to $1,085 at 12 months, and to $1,722 at 24 months, reflecting a steady increase in financial sustainability of *Better Together* clients.

ASQ Data

Findings. The ASQ, 3rd edition, measures the development of children from 0 to 6 years of age in five areas:

1. Communication,
2. Gross motor,
3. Fine motor,
4. Problem solving, and
5. Personal–social

(Squires & Bricker, 2009).



Based on parental report of child characteristics and abilities, children needed fewer referrals as they progressed in the program. At intake, 37% of children needed a referral for developmental services (n=15), down to 28% (n=9) at three months, 14% (n=3) at 6 months, 8% (n=1) at 12 months, and no children needing referrals at 24 months.

Referrals Needed Over Time							
Point in Time	**n**	**Communication**	**Gross Motor**	**Fine Motor**	**Problem Solving**	**Personal Social**	**ASQ Total**
Intake	41	1 (2%)	6 (15%)	5 (12%)	5 (12%)	7 (17%)	15 (37%)
3 months	32	2 (6%)	7 (22%)	7 (22%)	2 (6%)	4 (13%)	9 (28%)
6 months	22	2 (9%)	2 (9%)	2 (9%)	2 (9%)	2 (9%)	3 (14%)
12 months	13	0	0	0	0	1 (8%)	1 (8%)
24 months	2	0	0	0	0	0	0

Summary

The *Better Together* program allowed children to have permanency and stability in their living situations. While only a few of the children were placed with their parent at time of intake, two thirds of children reunified with their parents at 3 months into the program. Most *Better Together* clients who remained active in the program regained custody of their children. Of the children who did not reunify with their *Better Together* parent, most achieved some form of permanency, either through adoption or placement with another family member.

Better Together clients' median monthly income increased at each measurement point, reflecting a steady increase in their financial sustainability. Additionally, fewer children needed developmental services as they progressed in the program.

Outcome 5: Children Are Safe From Abuse/Neglect

NFC and ASQ Data

Findings. All but one client entered *Better Together* with involvement in the child welfare system due to substantiation for abuse/neglect. Child welfare had removed 9 in 10 children due to parental drug use, though additional types of abuse/neglect were often cited, including domestic violence, inadequate supervision, educational neglect, and a prior history of substance abuse. Other types of abuse/neglect were physical abuse, shoplifting, and abandonment.

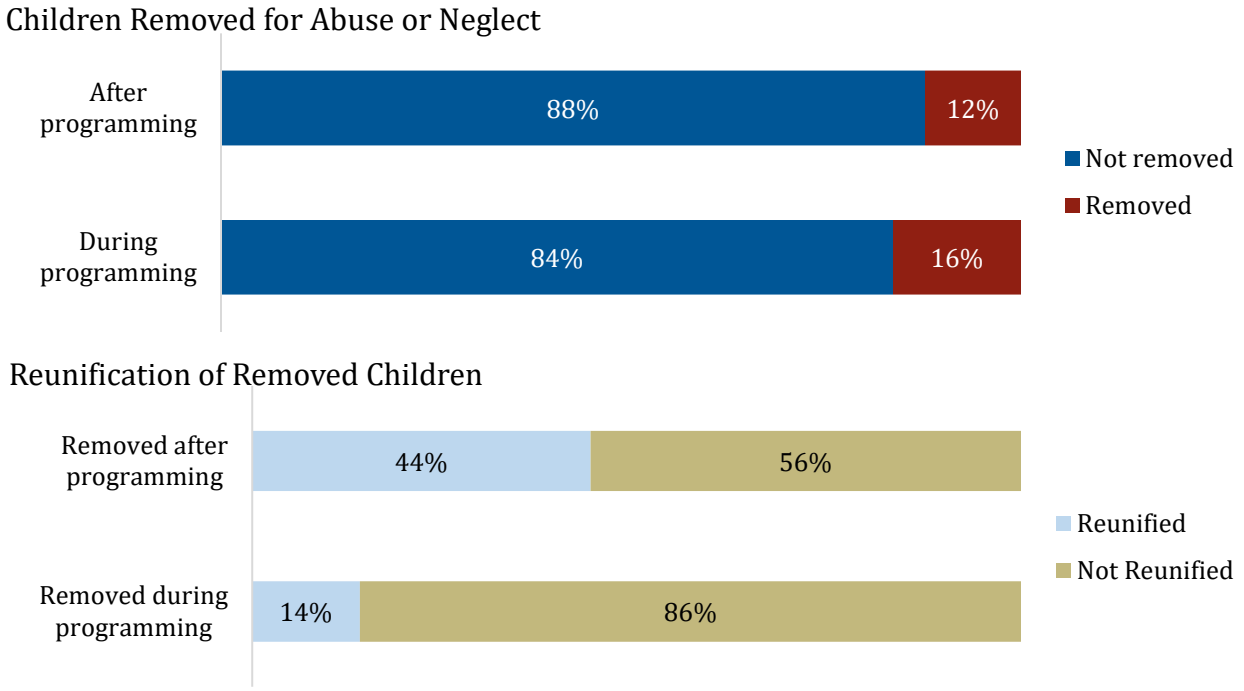
The program aimed to protect children from further instances of abuse/neglect, both during programming and after the clients were discharged. **Results indicated that 84% of the 58 children living with their parent at *Better Together* (n=49) were free from additional removal due to abuse/neglect while in the program.**

Nine children (16%) from five clients were removed from their parent's home while their parent was a client in *Better Together* due to drug use and the associated incarceration, reflected in the "While at *Better Together*/Removed from parent" line in the table. Of the nine children removed, four returned to their parent while the parent was still active in the *Better Together* program, reflected in "While at *Better Together*/Returned to parent" line in the table. Of the five children who did not return to their parent after removal, one remained in foster care and four lived in a kinship or relative placement with their maternal aunt.

Furthermore, an additional five children, plus two who were removed and returned while active in the program, constituted the seven children from five clients who were removed from their parents' custody after discharge from *Better Together,* reflected in the "After discharge/Removed from parent" line in the table. One of the seven children removed after discharge from *Better Together* had returned to their parents by the end of data collection, reflected in the "After discharge/Returned to parent" line in the table. Of the remaining six, all were in relative/kinship care placements.

At the end of data collection, 76% of all children served by the program had no additional incidents of removal during or after the parents' time in the program.

Children Removed for Abuse or Neglect		
	# of Children	**# of Clients**
During programming		
Removed from parent	9 of 58 (16%)	5 of 36 (14%)
Returned to parent	5 of 9	3 of 5
After discharge		
Removed from parent	7 of 58 (12%)	5 of 36 (14%)
Returned to parent	1 of 7	1 of 5



Summary

Nearly all children of *Better Together* clients had been removed because of abuse/neglect, most likely due to parental drug use. Most of these children reunified with their parents, with no additional reports or removals for abuse/neglect during the evaluation period. Half of the small number of children removed while their parent was in *Better Together* returned to their parents' care.

Multivariate Data Analysis

STEPs conducted multivariate data analyses for *Better Together* using a repeated-measures ANOVA to assess the change over time of parents' recovery from substance abuse, parenting capacity, and mental health. There was no statistically significant difference among the data collected at intake, 3 months, and 6 months.

STEPs also conducted hierarchical multiple regression, examining the predictors of parental outcomes, to determine what contributes to the changes in parents' increased parental capacity and mental health. STEPs entered three sets of independent variables in stages to control for and differentiate between the impact of the independent variables.

Order	Independent variables entered
Step 1	Demographic factors, including age and number of children.
Step 2	Adverse childhood experience, TSC at intake, and PSI at intake.
Step 3	Services: length of stay, number of sessions attended for each type of service.

After controlling for the demographic factors and clients' mental health status, services from *Better Together* were not significantly related to parental capacity or mental health at the conclusion of services.

Overall Outcome Evaluation Summary

Many *Better Together* clients demonstrated positive outcomes in all five outcomes:

1. Sustained recovery from substance abuse,
2. Increased parenting skills,
3. Increased mental health,
4. Children had permanency and stability, and
5. Children were safe from abuse and neglect.

Over an average of 15 months, one third of clients successfully discharged from the *Better Together* program. Over half of clients did not have a positive drug test while in the program. Most clients who were unsuccessful in the program had a positive drug test in the first 3 months, had further positive drug tests in subsequent months, and received significant services within their 7 months in the program.

Overall, clients increased their parenting skills, as measured through a self-reported reduction in parental stress. Parental stress improved the most between a client's 6- and 12-month marks in the program, especially in the area of parental distress. At the same time, clients reported increased stress due to parent-child interactions and having a difficult child at 6 months, which is about when clients' children had been returned for 3 months and services began to diminish.

Overall, *Better Together* clients improved their mental health as they self-reported a decrease in trauma symptoms at each point in time, both overall and in each subscale. Although they reported difficulties with sleep, that was an area in which they also improved the most, along with lower levels of depression.

Female and Black clients reported the highest levels of parental stress and trauma symptoms at both intake and 12 months. Clients who had experienced fewer types of ACEs and entered the program with lower parental stress and fewer trauma symptoms were somewhat more likely to finish the program successfully.

The *Better Together* program allowed children to have permanency and stability in their living situations. Two thirds of children reunified with their parents at 3 months. Most *Better Together* clients who remained active in the program regained custody of their children. Clients' median monthly income increased at each measurement point, reflecting a steady increase in their financial sustainability. Also, fewer children needed developmental services as they progressed in the program.

While nearly all children of *Better Together* clients had been removed because of parental drug use, most of these children were reunified with their parents, with no further reports of or removals for abuse during the evaluation period.

Benefit-Cost Analysis

The *Better Together* benefit-cost analysis found that for every $1 invested in *Better Together,* there is an immediate return of $1.50 to individuals and the community ($50,640 benefit/$33,792 cost). (See full report in Appendix G.)

Short-term benefits of *Better Together*, which occurred while clients actively participated in the two-year program, included:

- **Increased client income.** Clients increased their income from wages and government benefits, and they relied less on assistance from family and friends.
- **Decreased foster care costs for Nebraska Families Collaborative.** Children reunited with their parents and would have otherwise remained in paid foster care.
- **Decreased community costs from supportive housing and treatment.** Clients used fewer emergency services and detoxification or residential rehabilitation services and were less likely to be involved in criminal activity.

Short-term costs for the 27 clients served by *Better Together* in 2015 included:

- Heartland Family Service expenses for personnel, office space, transportation, and program supplies.
- Douglas County Housing Authority housing vouchers provided to program clients.
- Nebraska Families Collaborative rent payments, overdue client bill payments, and transition costs.

Long-term benefits from the program not factored into this calculation included:

- Increased family stability and improved child outcomes.
- Likely increase in productivity, income, and physical and mental health.
- Short-term benefits like decreased crime and emergency care use that will continue into the long term.

Conclusions

The *Better Together* program has many things to celebrate: they are serving mothers, fathers, and children; clients are remaining active in the program at a high rate, accessing services, and reporting high levels of satisfaction with the program. Clients who reported higher trauma symptomology and parenting stress remained active in the program and reported improvement.

In 12-month interviews, clients described *Better Together* as a chemical dependency program that treats each client as an individual and reunites families. Clients expressed gratitude for program staff and reflected on personal changes, but also viewed the location of the program as an obstacle to remaining sober. Continued focus groups along with 12-month individual interviews will provide further input for the program on areas of strength and challenge.

The *Better Together* benefit-cost analysis found that for every $1 invested in *Better Together,* there is an immediate return of $1.50 to individuals and the community ($50,640 benefit/$33,792 cost). Additional long-term benefits from the program include increased family stability and improved child outcomes.

The program has been successful at bringing community partners together to provide comprehensive services for high-risk families with numerous needs. While this is a positive result, continually balancing everyone's needs requires significant effort from the program staff. The program worked with numerous staff changes in management at the apartment complex, each of whom had a slightly different process for admitting *Better Together* families.

Clients in the program benefited from the individualized treatment *Better Together* provided. Clients were able to access services as needed to best fit their individual situation. This flexibility in treatment doses, particularly in behavioral health, is essential to meeting the clients where they are and continuing to provide the right amount of support in their recovery. The program staff worked to educate and collaborate with community partners on this approach. They also educated the clients on this, as they would often "compare" their treatment to their peers. However, after being in the program for a while, clients came to appreciate this unique approach and recognize the benefits.

Implications of Results and Recommendations

It is exciting to have data that supports the cost benefit of the program to the community. This data and subsequent report secured financial commitments from partners to sustain the program after the grant ended. The program benefits the housing systems, the state Medicaid and Behavioral Health systems, and the Child Welfare systems–in both cost savings and improved outcomes for vulnerable families. As a result, *Better Together* is currently operating due to these entities' funding. It is a model for family treatment services in Nebraska. Staff have received inquiries for how to replicate the program in other parts of the state, and even in other states.

To be successful, this program requires many community agencies' commitment. *Better Together* and STEPs held quarterly advisory council meetings to regularly check in with each other and provide feedback and strategic planning, all of which is essential to program success.

It is also important to obtain and listen to client feedback throughout program development and implementation. As this report shows, client feedback has been a constant part of our evaluation plan. One area we saw repeated feedback about was the need for a different location for *Better Together* service operation. The program's current location is limited to two-bedroom apartments, which limits larger families that need a three-bedroom apartment from participating in the program. Additionally, there is occasional criminal activity at the location that affects the clients' ability to feel "safe."

