PolicyLab

Report

TO: Pennsylvania Family Support Alliance

FROM: PolicyLab Evaluation Team

SUBJECT: Families in Recovery Implementation Evaluation Final Report

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Children's Hospital of Philadelphia℠

2716 South Street
Roberts Center, 10th Floor
Philadelphia, PA 19146

P 267-426-5300
F 267-426-0380

PolicyLab@email.chop.edu
policylab.chop.edu

Overview

This mixed-methods evaluation sought to identify and understand how contextual factors affect the successful implementation of the Families in Recovery (FIR) program and to assess whether the program has been implemented as intended. The evaluation process engaged stakeholders to understand concepts of program fidelity and implementation across varied sites. The aims of the evaluation were as follows:

1) Identify **best practices** and areas of congruence with other family-centered recovery programming and concepts of fidelity to group program models**.**
2) Understand core **concepts of fidelity and program participation** as perceived by key stakeholders implementing the program.
    a. Understand **families' perspectives** on participating in the program, including perceived benefits and facilitators to quality program implementation.
    b. Understand **instructors' perspectives** on concepts of fidelity to the program model, barriers and facilitators to implementation, perceived outcomes for families, and perceived mechanisms for how the program operates.
    c. Explore lessons learned from **PA Family Support Alliance (PFSA) staff** on program administration and instructor trainings.
    d. Understand **instructors' and PFSA staff's** experiences, barriers and opportunities with data (entry, metrics, processes).
3) **Assess fidelity** to the program model and the **range of implementation approaches** and settings to **inform quality improvement** efforts and **future outcomes evaluations.**

Key Findings & Recommendations

1. **Principles of trauma-informed care are widely accepted and utilized in delivery of FIR.**
   As a core tenet of the FIR curriculum is trauma-informed care (TIC), the evaluation sought to understand the adoption of TIC principles and approaches among FIR facilitators and sites. Evidence of robust TIC knowledge, attitudes, and practice uptake was found in multiple data points. The Nominal Group Technique (NGT) focus group identified that open discussions and creating a safe space were two essential components of implementing FIR, both reflective of TIC principles. Interviews with facilitators and participants highlighted how a strengths-based approach and individualization of services based on a participant's needs were utilized and an

impactful component of the FIR experience. The evaluation team also observed utilization of TIC practices during delivery of FIR Session 4 across sites, with sites most often excelling in the TIC domain and 6 out of 9 sites scoring "Well Developed." Longitudinally, across multiple surveys, facilitators consistently and highly endorse knowledge, attitudes, and practices related to TIC.

Recommendation: These findings may indicate that the FIR TIC curriculum and training components, facilitator education, experience, and background, sufficiently prepares facilitators to deliver FIR in a trauma-informed manner. As such, and given the importance and recognized relevance and appropriateness of TIC frameworks, PFSA should continue to leverage the existing materials and highlight this core component of the model. Continuing education regarding TIC during facilitator cohort calls or refreshers can be built on existing strengths.

2. **Specification of 1) onboarding requirements, 2) recruitment protocols, and 3) programmatic core components will improve implementation processes and program fidelity.**
    a. ***Recruitment challenges remain a barrier to program reach.***
    Several data points indicate that recruitment is a major implementation barrier for many sites. According to data from the Quarterly Reports, of the 20 sites enrolled in the evaluation, only 13 held groups or administered FIR in an individual setting between October 2021-March 2023. During interviews, facilitators noted that they find value in the program but struggle to recruit, enroll, and retain participants. FIR has been well received by facilitators and participants, but recruitment of participants has been a consistent challenge for many locations often related to the quality of referrals received. Organizations have found that while they might be receiving referrals for individuals to participate in the program, potential clients were found to be either unable or uninterested in participating in FIR. The lack of widely available information about the program makes it difficult to orient potential participants to FIR. Participants also noted that they are often pleasantly surprised by the program content and model, suggesting a disconnect between how FIR is being communicated or marketed to them and the actual program experience.