Ongoing and overall evaluation efforts are important to make continual program improvements. It was helpful for *Better Together* and STEPs to meet every 6 months to review the evaluation findings so staff could make program adaptations and evidence-informed improvements along the way. For example, the addition of economic self-sufficiency programming for clients: the evaluation team brought data showing that clients were having difficulties transitioning to employment or furthering their education, after depending on the system and fearing the lack of full assistance in the future. As a result, *Better Together* added a group to help clients process these fears, discuss generational dependence on the system, form resumes, search for jobs, etc. Being able to look at the program from a trauma-informed lens, viewing the clients' needs, the program's needs, and the community's needs in a non-judgmental approach is important.

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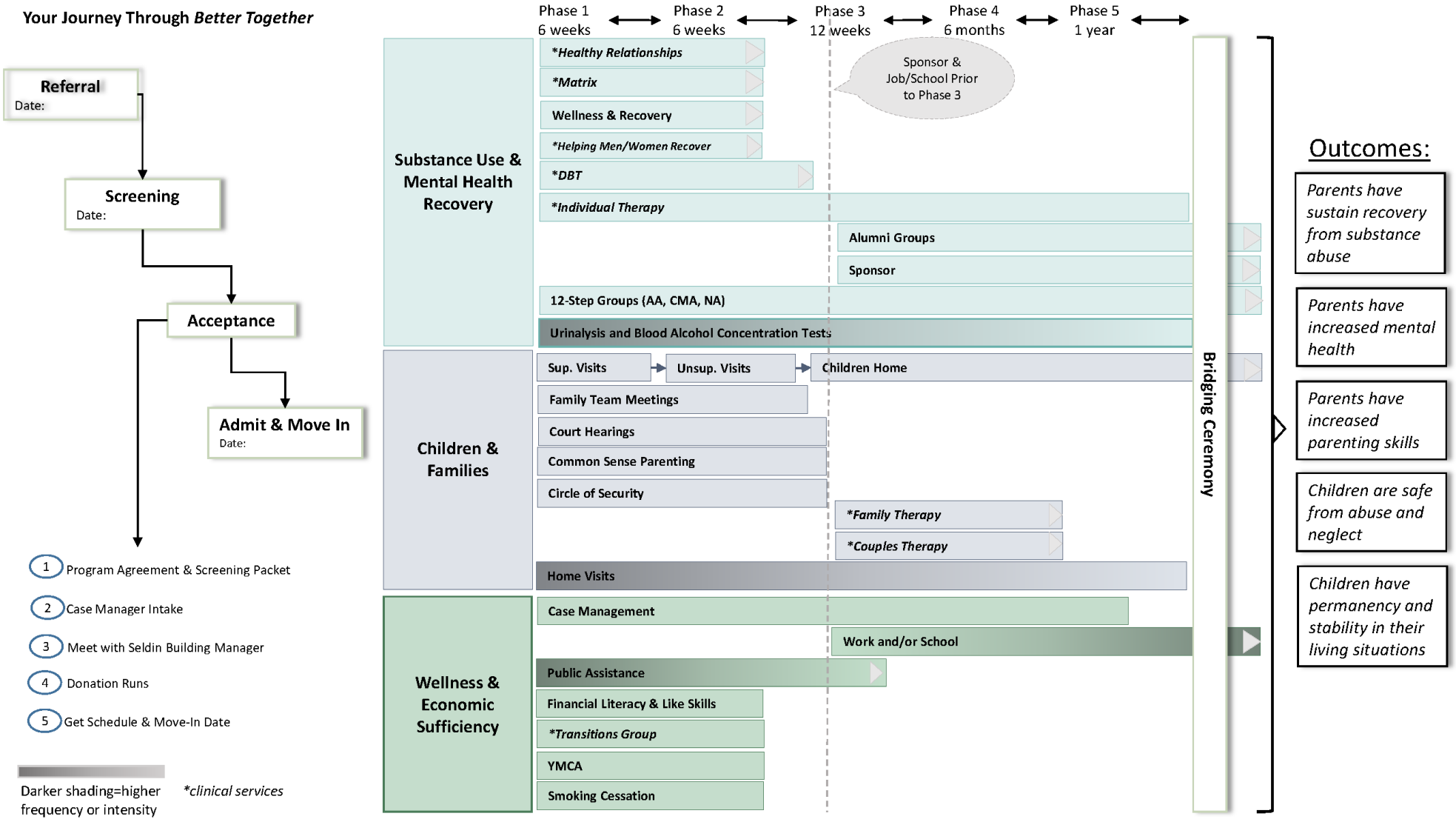
Appendix A: *Better Together* Logic Model

Statement of the problem: Parents referred by child welfare need substance abuse treatment and increased parenting capacity; children need increased well-being, safety, and permanency.

Inputs	Activities	Outputs	Short-Term Outcomes	Long-Term Outcomes
Subsidized housing for families On-site office space for service delivery and the Peer Support Specialist Personnel: • Program Director • 2 Therapists • Case Manager • Clinical Supervisor • Peer Support Specialist • Consulting Psychiatrist Staff training and supervision	On-site Enhanced Intensive Outpatient (IOP) substance abuse treatment, including mental health and trauma treatment, for 12 weeks: • Individual counseling • Group counseling On-site case management for childcare, job training, and transportation (and other services related to self-sufficiency) On-site parenting education and support On-site 24-hour peer support On-site infant/child developmental screenings and mental health sessions Psychiatric consultation and services on site Medical care, as needed	Families have housing Parents are reunified with their children, if applicable Parents successfully complete: • Enhanced IOP • Parenting education Children receive: • Infant/child developmental screenings • Mental health sessions Families access needed community services: • Childcare • Medical care • Dental care	Parents have sustained recovery from substance abuse Parents have increased parenting skills Parents have increased mental health Children have permanency and stability in their living situations Children are safe from abuse and neglect	Improved child well-being Sustained parental recovery from substance abuse Reunification of families

Collaborating partners: Nebraska Families Collaborative/DHHS (referral source), Douglas County Housing Authority (housing vouchers), OneWorld Community Health, Visiting Nurse Association and Nebraska AIDS Project (health care services and education), Goodwill, Financial Hope Collaborative (skill building), Early Development Network (Screenings), UNO (Evaluation).

Appendix B: Service Utilization Path



Appendix C: Additional Analyses

Table 1: Clients' # of ACEs			
# of ACEs	**n**	**Percent**	**Cumulative Percent**
0	1	4%	4%
1	1	4%	9%
2	2	9%	17%
3	2	9%	26%
4	3	13%	39%
5	4	17%	57%
6	3	13%	70%
7	5	22%	91%
8	1	4%	96%
9	1	4%	100%
Total	23	100%	

Table 2: Months of Programming Active Clients (n=15) as of 1/31/2017	
0-3 months	1 (7%)
4-6 months	4 (27%)
7-12 months	4 (27%)
13-18 months	3 (20%)
18-24 months	1 (7%)
25 months and over	2 (13%)

Table 3: Positive Drug Tests					
Close Reason	**n**	**0-3 months**	**4-6 months**	**7-12 months**	**Over 12 months**
Still in programming	15	2 of 15 (13%)	1 of 14 (7%)	0 of 10 (0%)	0 of 7 (0%)
Successful	10	1 of 10 (10%)	0 of 10 (0%)	0 of 10 (0%)	1 of 6 (17%)
Unsuccessful	19	12 of 19 (63%)	4 of 12 (33%)	4 of 6 (67%)	2 of 5 (40%)
Neutral	3	1 of 3 (33%)	0 of 2 (0%)	0 of 1 (0%)	n/a
Total	47	16 of 47 (34%)	5 of 38 (13%)	4 of 27 (15%)	3 of 18 (17%)

*data may be duplicated; clients may have had a positive UA in more than one time period.

Table 4: PSI Total and Subscale Scores (means) For All Clients Who Were Active and Had DR>10 at That Point in Time					
Point in Time	**n**	**Parental Distress**	**Parent-Child Dysfunctional Interaction**	**Difficult Child**	**Total Stress**
Intake	41	60.8 SD=14.410; range=32-96	54.4 SD=22.717; range=4-98	55.5 SD=23.417; range=2-94	56.2 SD=18.923; range=14-94
3 months	26	54.5 SD=17.367; range=10-78	56.8 SD=21.968; range=10-86	54.4 SD=26.551; range=8-92	54.8 SD=20.045; range=8-84
6 months	19	52.3 SD=19.474; range=10-82	63.7 SD=21.294; range=14-94	62.6 SD=18.013; range=30-90	59.9 SD=16.779; range=28-82
12 months	10	51.6 SD=13.882; range=32-70	57.0 SD=24.409; range=4-90	60.4 SD=20.587; range=30-90	55.6 SD=19.906; range=16-82
24 months	2	—	—	—	—

Table 5: PSI Total and Subscale Scores (means) For All Clients Active at 12 Months with DR>10 at That Point in Time					
Point in Time	**n**	**Parental Distress**	**Parent-Child Dysfunctional Interaction**	**Difficult Child**	**Total Stress**
Intake	14	59.6 SD=13.386; range=32-90	52.9 SD=22.840; range=4-90	53.9 SD=20.418; range=2-86	55.0 SD=17.360; range=14-88
3 months	13	48.2 SD=19.278; range=10-78	50.3 SD=22.699; range=10-82	46.5 SD=25.510; range=10-90	47.4 SD=22.396; range=8-84
6 months	13	48.0 SD=20.248; range=10-82	63.9 SD=22.94; range=14-94	63.1 SD=21.301; range=30-90	58.6 SD=18.608; range=28-82
12 months	10	51.6 SD=13.882; range=32-70	57.0 SD=24.409; range=4-90	60.4 SD=20.587; range=30-90	55.6 SD=19.906; range=16-82

Table 6: Differences in PSI Subscale Scores from Intake to 12 months (means) For the 11 Clients With DR>10 Who Were Active at Those Points in Time				
Subscale	**Intake**	**12 months**	**Difference**	**Statistics**
Parental Distress	63.6 (SD=10.726)	52.7 (SD=13.690)	10.9 (SD=12.818)	p=.018; df=10; t=2.823
Parent-Child Dysfunctional Interaction	52.2 (SD=27.047)	49.1 (SD=25.836)	3.1 (SD=32.266)	p=.757; df=10; t=.318
Difficult Child	54.2 (SD=23.177)	51.8 (SD=24.024)	2.4 (SD=26.197)	p=.787; df=10; t=.278
Total Stress	56.4 (SD=19.117)	49.6 (SD=21.068)	6.7 (SD=22.294)	p=.341; df=10; t=1.001

Table 7: PSI Scores for the 10 Clients Who Finished the Program Successfully* (means)				
Subscale	**Intake**	**Discharge**	**Difference**	**Statistics**
Parental Distress	49.4 (SD=28.191)	33.8 (SD=24.863)	15.6 (SD=14.961)	p=.009; df=9; t=3.297
Parent-Child Dysfunctional Interaction	44.8 (SD=26.284)	45.6 (SD=22.722)	-0.8 (SD=32.785)	p=.940; df=9; t=-.077
Difficult Child	51.2 (SD=22.885)	40.8 (SD=29.427)	10.4 (SD=34.017)	p=.359; df=9; t=.967
Total Stress	47.0 (SD=24.005)	36.6 (SD=26.966)	10.4 (SD=29.026)	p=.286; df=9; t=1.133

*Includes graduated, left with maximum benefits, either client- or *Better Together*-initiated

Table 8: PSI Total Stress by Demographic Characteristic For Clients With DR>10 at That Point in Time						
	Intake			**12 months**		
Demographic	**n**	**Mean**	**Statistics**	**n**	**Mean**	**Statistics**
Gender						
Female	29	60.5	p=.021; df=39; t=2.415	7	64.6	p=.002; df=10; t=4.179
Male	12	45.7		5	32.4	
Race/ethnicity						
White	29	53.6	p=.008; df=39; F=5.600	9	45.8	p=.124; df=11; F=2.824
Black	7	75.1		3	67.3	
Hispanic	4	44.0		—	—	
Marital status						
Single, separated	29	58.7	p=.184; df=39; t=1.352	*		
Married	12	50.0				
# of children						
1-2 children	19	56.8	p=.830; df=39; t=.830	4	47.5	p=.686; df=10; t=-.416
3-9 children	22	55.6		8	53.0	
Drug of choice (most recent)						
Methamphetamine	30	54.4	p=.335; df=39; t=-.975	7	45.1	p=.253; df=10; t=-1.214
Marijuana, alcohol, other	11	60.9		5	59.6	

*Sample too small to make comparison

Table 9: PSI Total Stress Scores for Clients Who Went Inactive					
	Intake	**3 months**	**6 months**	**12 months**	**Change**
Client 1	54	missing	8	(I) 16	increased
Client 2	50	42	(I) 62	(I) 28	increased
Client 3	16	4	4	(I) 30	increased
Client 4	56	(I) 64	(I) 66	missing	increased
Client 5	68	60	(I) 50	missing	decreased
Client 6	58	58	46	(I) 30	decreased
Client 7	46	missing	(I) 66	missing	increased
Client 8	56	(I) 70	missing	missing	increased
Client 9	20	(I) 1	missing	missing	decreased

*Sample too small to make comparison

Table 10: TSC Total and Subscale Scores (means) For All Clients					
Subscale	**Intake (n=44)**	**3 months (n=33)**	**6 months (n=28)**	**12 months (n=20)**	**24 months (n=6)**
Anxiety	4.41 SD=4.161 range=0-15	4.21 SD=4.052 range=0-13	4.36 SD=4.390 range=0-18	3.10 SD=4.689 range=0-15	1.69 SD=1.842 range=0-4
Depression	6.20 SD=5.263 range=0-19	5.39 SD=4.031 range=0-16	4.14 SD=3.587 range=0-13	2.85 SD=3.249 range=0-9	1.17 SD=2.401 range=0-6
Dissociation	4.32 SD=3.796 range=0-14	3.64 SD=3.151 range=0-14	2.75 SD=2.863 range=0-8	2.30 SD=3.614 range=0-13	0.67 SD=1.211 range=0-3
Sexual Abuse Trauma	3.68 SD=3.659 range=0-12	3.00 SD=3.112 range=0-12	2.07 SD=2.523 range=0-9	1.35 SD=2.007 range=0-6	0.50 SD=1.225 range=0-3
Sexual Problems	2.84 SD=3.660 range=0-13	2.58 SD=3.865 range=0-17	1.82 SD=3.991 range=0-15	1.05 SD=1.820 range=0-7	0.35 SD=.808 range=0-2
Sleep Disturbance	6.39 SD=5.017 range=0-16	6.30 SD=4.305 range=0-16	4.46 SD=3.574 range=0-11	3.60 SD=3.691 range=0-11	1.50 SD=1.761 range=0-4
Total	23.66 SD=18.484 range=1-71	21.24 SD=15.234 range=1-57	17.04 SD=15.296 range=0-59	12.80 SD=14.153 range=1-45	5.51 SD=7.028 range=0-19

Table 11: TSC Total and Subscale Scores (means) For All Clients Active at 12 Months				
Subscale	**Intake (n=15)**	**3 months (n=15)**	**6 months (n=15)**	**12 months (n=16)**
Anxiety	3.47 SD=3.248 range=1-13	3.07 SD=3.826 range=0-11	4.40 SD=5.409 range=0-18	2.69 SD=4.159 range=0-14
Depression	5.60 SD=4.501 range=1-15	4.27 SD=4.250 range=0-16	3.27 SD=3.283 range=0-11	2.88 SD=3.117 range=0-9
Dissociation	3.13 SD=3.441 range=0-12	2.53 SD=2.560 range=0-9	2.20 SD=2.704 range=0-8	1.88 SD=2.825 range=0-9
Sexual Abuse Trauma	2.67 SD=3.109 range=0-11	2.07 SD=2.815 range=0-9	2.00 SD=2.878 range=0-9	1.31 SD=1.991 range=0-6
Sexual Problems	2.40 SD=3.961 range=0-12	3.20 SD=4.989 range=0-17	2.67 SD=4.995 range=0-15	0.81 SD=1.870 range=0-7
Sleep Disturbance	5.93 SD=4.949 range=0-15	4.93 SD=3.751 range=0-14	3.93 SD=3.900 range=0-11	4.13 SD=3.879 range=0-11
Total	19.93 SD=15.832 range=6-59	17.60 SD=17.278 range=1-57	16.40 SD=18.357 range=0-59	12.50 SD=13.307 range=1-45

Table 12: Differences in TSC Subscale Scores from Intake to 12 months (means) For the 15 Clients Who Were Active at 12 Months				
Subscale	**Intake**	**12 months**	**Difference**	**Statistics**
Anxiety	3.47 SD=3.248	2.13 SD=3.642	-1.33 SD=1.915	p=.017; df=14; t=2.697
Depression	5.60 SD=4.501	2.47 SD=2.748	-3.13 SD=2.850	p=.001; df=14; t=4.258
Dissociation	3.13 SD=3.441	1.73 SD=2.865	-1.40 SD=2.414	p=.041; df=14; t=2.246
Sexual Abuse Trauma	2.67 SD=3.109	1.13 SD=1.922	-1.53 SD=2.475	p=.031; df=14; t=2.400
Sexual Problems	2.40 SD=3.961	0.87 SD=1.922	-1.53 SD=3.852	p=.145; df=14; t=1.542
Sleep Disturbance	5.93 SD=4.949	3.80 SD=3.783	-2.13 SD=2.326	p=.003; df=14; t=3.552
Total	19.93 SD=15.832	11.07 SD=12.430	-8.87 SD=10.405	p=.005; df=14; t=3.300

Table 13: Differences in TSC Scores (means) For 10 Clients Who Finished the Program Successfully*				
Subscale	**Intake**	**Closure**	**Difference**	**Statistics**
Anxiety	5.00 SD=5.228	4.40 SD=5.719	0.60 SD=4.006	p=.647; df=9; t=474
Depression	6.10 SD=4.508	3.20 SD=3.190	2.90 SD=2.726	p=.008; df=9; t=3.364
Dissociation	4.30 SD=3.831	3.10 SD=4.581	1.20 SD=3.910	p=.357; df=9; t=.970
Sexual Abuse Trauma	3.40 SD=3.836	1.50 SD=2.224	1.90 SD=3.143	p=.088; df=9; t=1.912
Sexual Problems	3.10 SD=3.814	1.50 SD=2.415	1.60 SD=4.033	p=.241; df=9; t=1.255
Sleep Disturbance	6.00 SD=4.761	3.00 SD=3.197	3.00 SD=3.590	p=.027; df=9; t=2.642
Total	23.50 SD=17.878	14.00 SD=16.357	9.50 SD=13.673	p=.056; df=9; t=2.197

*Includes graduated, left with maximum benefits, either client- or *Better Together*-initiated

Table 14: TSC-40 Scores by Demographic Characteristic						
	Intake			12 months		
Demographic	**n**	**Mean**	**Statistics**	**n**	**Mean**	**Statistics**
Gender						
Female	30	28.43	p=.001; df=42; t=3.452	13	16.46	p=.128; df=18; t=1.595
Male	14	13.43		7	6.29	
Race/ethnicity						
White	31	22.87	p=.013; df=42; F=4.823	16	9.94	p=.086; df=19; t=2.844
Black	6	41.83		3	29.33	
Hispanic	6	12.00		—	—	
Marital status						
Single, separated	30	27.27	p=.036; df=41; t=2.191	15	16.47	p=.002; df=18; t=3.720
Married	13	16.00		5	2.20	
# of children						
1-2 children	21	26.10	p=.410; df=42; t=.410	9	15.67	p=.444; df=18; t=.783
3-9 children	23	21.43		11	10.64	
Drug of choice (most recent)						
Methamphetamine	32	23.41	p=.884; df=42; t=.884	13	10.00	p=.221; df=18; t=-1.269
Marijuana, alcohol, other	12	24.33		7	18.29	

Table 15: TSC Total Scores for Clients Who Went Inactive					
	Intake	**3 months**	**6 months**	**12 months**	**Change**
Client 1	17	missing	10	(I) 11	decreased
Client 2	5	5	(I) 4	(I) 2	same
Client 3	40	45	26	(I) 43	same
Client 4	1	23	(I) 4	missing	same
Client 5	10	8	(I) 7	missing	same
Client 6	12	4	6	(I) 2	decreased
Client 7	4	missing	(I) 29	missing	increased
Client 8	38	(I) 26	missing	missing	decreased
Client 9	53	(I) 41	missing	missing	decreased

Appendix D: Client Focus Groups Report

***Better Together* Client Focus Groups**
Final Report

Prepared by:
Jodi McQuillen, Ph.D.

assisted by Pamela Ashley, M.Ed.
data transcribed by Katie Schmelzle, MSW student

with Jeanette Harder, Ph.D.

June 16, 2017

Process

UNO conducted four focus groups to gather program participants' overall impressions of the *Better Together* program. Prior to conducting any of the focus groups, STEPs met with *Better Together* program staff to determine the focus group questions and protocol. Focus group questions can be viewed in the Appendix.

The four focus groups occurred in December 2014, September 2015, July 2016, and December 2016. The intent was for focus group participants to have been active in the *Better Together* program through the completion of Phase 3 of treatment and/or approaching 6 months of treatment. This protocol was followed for Focus Groups 2-4, but the slow admittance of new program participants when the *Better Together* program began in late spring of 2014 meant this was not possible for Focus Group 1. Thus, the participants for Focus Group 1 had been participants in the *Better Together* program anywhere from 1-8 months. All focus group participants were active at the time of their participation in the focus groups. **In total, 21 individuals participated in the focus groups: 15 females (71%) and 6 males (29%).**

All focus groups occurred at the *Better Together* office in Omaha, NE. Two STEPs facilitators conducted each of the focus groups. No *Better Together* staff were present at any focus group. Prior to the start of all focus groups, one STEPs facilitator welcomed participants, explained the purpose of the focus group, and reviewed confidentiality. All participants were then given a copy of the consent form and were encouraged to read the form prior to signing it. The second facilitator orally reviewed the consent form with participants prior to having all participants sign the form. STEPs then informed the participants that the focus groups would be audio recorded and transcribed verbatim, with no identifying information included in the transcript. Finally, the facilitators reviewed the general rules for the focus group (i.e., speak one at a time and respect others' opinions). All participants could ask questions and/or obtain clarification prior to the start of formal questioning. At the conclusion of questioning, participants had the opportunity to add any additional thoughts on topics initiated by the facilitator or add additional thoughts on their own topics related

to *Better Together*. All participants were encouraged to speak privately to the facilitators if they felt uncomfortable at any time during the focus group. No participants expressed discomfort after any focus group. Finally, the facilitators reminded participants of confidentiality issues and thanked the participants for their time and thoughts.

STEPs offered food and refreshments at each focus group. Each group took approximately 1 to 1.5 hours to complete. Upon completion of each focus group, STEPs immediately downloaded its audio recording onto a secure network. A STEPs employee then transcribed the audio recordings verbatim and saved the transcriptions on a secure network. The transcriptions contained no identifying information regarding program participants.

STEPs program evaluators completed analysis of the transcribed data using MAXQDA software with a mix of indicative and *a priori* coding for data analysis. Evaluators utilized inductive coding, using *in vivo* codes, during the initial analysis of the transcriptions. Inductive coding is the process of coding data into meaningful analytical units based on emerging themes. *In vivo* coding is the research practice of assigning a code, or label, to a section of data using a word or phrase from the data, and thus, the codes represent program participants' actual words. Initially, evaluators analyzed each focus group transcript individually using inductive and *in vivo* coding, then completed multiple levels of analysis and thematic coding across all four transcriptions using constant comparison of themes and codes. During the final analysis of the data, evaluators recoded the themes from each transcript using *a priori* coding. *A priori* coding is the process of using codes that come from an outside source other than the data. In the case of the focus groups, the Client Satisfaction Survey categories for the *Better Together* program were the *a priori* codes in the final data analysis. Evaluators first conducted *a priori* coding within each focus group transcript, then across all four transcripts using constant comparison. In the end, four major themes emerged across all four focus groups. **The four themes, examined in detail below, were Program Access, Program Services, Client-Staff Interaction, and Program Impact.**

Themes

Program Access

The theme of Program Access not only refers to participants' literal access to the *Better Together* program, but also to what they needed to access within themselves in order to benefit from the services offered. The topic of trust was discussed by participants a number of times throughout the focus groups. Many participants described how they entered the *Better Together* program with a general feeling of distrust toward others, including staff and peers. Participants explained that staff expected them to be "open and honest" during their treatment. Yet, participants admitted that trust was initially a struggle for them, especially during intake. As one participant suggested, "I think that maybe a chance to meet with some staff before being put in the high pressure screening… to build some rapport." Another participant further explained:

> Being an addict, we do have those trust issues. There's reasons why we're addicts. And a lot of our addictions stem from trust issues. I think maybe if we did have like

> meetings with everybody, not like a huge to-do, but like 'Hi, I'm whoever and this is what I do here.' Just to get to know some people so it's just not so scary. And kinda warn us that you're gonna be asking some really personal questions and just to answer with the best of your ability.

In spite of their struggles with trust at the time of admission, all participants stated they felt welcomed by staff. One participant expressed appreciation for the warm welcome that was extended by staff to his daughter: "Everyone saying 'Hi' to her and taking a little time to just welcome her. So, we felt very welcome coming in here. And she liked it right away and I did too." Because of the warm welcome expressed by staff, participants stated they were able to "break down walls" and build trust with the professionals working in the program.

Ultimately, participants stated their own commitment to recovery allowed them to gain the most benefit from the program. As one participant stated:

> I've been through treatment before and I've held back. I'm at the point where I'm just sick and tired of being sick and tired so, why hold back? I'm not gonna get nothing out of this program if I don't work my program to the fullest. So I don't hold back.

Another participant further explained:

> As far as people who have been discharged, they've had chances…They've had opportunities to come through and shine. Instead, they chose to buck at the opportunity to have a sober environment and have a sober place for their children to come home to. They've made their decisions, *not Better Together*.

One concern regarding program access that participants repeatedly addressed was the community not being aware of the *Better Together* program. Some participants expressed concern about key referral sources not knowing about the program or misunderstanding its admission criteria. As one participant stated, "My NFC worker was like, 'I've never even heard of it.'" Another stated that her case worker initially said, "I couldn't get in. I didn't qualify." Others shared they learned about the program through word of mouth and not from professionals in the child welfare system. This issue led many participants to question if enough was being done to market the program and whether referral sources knew who would best fit the program. Many participants also stated that not every addict or alcoholic would be appropriate for the *Better Together* program. They believed that potential clients would need to join at the right stage of recovery. Many stated that treatment with *Better Together* must be the client's choice and not court-ordered or forced upon them by a case worker. They also stated that potential clients should not be in an acute state when they enter the program and that possible treatment in an inpatient facility should occur prior to admission to *Better Together*. These views were based on participants' observations of former peers who relapsed, dropped out, or quit the program.