    Recommendation: With recruitment being a challenge for successful implementation, we recommend developing an augmented recruitment plan to the current approach to be developed with sites during onboarding that identifies potential referral pathways, projected outreach and engagement methods, and goals for recruitment. Additional considerations include:
        i. PFSA develop and provide recruitment materials and messaging that clearly and succulently describe the program goals and activities in a way that is accessible and appeals to potential participants. Create written best practices for sites highlighting successful strategies.
        ii. Additional training modules for program administrators in engagement approaches may facilitate client recruitment and retention.
        iii. For PA-based sites, PFSA can also facilitate relationship building and warm, closed-loop referral workflows between new sites and potential referral sources that have an established relationship with PFSA.

iv. The quarterly data tracking system also provides PFSA more real-time monitoring opportunities of site recruitment and retention status and opportunity for ongoing technical assistance.
v. Additionally, FIR sites that have had the most success in recruiting and retaining participants are those that partner with substance use treatment centers, therefore, PFSA should explore lessons learned from the success of those partnerships when onboarding sites and look for additional recruitment sites with similar opportunities.

b. *There is an opportunity to reassess onboarding protocols and technical assistance processes for new FIR Sites.*

While recruitment is one component, limited uptake of program implementation can be moderated by additional structure and supports during onboarding and ongoing technical assistance.

Recommendation: We recommend that PFSA make modifications to their onboarding protocols and create tools that help sites to plan for successful implementation. This can include:

i. The creation of a goodness of fit assessment for interested sites.
ii. A written recruitment plan that maps out referral sources and recruitment strategies.
iii. A predetermined, regularly scheduled number of technical assistance calls during the first year of implementation with iterative adjustments in the frequency of maintenance support based on impact.
iv. An implementation plan that defines core components of the FIR program and model and outlines how sites will operationalize core components.
v. Advance a component of site-based supervisor observations of facilitated sessions to support identification of training needs and ongoing technical assistance.
vi. PFSA would complete at least one FIR Session observation during the first year of implementation.

c. *Facilitators appreciate the flexibility of the model, but guidance on core components and best practices is warranted to improve fidelity to the model.*

As highlighted in the surveys and observations, there are certain components of the program that have variable implementation across sites. Particularly, the role play and interactive activities, the inclusion of homework, the use of both the facilitator and participant guidebook, and agenda- and norm-setting.

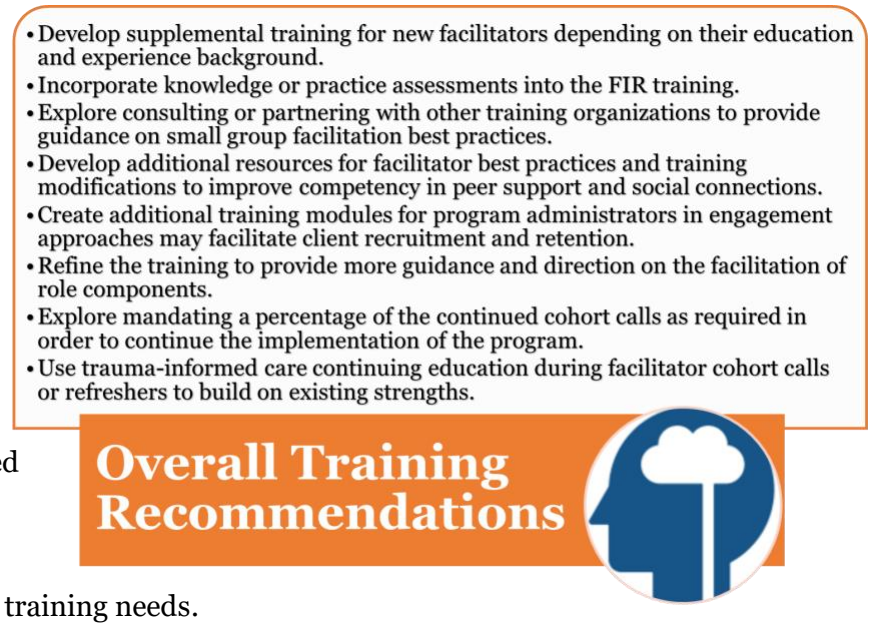
Recommendation: As PFSA evaluates the next iteration of the FIR program, consideration should be given to the balance between the flexibility of the model and the determination of core components that should be present during every session. Once those are decided, guidance should be included in the facilitator guidebook and facilitator training to support fidelity to core components.

Opportunities for variation can be identified through ongoing dialogue and observations with site facilitators and considered for placement within the curriculum and spread across sites.

i. There is an opportunity to translate the Session 4 Observation tool into a self-assessment document that sites can use during supervision and be incorporated into technical assistance calls and implementation support.
ii. Parallel assessment tools should be developed for all sessions to support identification of core curricular components and fidelity assessments.
iii. Create linkages between the facilitator and participant guidebooks to improve facilitators' ability to reference both books during the session and encourage fidelity.
iv. Develop a model of supervisor observations within sites to encourage and facilitate internal fidelity and buy-in.
v. As role play activities are not being conducted as described, PFSA should refine the training and/or curriculum to provide more guidance and direction on the facilitation of role play components.