Program Services

All focus group participants expressed gratitude for the *Better Together* program. While the reasons for their gratitude varied, all participants did express the desire to see the program continue to help others, like themselves. As one participant stated, "I'm really grateful for

this program and hopefully it can expand. And hopefully they can make it bigger to help more people."

Participants used the phrase "case-by-case" to describe the overall approach that *Better Together* took in providing treatment to program participants. As one participant stated, "Everything is case-by-case depending on what you need in treatment." At times, participants uttered this phrase with a tone that indicated their distaste for the approach, such as the comment, "Treatment should be case-by-case, not rules." While other expressed appreciation for this approach because "they give us a voice." Participants explained this approach allowed them to have a say in their treatment goals, which many stated they were unaccustomed to in other chemical dependency programs they had attended. As one stated, "I made up my treatment plan, which I kind of liked … they don't just tell us what we're going to work and that's it."

Many participants discussed the knowledge they and their families gained from the individual, family, and/or group therapeutic treatment. All were able to express how these services benefited their sobriety and led, or would lead, to their families reunifying. One participant shared that because of *Better Together*'s services, "I'm a way better parent. And I'm transitioning back with my daughter … we do lots of stuff here and it's worth it."

It was the consensus among participants that, while they benefited from the knowledge obtained in group therapy, group learning should be more interactive. Participants' requests often reflected the following comment made by one participant: "Make it a change of pace because it is a lot of just sitting, reading, and doing homework … Kind of get more creative with it."

Many participants stated the biggest benefit from therapy came after they reunited with their children. Many expressed initially being concern when their children returned to them, specifically that they would not be "bonded" or "attached" to them. Yet, with the help of individual and family therapy, all who expressed this fear stated their therapists successfully assisted them and their children in obtaining a healthy attachment with one another. One mother shared her story of how *Better Together* therapists helped her and her infant son upon reunification: "I was really worried about our connection because he was taken away at the hospital. That's one thing I really struggled with and the family therapist really helped me out with that … Now our bond is incredible."

Focus group participants further addressed the topic of trust when questioned about the program's services. As one explained, *Better Together* is a "trust-based facility." Many stated that being able to trust one's peers in treatment was a noted advantage to one's recovery. Participants particularly valued the therapeutic benefits of a peer community. As one explained:

> At any time, if I needed to talk to somebody or whatever, I could always go and knock on a door. If you have a problem you can address it right away because you have those people around you … versus, you can do something you're gonna regret because you weren't able to fix it right away or address it right away.

The components of this sense of community included living in close proximity to peers, living in close proximity to treatment, receiving respect from staff, and receiving emotional support from peers. As one participant stated:

> It's convenient that when I have to come to group that I just have to walk up the hill. It does help with security, too. To know that there's always someone there that you can reach out to if you're in dire need. Or, if you just need somebody to talk to. We live really close together.

Focus group members did note one potential downside to living in close proximity to peers, however: the risk of developing a personal relationship with a peer. Participants acknowledged that loneliness was a common feeling, and the desire for companionship was one of their basic human needs. Yet, they also recognized involvement with a peer or the termination of a romantic relationship often triggered relapses. Participants reflected on the need for increased guidance from staff on how to navigate this complex issue. As one participant stated, "I hate being lonely. I hate being bored. Those are triggers for me."

Many participants noted that the physical location of the *Better Together* program was a concern. Many female participants expressed feeling physically unsafe living in the neighborhood. Both male and female participants expressed safety concerns for their children. Specific safety concerns brought up in the focus groups included gunshots, drug and alcohol use at the apartment complex, and break-ins. Participants stated that safety was not just on their minds, but on the minds of some of their children. As one participant stated, "My son has expressed fears about where we live … and I know there were gun shots outside the apartment Friday night."

Some participants perceived the location of *Better Together* as a challenge to their sobriety. One commented, "It's definitely not where I would choose to put a bunch of people who are trying to be sober." Others found the location a necessary means in which to prepare for life after supportive treatment ended. As one participant explained:

> My next-door neighbor smokes weed. That was my drug of choice. Every day when I go home I smell that, and it's a constant choice of whether I go next door and ask him for weed or do I stay home? And that's what I like about this program, is that they prepare you for that.

Client-Staff Interaction

During the focus groups, participants reflected on their relationship with *Better Together* staff. The vast majority spoke positively of program staff and their interactions. One participant explained, "They don't treat us like clients, which is something that is really personal to me. They treat us like one of their own." Another participant stated, "The staff do have open minds. They do treat us as people instead of just clients or drug addicts or alcoholics. That's a good thing." A number of participants even expressed appreciation that staff held them accountable for their choices and behaviors. As one participant stated, "I have a really good relationship with my therapist. I like my therapist, and she holds me accountable to my bullshit."

Yet, participants acknowledged that in order to trust staff, they had to "surrender" to the program. Participants stated their ability to do this was based on a conscious choice to choose sobriety and to work with staff. One participant explained this thought process as, "I don't know you, but I'm willing to get help from you." Furthermore, participants were often able to take into consideration the bigger picture when staff had to confront them. As one stated, "I feel like they should be able to redirect us because that's their job… to make sure we are not putting ourselves in danger or putting our children in danger."

Some participants noted that while they liked, and even trusted, staff, they were still aware that no staff member had recovered from an addiction themselves, with the exception of the peer support worker. This was borne out by statements such as "They never lived our life" and "They only know textbooks." As one participant further explained, "I kind of feel indifferent sometimes sharing with them because they don't know what it's like."

Most participants requested that the program hire an additional peer support so they could choose to whom to reach out. They also expressed a need for another role model in recovery, and, more specifically, many requested that the program hire an alumnus of the program. As one participant explained, "That helps with people's goals, too. 'Wow, I can go through this program. I can learn this. I can get these skills and that's something to aspire to. Look, she's got a job doing that.'"

Program Impact

Nearly all focus group participants expressed appreciation for the positive impact that *Better Together* had in their lives. For some, they appreciated their sobriety and the skills they had learned. As one participant explained:

> I thank God that *Better Together* was here because at the time, I don't think I would've been able to just jump right off into the functioning world … Because when you're deep in your alcoholism or your drug addiction, you don't really know how deep you're in. And I was in deep.

Another participant discussed the challenge of recovery, but also acknowledged how *Better Together* helped her reach her goal, tearfully stating, "I wanted to be different; like get better. And they helped me… I do appreciate this program and the people here. This is not easy. Just know that."

For others, the biggest impact on their lives was the program's provision of basic needs while they were in recovery. As one participant stated, "When you come into this program, they bust their ass to make sure that you have everything that you need because a lot of us came in here with absolutely nothing." Participants even acknowledged how the program would continue to help them meet their basic needs even after reaching their treatment goals:

> There's some definite aftercare things here that I'm taking advantage of and one is my education. That voucher allows me to pursue my education without having to really worry about our day-to- day existence. It's a big load off my mind.

Finally, others expressed appreciation for how their participation in *Better Together* allowed them to reunify with their children. The severity of their situations was not lost on

most participants. As one stated, "I gotta get my kid out of the system … This is serious business for us." Repeatedly, participants expressed gratitude toward staff for acknowledging the seriousness of their cases and advocating for their reunification with their children, whether in court or through written recommendations. One shared, "You know, if it wasn't for my therapist, I don't think my kids would be home. Because she really helped and worked with me and my NFC worker." And one participant may have said it best when she stated, "My kids are home … It brought them home sooner."

Appendix: Focus Group Questions

1. Tell me about your experiences as you went through the admission process and entered the *Better Together* program?

2. In what ways has the *Better Together* program ensured that you safe, both physically and emotionally?

3. What has it been like working with the *Better Together* program and staff in planning your treatment?

4. Part of the *Better Together* program involves attending groups. How can the groups you attend be enhanced or made better?

5. How have the services for your children provided by the program impacted your children and your family?

6. Tell us about how your treatment and recovery are impacted by receiving services where you're living.

7. What are your recommendations for the *Better Together* program?

Appendix E: Client Interview Report

***Better Together* 12-Month Client Interviews**
Final Report

Prepared by:
Jodi McQuillen, Ph.D.

assisted by Pamela Ashley, M.Ed.
data transcribed by Katie Schmelzle, MSW student

with Jeanette Harder, Ph.D.

June 16, 2017

Process

STEPs conducted 15 individual interviews with program participants during or after their 12th month in the *Better Together* program. The purpose of these interviews was to gather information from program participants' viewpoints at their halfway mark in the program. The interviews allowed participants to reflect on their recovery and journey to reunification with their children. STEPs invited all active and inactive program participants to the interviews. Prior to conducting any of the individual interviews, STEPs met with *Better Together* program staff to determine the interview questions and protocol. The questions for active program participants can be viewed in Appendix 1, and the questions for inactive program participants can be viewed in Appendix 2.

Interviews occurred between June 2015 and December 2016. The goal was for interview participants to have been in their 12th month of the program when interviewed. Those who were inactive at the time of the interview were invited to participate in what would have been their 12th month of the program, had they remained active with *Better Together*. STEPs followed this protocol for 13 of the 15 interviews, but due to scheduling conflicts, the two remaining interviews occurred during the participants' 14th and 15th months. Of the participants, 14 were active at the time of their participation in the interviews and one was inactive. **In total, 15 individuals participated in individual interviews: 11 females (73%) and 4 males (27%).**

Participants chose between three locations for their interviews: their home, their place of employment, or the *Better Together* office in Omaha, NE. One STEPs facilitator conducted each of the individual interviews. *Better Together* staff were not present at any interview. Prior to each interview, the facilitator thanked the participant, explained the purpose of the interview, and reviewed confidentiality. The facilitator then gave the participant a copy of the consent form and each encouraged them to read the form, as well as orally reviewed the form, prior to signing. The STEPs facilitator informed participants that the interviews would be audio recorded and later transcribed verbatim, with no identifying information included in the transcript. Finally, each participant could ask questions and/or obtain

clarification prior to the start of formal questioning. At the conclusion of the interviews, participants had the opportunity to add any additional thoughts on topics initiated by the facilitator or add additional thoughts on their own topics related to *Better Together.*

Participant interviews lasted between 10 and 40 minutes, depending on how conversational they were and how much detail they were willing to share. Upon completion of each interview, STEPs immediately downloaded its audio recording onto a secure network. A STEPs employee then transcribed the audio recordings verbatim and saved the transcriptions on a secure network. The transcriptions contained no identifying information regarding program participants.

STEPs program evaluators completed analysis of the transcribed data using MAXQDA software with a mix of inductive and *a priori* coding for data analysis. Evaluators utilized inductive coding, using *in vivo* codes, during the initial analysis of the transcriptions. Inductive coding is the process of coding the data into meaningful analytical units based on emerging themes. *In vivo* coding is the research practice of assigning a code, or label, to a section of data using a word or phrase from the data, and thus, the codes represent program participants' actual words. Initially, evaluators analyzed each interview transcript individually using inductive and *in vivo* coding, then completed multiple levels of analysis and thematic coding across all 15 transcriptions using constant comparison of themes and codes. During the final analysis of the data, evaluators recoded the themes from each transcript using *a priori* coding. *A priori* coding is the process of using codes that come from an outside source other than the data. In the case of the individual interviews, the targeted outcomes for the *Better Together* program were the *a priori* codes in the final data analysis. Evaluators first conducted *a priori* coding with each individual transcript, then across all 15 transcripts using constant comparison. In the end, three major themes emerged across all 15 interviews. **The three themes, examined in detail below, were Recovery, Parenting, and Family Reunification.**

Themes

Recovery

The data revealed a picture of who the typical *Better Together* client was at the 12th month. When the interviews took place, most participants had reached sobriety and were working on maintaining it. Many understood they needed to focus on their recovery prior to reunification with their children. As one participant explained, "My recovery comes first; before my children … If I don't want recovery for me, then I'm not going to want it for them either."

The interview participants had much to say about their process of recovery. When reflecting on what had helped them achieve successful recovery, most participants identified that their own willingness to change and *Better Together* staff were key components to their recovery. As one participant stated, "Every treatment is different, and you gotta go in with an open mind … it is what *you* put into it." Another explained that successful recovery "depends on how much support you really want. How much do you really want to give to your recovery and to you as an individual?" Many interviewees

shared their view on who should be allowed into the *Better Together* program. Many defended their view that program participants should be required to attend inpatient recovery before admittance to *Better Together,* so new program participants would more likely be committed to sobriety and less likely to relapse while in the program. As one participant explained:

> It's something you have to be ready for. You have to be ready to be done using … Individuals should always come from a prior inpatient program; whether it was short term or long term. You have to have abstained from use for a certain time; even if they come from prison or jail. Just not right off the street.

All participants had positive comments when talking about *Better Together* staff. Many expressed gratitude, typified by, "I would say that they're my blessing. I'm very grateful." They also described the multiple hats that staff wear. As one participant stated, the staff's roles "are many things." This was further explained by another, who shared, "I would say that they're there for you for whatever you need. Not just recovery, but like if you're struggling with depression or struggling with anger… They're there to help you with anything they can help you with." Participants also discussed how staff balanced support with client accountability: "I feel that they really stayed on top of me to make sure that I progressed, and if I stumbled along the way, they were there to help me pick up and move forward." Participants also verbalized appreciation for staff's collaborative approach with program participants, with comments such as "They're very open to your feedback."

Learning to trust staff was a critical component to many participants' recoveries. Many interviewees discussed their history of distrust, and how *Better Together* helped them overcome this barrier. As one explained:

> I've gained the ability to reach out more. They've helped me feel safe doing so, when I might not have in the past. So, that helps a lot. Before I wouldn't tell anyone that I needed help or that I was going through something … I guess that's one thing they've been particularly helpful with. When I came into the program I didn't trust anyone, at any time. I had serious trust issues. Today I can say that I trust people.

The consistency of staff support was another reoccurring topic interviewees discussed. Many acknowledged the obstacles they faced during the previous 12 months and that it was the consistent support of staff that helped them navigate their lives while in treatment. One participant described the support of staff during the first 12 months of treatment as:

> Super awesome! I went through ups and downs through the whole year and they were there with me every step of the way. Whether it be advocating for me in court, or teaching me skills to handle situations … They've always been there.

In addition to staff, participants mentioned benefitting from the various therapeutic and educational programs that *Better Together* offered. Individual therapy, DBT classes, and peer support were most frequently mentioned in the interviews as being critical to one's sobriety. One participant discussed how working with his individual therapist benefited his recovery, "Just working one on one with her … so that I could get myself to be a better person." Another explained the benefit of the DBT class: "It's opened my mind up to a lot of different ways to look at each situation … [it] actually gave me a lot of skills to use."

Participants also addressed the impact of their therapeutic relationship with staff. As one described, the staff's therapeutic role was "to teach us a lot of things about life. And the way to love life without drugs." The overall impact of staff support, therapy, and classes offered by *Better Together* was summarized by one participant who stated that her life had "changed drastically from where I was 12 months ago. I actually would have to say I have a life now. Whereas before, I was just kind-of existing in the world."

The benefit of peer support (either by the peer support worker or by peers within the *Better Together* community) also arose numerous times during the interviews. One participant explained, "It's given me more of an opportunity to have more peers and more friends that are healthy." Another stated, "I've got a close community of friends that I didn't have before and it's helped me learn a little bit more about myself… I can handle stressful situations better."

The general consensus among interview participants was that *Better Together* is a "case-by-case program" and that staff "take into consideration each individual situation." Thus, participants expressed appreciation that the program allows for individualized and client-centered treatment. One participant explained the case by case approach as follows:

> There's a set of program rules that apply to everybody. But then, on your individual part, it all depends on case by case. Which is fine, because I don't mind. I realize that not everybody gets clean the same way. Not everybody works their program the same way.

Another participant expanded the idea:

> I think the cool thing is that every person isn't the same. Every situation isn't the same. Every family here is not the same. We have moms. We have dads. We have singles. We have couples. We have people that don't have their kids back and we have people that do have them back. It's so much difference.

Not only did participants describe *Better Together* as a chemical dependency program, but also "a place to work on your individual needs, as well as reunite the family." Many participants stated that *Better Together* was unique compared to other treatment programs. One mentioned difference was the "depth" of treatment provided by *Better Together.* As one participant stated, *Better Together* makes program participants look at "the root problems that caused your addiction." Many described its holistic approach to helping clients and their families as a unique strength of the program. As one participant stated, *Better Together* "gives you more of an opportunity to have your own place, get your kids back, and get back in the swing of being a productive member of society." Others discussed how the program better prepared them for "real life." As one participant stated:

> I have more real life experience, because I have my own apartment … It kinda tests my strengths because I have neighbors across from me, and below me, that smoke weed. That was one of my drugs of choice, so I have to smell that every day. But you know, that's reality. I'm never going to be away from it.

Maintaining their sobriety was not a concern for most interviewees. As one stated, "I've got a lot of tools in my tool box now, to stay sober." Another stated, "I now know what to do in the case of relapse." Additionally, many participants mentioned the alumni group and its

role in their maintenance of sobriety: "When I graduate, I know that I can still go back and be a part of the group that changed my life."

In addition to sobriety as a treatment goal for the interviewees, but several individuals also addressed improved mental health. Many participants mentioned their new ability to successfully regulate their emotions as a marker of improved mental health. Others discussed improved decision making as a positive outcome of their therapy. Additionally, many expressed pride in their new employment or advanced education. A number of participants stated that the program had influenced their decision to go back to school and become a peer support specialist or a substance abuse counselor.

Finally, participants addressed *Better Together's* unique feature of allowing mothers, fathers, and couples to live in a treatment community while simultaneously having their children live with them. As one participant stated, "This is the only program that I've heard of like this." The motivation and hope that came from being able to obtain treatment while still parenting was a key component of many respondents' treatment success.

Parenting

All participants identified improved relationships with their children as a result of participating in the *Better Together* program. Some even noted that learning how to parent was the most significant skill they learned from *Better Together*. As one stated, "I'd say the biggest change would probably be parenting. Like knowing how to be the right parent for my child."

The development of trust between parent and child, and with other family members who were caring for participants' children, was also a frequent topic in the interviews. One participant shared:

> I'm starting to get trust and relationships back with my family … My oldest son, now I have a relationship with him, which I didn't have for like two or three years because of drug use. It's changed a lot.

A mother, whose partner also participated in *Better Together,* further explained: "Because of the program, and my success in the program, my mom has been able to trust me and let us have a relationship with our son."

Most participants also noted their improved parenting skills, and they credited individual therapy, family therapy, and Circle of Security for making the biggest impacts on their parenting skills. Regarding Circle of Security, one father stated it "helped a lot. Like knowing how to be with your child." When the interviewer asked the same participant to describe how his relationship with his daughter had changed as a result of what he learned, he shared, "Oh, she is a Daddy's girl! My relationship with her has grown stronger. The attachment part of it is great. I don't know how to explain it. It's happy! It's wonderful! I love it!"

Learning how to handle their children's behavioral needs was a common topic of discussion across program participants. Being able to discuss parenting stressors with program staff was a benefit that many noted in their interviews. One parent explained the

benefit of having supportive staff when reunification occurred: "We've had our ups and downs, but I'm always able to go in and talk about it with one of the staff and they kind-of give me advice." Others discussed how they have been able to implement parenting skills they have learned. One mother explained, "I've been able to step back and be like 'Oh, gosh, she's only one. It's ok.' Our relationship has gotten better because I don't yell as much." A father also explained how he now implements skills he has learned when parenting his two-year-old:

> When she's doing something that bothers me … I kind-of step out, and I'll go into the bedroom. I'll breathe and think about what I am going to do so I'm not yelling or screaming. So, when I come out, I'm 10 times calmer, and I'm able to talk to her.

Learning how to effectively communicate with their children was often noted as a valuable learned skill, regardless of the age of participants' children. One mother stated, "Me and the kids established a communication that has been amazing! Now I have open discussions with them." Another mother stated, "I have a 13-year-old daughter. She lives with my mom. We get along better now. She'll talk to me about her life rather than just be angry."

Finally, program participants frequently addressed the bonds and attachments that grew between themselves and their children as a result of being in *Better Together.* Some discussed how therapy and parenting classes helped them "get that bonding back" after months or years of separation from their children. As one participant ventured, "I think my children feel more safe and more secure now." Participants' attachments to their children was also evident throughout the interviews. One mother explained when describing her relationship with her son, "My relationship with him is amazing! He is my favorite person in the whole wide world. I would say he is my guardian angel."

Family Reunification

While sobriety was the initial focus of treatment, participants' reunification with their children was the ultimate goal for all program participants. All credited *Better Together* with allowing them to obtain, or maintain, reunification with their children. As one participant stated, "I really love the program … It was the hand up that I needed to be stable and get my son back. I know that being in this program had a huge part in getting custody back." As a father further explained, "This program has helped a tremendous amount with getting my kid back with me. Helping me grow a relationship with her. Being the father that I needed to be." He also acknowledged the unique opportunity that *Better Together* provides for fathers when he stated:

> This is a one-of-a-kind program for single fathers … There's no other program that accepts single fathers into recovery. And they give you an apartment and get you back on your feet *and* get your kids back with you. It's an amazing program. It truly is.

Many participants credited *Better Together* staff with helping them navigate the child welfare system so that reunification could occur. As one participant stated, "*Better Together* is an awesome program! They will advocate for you to get your kids back." Another participant further explained how staff supported her on her journey to reunification:

> They were great at advocating for me in the court system. I was doing everything that I possibly could. I was ready. I did all my individual therapy and they [the court system] were beating around the bush about having them come home. *Better Together* are the ones that stepped up and was like "No, we'll follow this schedule and they'll be home."

Stable housing was a final component of reunification for which participants acknowledged *Better Together's* provision. As one participant stated:

> It's given me a place to live. A secure place to live. This is the longest I have had a home for my children, so it has given me that stability for my children … For most of their lives, we have been from home to home and homeless shelters to whatever. So, for them to have an address for a year is amazing in itself!

When describing the impact that stable housing had on her children, another mother stated, "They're comfortable. They're at peace."

The ultimate success in the *Better Together* program is family reunification. Many participants discussed their "fight" for, or "journey" to, reunification. This process not only included obtaining sobriety and learning parenting skills, but learning to trust again, and learning how to access community resources like employment and housing. While all interviewees were only halfway through the *Better Together* program at the time of their interviews, many were able to say with pride, "My case is closed."

Appendix 1: Individual Interview Questions–Active Participants

1. How would you describe the *Better Together* program to someone else? How is it the same or different from other programs?

2. How has life changed for you by being in the *Better Together* program?

3. During your time in the *Better Together* program, did you ever consider leaving the program?

4. Are there needs you have that are not being met through the program?

5. When there are obstacles, what is it like working with the *Better Together* staff to overcome these challenges?

6. Describe your relationship with your child(ren). How has this relationship changed through participation in the *Better Together* program?

7. What do you need to live a life without social service (agency) involvement?

8. What is your understanding of the role of *Better Together* staff? Explain a time when you were helpful or unhelpful in your recovery.

9. *Better Together* often uses the term "case-by-case." Give an example of a time when this was beneficial. Give an example of a time when this was frustrating.

Appendix 2: Individual Interview Questions–Inactive Participants

1. How would you describe the *Better Together* program to someone else? How is it the same or different from other programs?

2. How did your life change while in the *Better Together* program?

3. Since you left the *Better Together* program, what has been going well? What is currently a struggle for you?

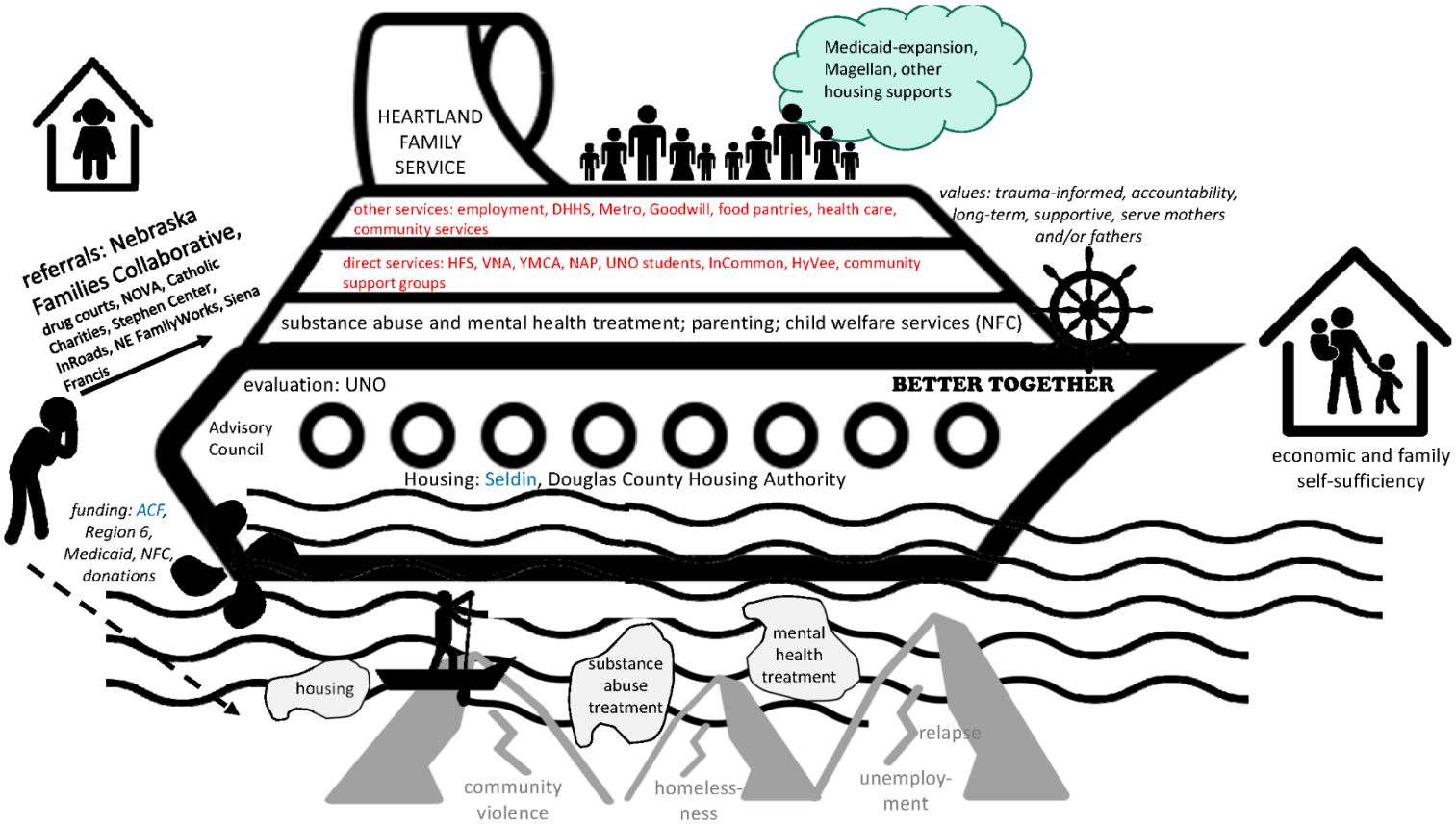
4. What could the *Better Together* program have done to help you stay in the program?