3. PFSA FIR training is well-received, with opportunities to strengthen cross-discipline competency of the diverse workforce serving as facilitators.

After the PFSA training, most facilitators feel well prepared to deliver FIR, found the training helpful, and appreciated the practical application time to understand the curriculum. Some critical gaps in facilitator knowledge were reported. Additionally, facilitators desired peer support and community within their training experience and found the continuing education cohort calls an effective space to network and discuss issues. Facilitator experience with FIR training and continuing education varied depending on their prior working history, and facilitators from different backgrounds had different training needs.



Recommendation: We recommend that PFSA make modifications to the training program and continuing education requirements. This can include:

i. Develop supplemental training for new facilitators depending on their education and experience background. Due to facilitators varied educational and experience

backgrounds, there are potential blind spots in the FIR training. Facilitators lacking a background in substance use disorder (SUD) expressed the need for additional knowledge on addiction and treatment, while those coming from SUD backgrounds needed further education on parenting and stages of development. For example, while nearly all facilitators "strongly agreed" or "agreed" that knowledge of parenting and child development were a high priority for their clients, though an average of 60% reported mastery-level competency in this area. Facilitators who do not have a child development or parenting education background would need additional training and support to better facilitate this core component of the model. By creating breakout sessions by experience or competency level for additional training modules, FIR facilitator training would be able to address the varied backgrounds of facilitators and give more space for clarification and education for some without covering material that is review for others.

ii. To further access facilitator competency and knowledge retention during the training, we suggest incorporating knowledge or practice assessments into the FIR training.

iii. Explore mandating a percentage of the continued cohort calls as required in order to continue the implementation of the program. Cohort calls are beneficial in providing a space for peer support and mentorship between FIR facilitators, as well as an opportunity to provide continued educational material as new recommendations go into effect within the program.

4. **Virtual implementation of FIR continues to be utilized but with variable implementation practices across sites.**

During the evaluation period, nearly half of active sites, 6 out of 13, delivered FIR in a virtual format. Facilitators and participants both appreciate the flexibility and convenience of virtual facilitation and saw it as a mechanism to increase recruitment and support caregivers who have many competing demands. Concurrently, stakeholders also noted some of the drawbacks to virtual delivery, including difficulty connecting and building relationships, and distractions that may be present in the home or place where they are joining from. Sites have had to weigh the benefits of virtual implementation with the potential drawbacks. In addition to the facilitator and participant perception of virtual implementation, the actual practices used by sites often do not align with established virtual delivery best practices. All three sites where the team observed a FIR session virtually scored "Needs Improvement" in that domain, and fidelity observations also revealed challenges in translating the curriculum activities to a virtual setting. The fidelity data in Survey 2 and Survey 3 consistently found variation in session length, security and stage-setting measures, and facilitation methods.

Recommendation: As previously noted and discussed, we recommend that PFSA create and test a guidebook addendum with virtual facilitation best practices or a virtual-specific facilitator guidebook. Facilitators who implement the program virtually have found their own resources to keep the session engaging and may lack the materials and resources to successfully deliver the curriculum to participants as intended. As such, it would also be beneficial to modify activities to be delivered in a virtual setting and provide sites with visual aids or resources, such as slide decks or videos.

5. **Facilitator "soft skills" are a key element of program reception.**
In understanding the perception of FIR among participants, they almost universally praised the work of facilitators and credited their personalities, humor, lack of judgment, and particularly their relatability, as key components of what made FIR a positive experience. Participants cited relatability as an important component in perceiving their facilitator to be knowledgeable and in creating a comfortable environment in which to learn. When facilitators took the time to convey genuine interest and knowledge of their individual lives, participants noticed and appreciated this effort. In the NGT focus group, facilitators equally understood the importance of a strengths-based, non-judgmental approach to successfully implementing FIR.

   Recommendation: During onboarding communications and training of new FIR facilitators, we recommend that PFSA highlight the intangible or soft skills necessary to connect with participants. Building rapport and creating a safe environment, key elements of facilitation best practices, should be emphasized in materials to sites and facilitators.
      i. PFSA may explore consulting or partnering with other training organization to provide guidance on small group facilitation best practices.