5. If you could go back, is there anything you would do differently to remain in the *Better Together* program?

6. Describe your relationship with your child(ren). How did this relationship change during your participation in the *Better Together* program?

7. What do you need to live a life without social service (agency) involvement?

Appendix F: Systems Map



Appendix G: Benefit-Cost Analysis of *Better Together*, 2015

UNIVERSITY OF NEBRASKA AT OMAHA
SUPPORT AND TRAINING FOR THE EVALUATION OF PROGRAMS

College of Public Affairs and Community Service
The Grace Abbott School of Social Work

Benefit-Cost Analysis of Better Together, 2015

Joseph Forrest, MSW student
Christopher Goodman, Ph.D.
Pamela Ashley, M.Ed.
with Jeanette Harder, Ph.D.

9/6/2016

I. Executive Summary

This analysis examines the benefits and costs of *Better Together*, a comprehensive program for families involved with the child welfare system and affected by substance abuse. The analysis found that **for every $1 invested in *Better Together*, there is an immediate return of $1.50 to individuals and the community** ($50,640 benefit / $33,792 cost).

Short-term benefits of *Better Together*, which occur while clients actively participate in the two-year program, include:

- **Increased client income**. Clients increased their income from wages and government benefits, and they relied less on assistance from family and friends.
- **Decreased foster care costs for Nebraska Families Collaborative (NFC)**. Children were reunited with their parents; these children would otherwise have remained in paid foster care.
- **Decreased community costs from supportive housing and treatment**. Clients used fewer emergency services and detoxification / residential rehabilitation services; and were less likely to be involved in criminal activity.

In 2015, *Better Together* served 27 clients; program costs included:

- **Heartland Family Service (HFS)** expenses for staff, office space, transportation, and program supplies.
- **Douglas County Housing Authority (DCHA)** housing vouchers provided to program clients.
- **Nebraska Families Collaborative (NFC)** rent payments, overdue client bill payments, and transition costs.

Figure 1: Annual Benefits and Costs per Client

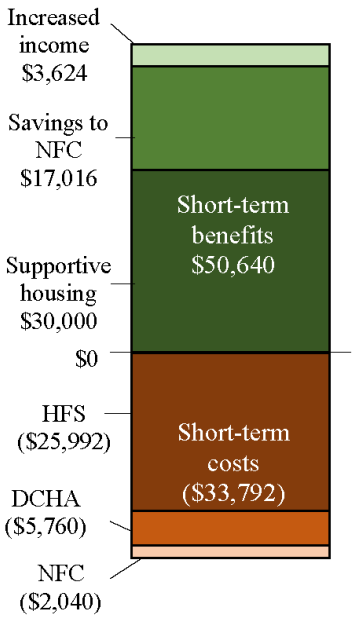
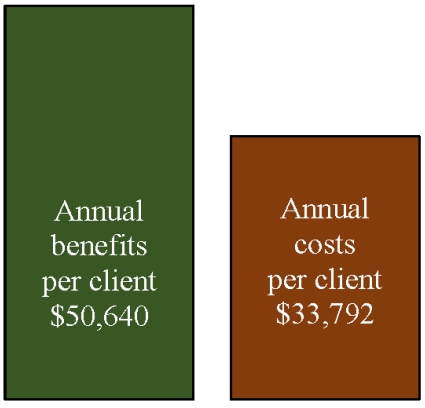


Figure 2: Short-term Benefits Outweigh Costs



When short-term benefits are compared to costs, ***Better Together* provided a net annual benefit of $16,848 for each client served** ($50,640 benefit - $33,792 cost). Accounting for the 27 clients served during 2015, the program's annual net benefit exceeds $450,000 (27 x $16,848).

Long-term benefits from the program, which are not factored into this calculation, include increased family stability and improved child outcomes. Clients are likely to see long-term improvements in productivity, income, and physical and mental health. Some short-term benefits like decreased crime and emergency care use will continue into the long-term as well.

II. Introduction

Better Together is a comprehensive program for families involved with the child welfare system and affected by substance abuse. An Omaha-based program of Heartland Family Service with many collaborative partners, *Better Together* provides outpatient and intensive outpatient substance abuse treatment in a community-based treatment setting. Clients receive 6 months of treatment, 6 months of aftercare, and 1 year of sober living support. Long-term outcomes of *Better Together* include reduced parental substance use, increased parenting capacity, and improved child well-being. The project is funded in part through a grant from the U.S. Department of Health and Human Services Administration for Children and Families and Region 6 Behavioral Healthcare.

This benefit-cost analysis focuses on the 2015 calendar year, and includes costs associated with clients served during that time.

This benefit-cost analysis focuses on the 2015 calendar year, and includes costs associated with clients served during that time. Not all clients in this group were served for the entire year, and therefore costs and benefits were examined by client month. This means that this report will calculate the average cost of providing services to one client for 12 months, and compare this to the average benefit of serving one client for 12 months. The following are examples of how client months are calculated:

- A client who started the program prior to 2015 and received services for the entire year is counted as having been served for 12 months.
- A client who entered the program on September 1, 2015, and was served for the rest of the year, is counted as having been served for 4 months.

When the months are counted for all clients served in 2015, *Better Together* served 27 clients for a total of 198 months in the study period. Four of the 27 clients who were served in 2015 dropped the program by the end of the year and did not successfully complete treatment. Twenty-three of the 27 clients served in 2015 are currently part of the evaluation study; two chose not to participate in data collection, and two have been dropped from the study because they have stopped responding to interview requests. Some benefit data, which relies on data collected from clients participating in the evaluation study, comes only from these 23 clients. All benefits and costs are adjusted based on the number of clients included in the data to reflect the average per client monthly benefit or cost of *Better Together*.

Costs are calculated based on the actual expenses of agencies that support *Better Together* clients. Benefits are more difficult to quantify; short-term benefit data is the most reliable and able to be monetized. The benefit-cost comparisons in this report focus on the period when clients are actively involved in *Better Together* programming and include cost savings to child welfare providers, as children are re-unified with their parents instead of remaining in paid foster care.

Long-term benefits include the impact of long-term sobriety on clients' employment, education, criminal justice involvement, physical/mental health, and parenting ability. Children of clients also benefit from increased home stability, fewer new adverse childhood experiences

(ACEs), and decreased foster care involvement. Data is not yet available to determine the extent to which these long-term benefits have been realized by *Better Together* clients. In the future, changes to data collection tools and methods could provide more details about long-term program benefits.

This analysis relies on the conservatism principle, which means that every effort has been made not to overstate the benefits of *Better Together*. Throughout this report, there will be references to *underestimated* benefits and *overestimated* costs. This is not to imply inaccuracy in the report, but rather to assure the reader that this is a conservative analysis of the benefits provided by *Better Together*.

Additional process and outcome evaluation reports for *Better Together* are available from Heartland Family Service and *Better Together*.

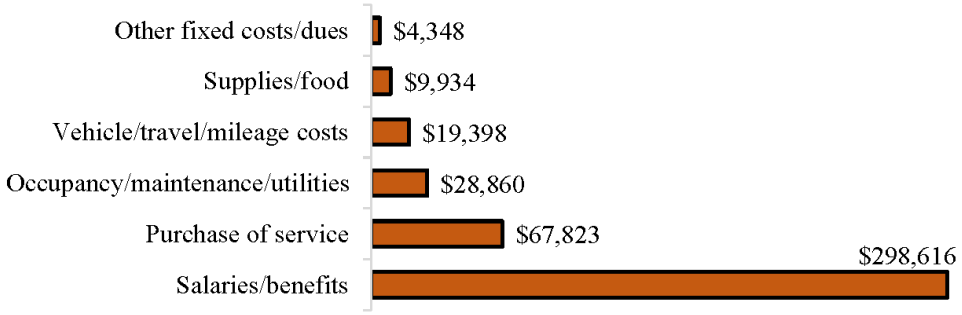
III. Costs

The costs of *Better Together* are shared among private agencies, the Nebraska state government, and the federal government. Short-term costs are detailed here, and include actual expenses incurred by program support agencies in 2015. These expenses represent the cost of *Better Together* for 27 clients served in 2015. As more clients are served, costs would increase with the need to pay for more support staff, housing, and other program materials. However, economies of scale dictate that cost per client can be expected to decrease as more clients are served, since fixed costs are already established. For example, doubling the number of clients from 25 to 50 would not necessarily double the rent for the *Better Together* office, but it would likely require additional staff.

Heartland Family Service

The largest portion of costs for the program are taken on by Heartland Family Service (HFS), the agency that directly administers *Better Together*. Costs for HFS include salaries and benefits for case managers, therapists, peer-support workers, and supervisors of the program. HFS also pays for office space, transportation, and other supplies for group and therapeutic needs. HFS spent $428,984 on *Better Together* between January 1, 2015 and December 31, 2015, spanning the following budget categories:

Figure 3: HFS 2015 costs totaled $428,984



Nebraska Families Collaborative

Nebraska Families Collaborative (NFC) also incurs costs related to *Better Together*. NFC expenses include paying the balance of overdue rent and utility bills for clients who enter *Better Together*, assisting with relocation, and paying for client housing until clients begin receiving housing vouchers through the Douglas County Housing Authority. The largest cost to NFC is paying for overdue bills and rent in order to allow clients to enter housing with *Better Together*.

NFC pays for transition costs, including overdue bills and rent, to allow clients to enter housing with *Better Together*.

This report includes all NFC costs for clients who were active in *Better Together* in 2015. Some of these expenses occurred in 2014, but are included to provide a picture of the real cost to NFC. NFC paid $11,292 in transition costs for four clients who began *Better Together* in 2014 and were still active in 2015. NFC's expenses related to clients served by *Better Together* in 2015 are shown below:

Table 1: NFC Costs 2015

Payment of overdue bills/rent, moving expenses, and transition costs	$33,762
Total Cost	**$33,762**

Additional costs are excluded from this report because they were not provided as a part of the *Better Together* program model. NFC continued to assign a support worker to clients who participated in *Better Together*, but this position is not a part of the model and provided client services similar to those of the program's case manager. NFC reported that a support worker assigned to *Better Together* clients assists with the transition into the program, transportation, and connection to community resources. Once the children are returned home and a housing voucher is obtained, NFC closes the family's case. Costs for this support worker totaled $28,945/year (salary of $15.67/hour plus $500/month in mileage reimbursement, with 75% of that time charged to work on *Better Together* clients).

However, *Better Together* employs a case manager who handles all client needs in-house, and so the NFC worker is not a cost that would necessarily be incurred by an agency reproducing the *Better Together* model. The cost of this NFC support worker is included in a sensitivity analysis at the end of this report.

State and Federal Agencies

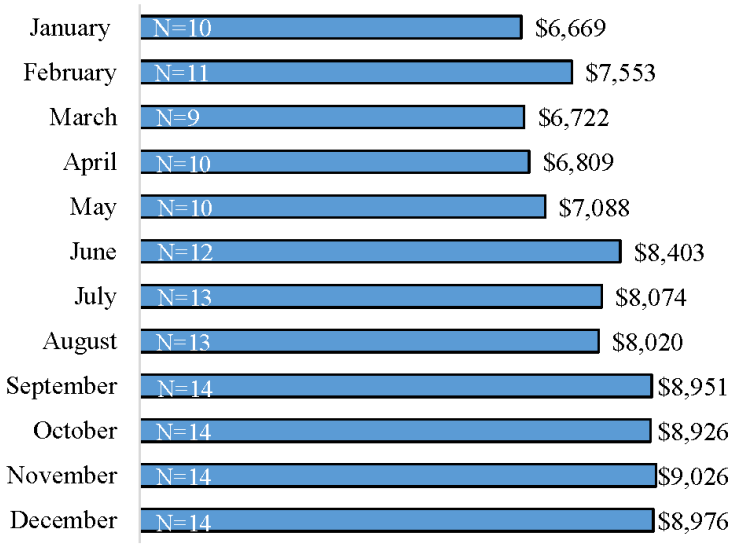
State and federal governments incurred costs through provision of income-based public assistance programs. These costs are borne by taxpayers at the local and national levels. *Better Together* assists clients in applying for Medicaid and federal public assistance programs like the Supplemental Nutrition Assistance Program (SNAP); the Women, Infants, and Children (WIC) program; Temporary Assistance for Needy Families (TANF); and claims for disability. The costs of these programs are shared by both the state and federal government.

Better Together assists clients in applying for Medicaid and federal public assistance programs like SNAP, WIC, TANF, and claims for disability.

While clients may have been able to access state and federal assistance without participation in the program, *Better Together* assists them with completing applications. The application process can be overwhelming for clients, and the assistance of *Better Together* case management staff helps clients to move through complicated systems more quickly and efficiently. For purposes of this report, data was not collected in a way that allows for a detailed analysis of clients' use of these services. A more comprehensive collection of data would allow for a comparison of the change in utilization of government programs by clients, and the costs and benefits that such use incurs. For purposes of this analysis, these programs are not included in the calculations but are acknowledged as client supports that make participation in *Better Together* possible.

Better Together clients also receive housing vouchers through the Douglas County Housing Authority (DCHA). Costs vary based on the number of clients receiving vouchers, their income levels, and the apartment size needed. A breakdown of monthly DCHA voucher expenses is shown in Figure 4.

Figure 4: DCHA costs 2015



Other costs associated with *Better Together* include child care, transportation, education at community college, job training, and community programming. These community supports are either provided free of charge to anyone in the community, or were paid for privately by *Better Together* clients with their own income. For these reasons, these costs are excluded from this analysis.

Total Short-Term Costs

The total costs for *Better Together* clients in 2015 are summarized below. This is a conservative estimate, and includes NFC costs from 2014 for clients who entered the program during that year and remained active in 2015.

Based on 198 months of client services, the total monthly cost per client in 2015 was $2,818, and the total annual cost per client was $33,816.

Better Together served 27 clients in 2015 for a total of 198 months. The average client received 7 months of service; while some clients were active for all 12 months of 2015, others left or entered the program during that calendar year. Because clients were served for different lengths of time, costs are broken down to a monthly figure.

Months of service were calculated regardless of the client's phase in the program. Phases 1-3 are more intensive and require greater staff time and case management than phases 4-5. In 2015, 16 of the 27 clients served were in phases 1-3, and so the overall cost per client is likely overstated in this analysis.

Based on 198 months of client services, the total monthly cost per client in 2015 was $2,818, and the total annual cost per client was $33,816. The following are costs per client month and year:

Figure 5: Total Costs 2015

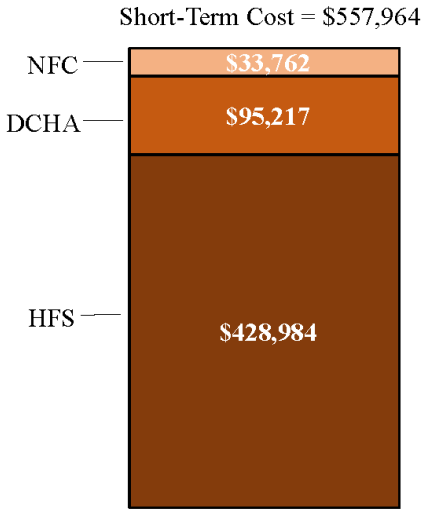


Table 2: Costs per client month and year

Timeframe	Calculation	Total
Cost per client month	Total cost ($557,964) / client months (198)	$2,818
Annualized cost per client	Cost per client month ($2,818) * 12 months	$33,816

IV. Short-Term Benefits

Benefits of *Better Together* are shared among program clients and their children, partner agencies, and the larger community. For purposes of this analysis, all benefits are determined based on participation in *Better Together* during the 2015 calendar year. Benefits are calculated based on the conservatism principle, and likely underestimate the true benefits of the program.

Short-term benefits are immediate, and occur while clients are actively involved in *Better Together*.

Savings on Foster Care Costs

A main goal of *Better Together* is to reunite parents with children whenever possible, and to support these families with case management and therapy. Because reunification happens more quickly for parents in *Better Together* than it otherwise would, there are cost savings to agencies which would otherwise be paying foster care costs.

Nebraska Families Collaborative saved $247,854 in 2015 because of children reunited with parents in *Better Together*.

Nebraska Families Collaborative (NFC) experiences cost savings as a result of the early and sustained reunification of children with parents in *Better Together*. In 2015, 37 children lived with a parent in *Better Together* instead of in out-of-home care with NFC. On average, children were reunited with their parents within two months of their parents entering the program.

Based on potential and actual payments, NFC saved $247,854 in 2015 foster care costs because of *Better Together*. Foster care savings for 2015 are calculated by subtracting actual foster care payments ($90,830) from potential payments ($338,684).

Using foster care payment rates provided by NFC, potential payments for the 37 children of 27 clients served in 2015 totaled $338,684. Potential payments are calculated by multiplying the daily foster care costs for each child by 365 days to find an annual cost. Potential payments are identified in Figure 6 as "NFC Foster Care Costs without *Better Together*."

Figure 6: 2015 NFC Foster Care Costs

Actual payments, which reflect the cost of the identified 37 children to NFC before reunification with their parents, totaled $90,830 in 2015. Shown in Figure 6 as "NFC Foster Care Costs with Better Together," actual payments are calculated based on each child's cost of daily foster care and the date of reunification with his or her *Better Together* parent. The total of $90,830 equals the sum of the daily cost of foster care for each child multiplied by the number of days NFC provided out-of-home care.

Better Together not only facilitates the early return of children to their parents, but also provides supports including family therapy and connections to child care and behavioral

resources (e.g., KidSquad). These additional supports help to increase family permanency and to decrease the likelihood of re-entry into the foster care system. Children immediately experience the benefits of reunification with their parents, and benefit from increased family stability as time goes on. Family reunification and stability contribute to decreased child trauma and improved outcomes in health, mental health, and education. These benefits are discussed in more detail in the long-term benefit section.

This report provides a conservative estimate of savings to NFC resulting from their collaboration with *Better Together*. While this analysis looks at the benefits for 37 children in 2015, NFC reported that 56 children have been reunited with their *Better Together* parent in the past two years. Additionally, this analysis does not include the additional costs of NFC caseworkers for children with active child welfare cases, or other support services provided to foster children. Overall cost savings to NFC likely exceed the $247,854 estimate for 2015.

Supportive Housing and Case Management

Housing clients is a unique component of the *Better Together* program designed to increase the stability of families, and to build a supportive recovery community made up of program clients and alumni. The program offers on-site intensive outpatient and outpatient substance abuse treatment. Onsite supports include peer support and therapeutic groups, individual therapy, and family therapy. *Better Together* also employs a peer support specialist and case manager to guide clients through treatment. As clients progress in the program, they will ideally remain on-site and act as additional peer supports to new clients. It is too early to determine whether alumni will stay in the *Better Together* housing complex to build this supportive community, as only three clients have reached the final 24-month measurement point as of May, 2016.

The benefits of housing clients who lacked adequate housing before entering the program are clear. Under guidelines used by the U.S. Department of Health and Human Services (DHHS), which are used by medical facilities to track services provided to individuals who are homeless or lack adequate housing, 17 of 23 study clients served in 2015 could have been classified as homeless prior to entry into *Better Together* (National Health Care for the Homeless Council, 2016). At each of their most recent measurement points, all 23 of these individuals reported living in their own home or apartment.

Studies in Denver, Seattle, Florida, and Rhode Island found that supportive housing benefits outweighed costs by an average of 198%.

Numerous studies across the United States have demonstrated that housing previously homeless individuals leads to benefits that far outweigh costs. Housing programs similar to *Better Together* provide savings to communities by decreasing the use of emergency shelters, which are costlier than long-term housing; decreasing the use of emergency room care; decreasing criminal activity and incarceration; and decreasing the use of detoxification and residential rehabilitation programs.

The following is a summary of studies from across the country which demonstrate significant benefits to supportive housing similar to that provided by *Better Together*:

- Denver, CO – Providing supportive housing to clients who were previously homeless led to a savings of over $31,500/year per client. Program costs totaled $26,800/year per client, and provided a **net benefit of $4,745/year** for each client served (Perlman & Parvensky, 2006). The benefits were 113% of costs.

- Seattle, WA – Identified savings of $42,828/year per client. Program costs totaled $13,440/year per client, and provided a **net benefit of $29,388/year** for each client served (Larimer, Malone, Garner et al., 2009). The benefits were 319% of costs.

- Rhode Island – Supportive housing led to a savings of $23,089/year per client. Program costs totaled $15,143/year per client, and provided a **net benefit of $7,946/year** for each client served. (Hirsch, Glasser, D'Addabbo & Cigna, 2008). The benefits were 152% of costs.

- Central Florida – Supportive housing provided a savings of $31,065/year per client. Program costs totaled $10,051/year per client, and provided a **net benefit of $21,014/year** for each client served (Shinn, 2014). The benefits were 209% of costs.

Taking the average of these studies, supportive housing provided a benefit equal to 198% of program costs. In the case of *Better Together*, program costs totaled $33,816/year per client, which is slightly higher than the studies included here. **Applying this benefit-cost ratio to *Better Together*, the program could be expected to provide a housing benefit of nearly $67,000/year per client**. This would total a net benefit of more than $33,000/year per client. While the measures employed in the evaluation of *Better Together* in its first three years do not allow for a robust analysis of the impact of housing on medical costs and contact with the criminal justice system, these studies point to the large benefits that could be seen from the program.

Although there is clear evidence of the cost savings of supportive housing, there is limited data supporting the savings associated with *Better Together* clients at this time, and so a conservative estimate must be used. Assuming a lower benefit ratio than any of the studies found in the literature, this report will conservatively estimate that *Better Together* provides a gross savings of $30,000/year per client (benefits as 89% of costs) as the result of supportive housing. It is possible that actual benefits of the program are more than double this number, and more robust data collection could confirm this in the future.

Data from similar programs indicate that *Better Together* could provide savings of up to $67,000/year for each client.

Health care costs are generally significant for individuals who are homeless or have substance use disorders. Visits to an emergency department (ED) have been estimated to be 30-36% higher for substance users than for the general population (Pauly, McGuire, & Barros, 2012). The Centers for Disease Control and Prevention reported that, in 2011, there were

44.5 ED visits per 100 people in the United States. The rates were around 50 in 100 for individuals between the ages of 15 and 44 years old (Centers for Disease Control, 2011). Given this, a conservative estimate of *Better Together* client ED visits in a given year would be 13 (58 in 100 likelihood of visit, out of 23 individuals). On the contrary, clients reported only 3 visits to an emergency room in 2015 after starting *Better Together* programming. While this is a small sample size, there appears to be a significant reduction in the use of emergency care by clients.

Limited data on crime and costs related to incarceration also indicate reductions for clients participating in *Better Together*. Based on both client self-report and agency reporting, there was only one arrest in 2015 out of the 27 clients served. Considering that 11 of these clients were on parole or probation when they entered the program, only one arrest represents a significant reduction in crime and incarceration.

Staff and administrators involved in *Better Together* and partner organizations confirm these assumptions of cost savings. Perceptions and experiences of members of the *Better Together* Community Advisory Council affirmed that unstable housing leads clients to increase use of emergency shelters, emergency rooms, detoxification programs, and criminal activity. They also highlighted that unstable housing often leads to child welfare involvement and removal of children from the home. Because clients would be concerned about basic needs and safety, they would be less likely to prioritize education, mental health services, and child development supports.

Increased Income

Clients' average monthly income increased by **$302.**

Clients served by *Better Together* at any point in 2015 saw their incomes rise over the course of the program. Income data was broken down by money received from family and friends, public assistance, and wages. Between intake and 6 months, clients relied less on income from family and friends, and increased their income from both public assistance and wages. Average monthly income at intake was $575 (n=23), and by the 6-month measurement point had risen to $877 (n=20). **Monthly income increased an average of $302.13 per client in the first six months of programming.** Income remained largely stable between the 6-month and 12-month measurement points.

Total Short-Term Benefits

The total benefits for *Better Together* clients in 2015 are listed below. This is a conservative estimate and includes only benefits that occur while clients are actively participating in the program.

Better Together served 27 clients in 2015 for a total of 198 months. This average of just over 7 months of service per client represents the fact that, while some clients were active for all 12 months of 2015, others left or entered the program during that calendar year. For this reason, benefits are identified as a monthly figure. A list of benefits by month are provided in Table 3, and annualized benefits for one client are calculated in Table 4.

Table 3: Short-term benefits per client month

Foster care savings	$ 1,418
Supportive housing benefits*	$ 2,500
Increased income	$ 302
Total Monthly Benefits	$ 4,220

*Based on a conservative estimate of gross housing benefits of $30,000/year per client.

Table 4: Annualized benefits per client month

Timeframe	Calculation	Total
Benefit per client month	Sum of individual benefits	$ 4,220
Annualized benefit per client	Benefit per client month ($4,220) * 12 months	$50,640

V. Short-Term Benefits versus Costs

Costs to HFS, DCHA, and NFC are divided based on 198 months to determine the cost of services for one client for one month. The benefits of housing and income are also divided by 198 months to determine the benefits to one client for one month of participation in the program. Cost savings to NFC for foster care are calculated by multiplying the average daily cost for foster care of each child placed with a *Better Together* client by 30 days. This estimates the average monthly savings to NFC for each month that a client has their child placed in the home instead of in foster care.

The net benefit for a client completing one year of *Better Together* is $16,824, with a benefit-cost ratio of 1.5.

The costs and benefits listed are conservative estimates, and likely overstate the cost and understate the benefits of the program. NFC costs include 2014 costs associated with clients active in *Better Together* in 2015, and HFS costs are likely higher than average because 16 of 27 clients were in the more intensive and costly phases 1-3.

Housing benefits are likely understated because not enough data was collected on *Better Together* to be confident in providing a specific savings figure for this program. Data from similar programs indicate that *Better Together* could provide savings of up to $67,000/year for each client, but this report uses a conservative estimate of $30,000/year per client.

Based on these conservative estimates, **the net benefit for a client completing one year of *Better Together* is $16,824**, with a benefit-cost ratio of 1.5. This means that **for every $1 spent on *Better Together*, there is an immediate return of $1.50.** If the 27 clients served in 2015 had been in the program for a full year, this would total a net benefit of $454,248 after accounting for all program costs. Calculations and results are detailed in Tables 5, 6, and 7; and Figures 7 and 8.

Table 5: Costs and Benefits per Client Month, 2015

COSTS	
HFS costs	$ 2,166
DCHA housing vouchers	$ 480
NFC costs	$ 170
Total Monthly Costs	$ 2,818
BENEFITS	
Foster care savings	$ 1,418
Supportive housing benefits*	$ 2,500
Increased income	$ 302
Total Monthly Benefits	$ 4,220
NET MONTHLY BENEFIT PER CLIENT	**$ 1,402**

*Based on a conservative estimate of gross housing benefits of $30,000/year per client.

Table 6: Annualized short-term benefits and costs per client

BENEFITS		COSTS	
Foster care savings	$17,016	Heartland Family Service costs	$25,992
Supportive housing benefits	$30,000	DCHA housing voucher	$5,760
Increased income	$3,624	NFC costs	$2,040
Annual single client benefit	$50,640	Annual single client cost	$33,816

NET ANNUAL BENEFIT per client ($50,640 benefit - $33,816 cost)	**$16,824**
BENEFIT-COST RATIO ($50,640 benefit / $33,816 cost)	**1.5**

Annualizing this net benefit for all 27 *Better Together* clients during 2015 produces an annual net benefit of $454,248.

Table 7: Annualized costs and benefits

ANNUALIZED PROGRAM COSTS		
Timeframe	Calculation	Total
Annual cost for one client	cost of 1 client month ($2,818) * 12 months	$33,816
Annual cost for 27 clients	cost of 1 client year ($33,816) * 27 clients	$913,032
ANNUALIZED PROGRAM BENEFITS		
Timeframe	Calculation	Total
Annual benefit for one client	benefit of 1 client month ($4,220) * 12 months	$50,640
Annual benefit for 27 clients	benefit of 1 client year ($50,640) * 27 clients	$1,367,280

Figure 7: Annual benefit and cost per client

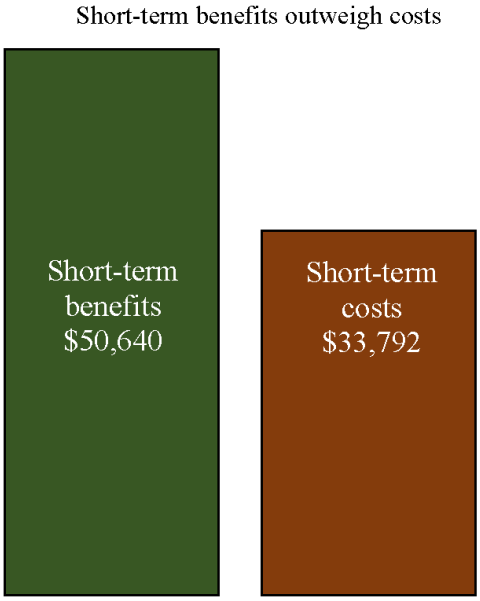
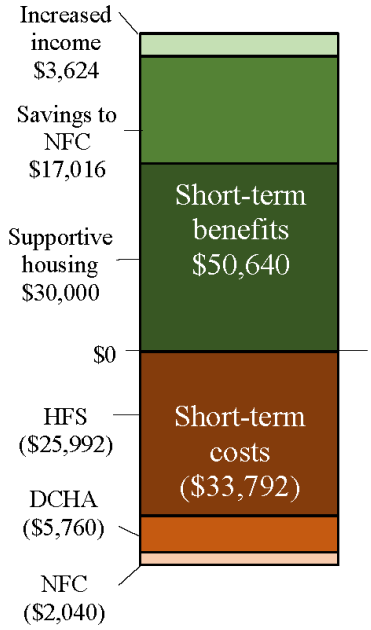


Figure 8: Detailed short-term benefits and costs per client



VI. Long-Term Benefits

While *Better Together* costs remain fixed when clients are in the program, and end after their program involvement, benefits continue to accrue after clients and their children complete treatment. Long-term benefits include the impact of long-term sobriety on clients' employment, education, criminal justice involvement, physical/mental health, and parenting ability. Children of clients also benefit from increased home stability, fewer new adverse childhood experiences (ACEs), and decreased foster care involvement. Overall, *Better Together* will lead to lasting benefits for individuals, families, and the wider community.

A key strength of *Better Together* programming that is missing from the short-term benefits section of this analysis is the impact of improved mental health. The program combines drug and alcohol treatment with individual and family therapy designed to reduce trauma and improve mental health. Measurement tools used to examine mental health and trauma in the first three years of *Better Together* are based on self-report, and do not provide clinically significant cutoffs. The data collected thus far point to improvements in trauma symptoms and mental health overall. Further analysis of these factors in the long term would likely show additional benefits to clients who participate in the mental health services provided by this program.

The short-term benefits of reduced crime and criminal justice involvement, along with the reduced cost of emergency care and rehabilitation use, are likely to continue through the long term as well. As clients complete treatment and remain sober, they are also likely to improve their long-term health and life expectancy.

Long-term benefits include increased family stability, improved child outcomes, decreased trauma, and improved mental and physical health.

Numerous benefits are linked to long-term sobriety–the most significant of which relate to cost savings from reduced incarceration and emergency medical treatment, and increased workplace productivity (Frone, 2011; McCollister & French, 2003). Studies show that drug and alcohol treatment is more effective when parents and children are involved in the process together (Rowe, 2012). Parents in *Better Together* can be expected to have better long-term outcomes than they would in programs that do not incorporate family therapy and support for their children.

The benefits of *Better Together* for client children will likely be large in the long term as well. Children suffer more trauma and worse outcomes the longer they stay in foster care and the more placements they have in the system (Ringeisen, Tueller, Testa, Dolan, & Smith, 2013). By reunifying children with their parents in a treatment environment, *Better Together* should reduce the time and number of placements children experience in foster care, and as a result improve their long-term outcomes. Benefits could include increased family stability, decreased child trauma symptoms, and limits to further ACEs. These factors contribute to higher educational attainment and work skills, higher lifetime income, and improved mental and physical health (Sun & Li, 2011).

The full extent of long-term benefits can be calculated by using the successful completion rates for program clients. Because *Better Together* has been operating for less than three years, not enough clients have reached the two-year completion point to include in this analysis. In the future, more data should be collected on program completion outcomes. These completion rates, as well as follow-up data collection, can be used to determine the impact of *Better Together* on the long-term well-being of clients, their children, and the community.

VII. Sensitivity Analysis

A benefit-cost analysis is based on assumptions about the important benefits and costs of a program; therefore, it is important to test these assumptions in a sensitivity analysis. If the findings are based heavily on one or two assumptions about benefits and costs, a change in these assumptions can drastically change the net positive or negative monetary impact of the program.

This sensitivity analysis tests several key assumptions about the sources of benefits and costs to *Better Together*, and demonstrates the impact that changing these assumptions would have on the calculated net benefit of the program. The results of this analysis are described here, and detailed in Table 8.

Report Assumptions

What if stated assumptions are accurate in this report?

This section of the sensitivity analysis provides a baseline for comparison. The total benefits and costs listed here come from the short-term benefits and cost section of this report. This information is provided for comparison with the changed assumptions that are tested below it.

Benefit Sensitivity Analysis

What if benefits are overestimated in this report?

This section of the table tests the two largest sources of short-term benefits: foster care cost savings to NFC, and benefits that result from supportive housing provided by *Better Together*. If these benefits are overestimated, the net annual benefit for the program will be reduced. In this table, the benefits are reduced by 25% and by 50% (assuming they were overestimated by 50% or 100%). In most cases, the annual net benefit of *Better Together* is still positive even if these benefits are dramatically reduced.

It is important to note that the negative net benefit scenario (if both supportive housing benefits and foster care savings are 50% less than report assumptions) is highly unlikely to occur. Foster care savings figures were provided by NFC, so it is unlikely that the savings calculated in this report are dramatically overestimated. At the same time, the supportive housing benefits used in this report are already a conservative estimate (assumed to be half of the benefit that similar programs have demonstrated). It is unlikely that either of these benefits are overestimated by a large amount, and this test demonstrates how unlikely it is that annual net benefits of *Better Together* would be negative.

Cost Sensitivity Analysis

What if costs are underestimated in this report?

This section tests how short-term costs would change with the inclusion of the cost of a support worker provided by NFC. The monthly cost of this worker is calculated by dividing the cost of the worker ($28,945/year based on data provided by NFC) by 198 client months. This results in a cost increase of $147/client month, and annual net benefits remain higher than $15,000.

Benefit and Cost Sensitivity Analysis

What if benefits are overestimated and costs are underestimated in this report?

The final section of this table combines changed assumptions for both benefits and costs. Even allowing for underestimated costs and significantly overestimated benefits, the final line of Table 8 shows that *Better Together* still provides a net annual benefit per client of $3,330. These results suggest that there is a clear positive net benefit to *Better Together*, and that this positive net benefit does not rely too heavily on any single assumption.

Table 8: Sensitivity Analysis (per client benefits and costs)	Short-Term Costs	Short-Term Benefits	Monthly Net Benefit (benefits-costs)	Annual Net Benefit (Monthly net benefit * 12)
REPORT ASSUMPTIONS *What if stated assumptions are accurate in this report?*				
Report Assumptions *(No changes to benefits or costs)*	$ 2,818	$ 4,220	$ 1,402	**$ 16,824**
BENEFIT SENSITIVITY ANALYSIS *What if benefits are overestimated in this report?*				
Supportive housing benefits 50% of report assumptions (*If supportive housing benefits = $2,500 * .5, short-term benefits decrease to $2,970/month*)	$ 2,818	$ 2,970	$ 152	**$ 1,824**
Foster care savings 50% of report assumptions (*If foster care savings = $1,418 * .5, short-term benefits decrease to $3,511 /month*)	$ 2,818	$ 3,511	$ 693	**$ 8,316**
Supportive housing benefits and foster care savings each 50% of report assumptions (*If supportive housing benefits = $2,500 * .5 and foster care savings = $1,418 * .5, short-term benefits decrease to $2,261 /month*)	$ 2,818	$ 2,261	$ (557)	**$ (6,684)**
Supportive housing benefits and foster care savings each 75% of report assumptions (*If supportive housing benefits = $2,500 * .75 and foster care savings = $1,418 * .75, short-term benefits decrease to $3,241 /month*)	$ 2,818	$ 3,241	$ 423	**$ 5,070**
COST SENSITIVITY ANALYSIS *What if costs are underestimated in this report?*				
Costs including NFC caseworker (*If caseworker pay is included, short-term costs increase to $2,963 / month*)	$ 2,963	$ 4,220	$ 1,257	**$ 15,084**
BENEFIT AND COST SENSITIVITY ANALYSIS *What if benefits are overestimated and costs are underestimated in this report?*				
Supportive housing benefits and foster care savings 75% of report assumptions; costs with NFC caseworker (*If short-term benefits decrease to $3,241 /month and short-term costs increase to $2,963 / month*)	$ 2,963	$ 3,241	$ 278	**$ 3,330**

VIII. Limitations

A number of limitations to this analysis exist, including the scope and significance of measurement tools used, the lack of a comparison group, and the use of client self-reported data. These limitations are detailed below:

- **No comparison group.** The lack of a comparison group means that this analysis relied on an extensive literature review to develop comparisons for *Better Together* client outcomes. A comparison group of similar individuals living in the Omaha area would provide a much more accurate and reliable baseline to which the program could be compared.
- **Mental health measures do not have clinical significance.** Changes in client mental health can be tracked by data collected for this report, but the measures used do not have corresponding clinical cutoff points. This means that it is difficult to estimate the monetary impact of improved mental health. For example, if a client who was clinically depressed is no longer depressed, there are implications for work productivity and health costs that can be identified. However, current measures cannot determine whether mental health conditions exist or have significantly improved through treatment in *Better Together*.
- **All measures are self-reported by clients.** Data on income, health and mental health, employment, education, parenting skills, and child well-being have been collected through client interviews. Independent measures do not currently exist to corroborate the self-reported data, and this decreases the reliability of the data.
- **Program was still in development as data collection began.** Because *Better Together* began in 2014, few clients have reached the end of the two-year treatment timeline. The program also changed entry screening methods and treatment models within the first year of operation, which makes it difficult to compare data across years.

IX. Recommendations for Further Study

The results presented in this report could be confirmed and broadened with the collection of more detailed outcome measurements in several areas:

1. Include a comparison group
   - Develop a comparison group to determine the benefits of *Better Together* when compared to a control group.

2. Adjust data collection methods.
   - Collect data for missing months (between measurement points).
   - Confirm client self-reported medical care usage and criminal justice involvement with program staff.
   - Collect more detailed income data to determine which government programs clients use, and to what extent.

3. Re-evaluate and improve measurement tools.
   - Use measurement tools that have clinically significant markers for trauma and mental health.
   - Introduce tools to measure mental health and trauma of client children.
   - Revisit tools used to measure parenting stress and skills.

4. Collect and analyze longitudinal data.
   - Continue to collect data on an annual basis from clients who have passed the 24-month data collection window.

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