6. **Peer support and social connections remain an important component of FIR with an opportunity to strengthen formal and standardized program practices in this domain.**
Facilitators and administrators consistently endorsed that two of the top three intended impacts of FIR on clients were related to strengthening families' networks of support and social connections through the program, priorities of the Strengthening Families Protective Factors (SPPF) framework and of FIR. While the surveys found that over 97% of respondents "strongly agreed" or "agreed" that social connections were a high priority for clients, only an average of 34% said they felt they had a mastery-level competency in this area. 92% of respondents agreed or strongly agreed that FIR is effective at increasing participants' peer and/or social support; however, when asked how effective, the majority (61%) reported that the program is only slightly or moderately effective. Facilitators also identified during interviews that the curriculum does not adequately create opportunities or coach facilitators to generate peer support or meaningful relationships between participants. Participants repeatedly credited being in FIR with making them feel less alone and increasing feelings of connectedness, but there was mixed success in developing lasting peer relationships through the program. Some of the identified barriers included participants in different stages of recovery, triggers limited anonymity in small communities, the lack of continuity in relationships beyond FIR sessions, and access to other community resources. Despite these challenges, building the social and peer support aspects of FIR remain crucial for meeting the social isolation need of participants.

   Recommendations: Considering the identified importance of peer and social support from both participants and facilitators, we recommend that PFSA:

      i. Revise the facilitator and participant guidebooks to include additional activities, discussion prompts, handouts, and/or text to support the program's goals related to peer connections.
      ii. Develop curricular modifications, additional resources for facilitators, best practices, and training support.

iii. Incorporate and inform training and technical support from the team-science literature. Consider partnering with agencies experienced in team-science to augment PFSA training expertise to expand opportunities to train specifically on group dynamics and team-building among FIR sites and PFSA staffing to support the development of group dynamics and team-building among program participants.
iv. As facilitators consistently ranked Session 7 – Bridging the Gap: From Here to Home as the weakest and least competent session, consider curriculum revisions to strengthen this session and the program's aftercare planning components.
v. Develop a comprehensive aftercare plan and mapping of community resource connections into implementation plans for onboarding sites.
vi. Identify and create supplemental programming to increase social support, including extracurricular activities with program participants.
vii. Build in socialization time and structures into the session programming.
viii. Offer an in-person component for virtual attendees.

7. **Theoretical framework for FIR should be included in program materials.** Members of the Community Advisory Board (CAB) noted that there were distinct similarities between content in the FIR guidebooks and principles of the 12-Step model and programming. As there are mixed opinions in the recovery and SUD field about the use and efficacy of 12-Step, the evaluation team wanted to understand participant perspectives on these elements of the FIR curriculum. Interviews with participants found that most individuals who had previous experience with a 12-Step program spoke of and noted similarities with FIR neutrally. While some participants had negative feelings about 12-Step programs, the similarities between FIR and 12-step programs were viewed as negative.

   Recommendation: As PFSA plans curricular modifications and an outcomes evaluation, we recommend including details of the FIR model's theoretical framework in the facilitator and participant guidebooks and in communication to potential new sites. Consider building in transparency between the overlap and distinctions between the FIR approach and 12-step programming during FIR site trainings and curricular delivery.

Activities & Methods

We used a mixed-methods approach to evaluate the implementation of FIR. The evaluation team developed a quarterly report and longitudinal surveys to measure concepts of implementation across sites, including organizational infrastructure and culture, community needs, implementation readiness, facilitator experience, and fidelity. We also used qualitative methods to understand stakeholder perspectives and conducted a focus group (NGT) along with participant and facilitator interviews. Lastly, to further understand implementation and fidelity to the model, the team developed an observation guide and observed FIR at implementing sites.

Best Practices Research:
We reviewed the literature on best practices in family-centered recovery programming and concepts of fidelity to group programming, which informed the development of stakeholder engagement tools including the surveys and interview guide.

Community Advisory Board:
The purpose of the CAB was to develop a shared understanding of the evaluation process and its findings. The four members were Christine Glover, Project Coordinator of Joining Forces for Children at Penn Medicine Lancaster, Keli McLloyd, Deputy Director of the Opioid Response Unit at City of Philadelphia Managing Director's Office, and Kelli M. a former FIR participant at Greene County Human Services Family Center, and Essence Hairston, Director of Outpatient Services at University of North Carolina (UNC) Horizons. Members shared opinions on evaluation procedures and materials, including interview guides, surveys, and observation plans; provide feedback on evaluation progress, project challenges, and findings. The CAB met quarterly between February 2022 – June 2023, for a total of 6 meetings. Members provided feedback on evaluation activities, participant interview guide, site observation guide and protocol, and peer support components of FIR, and evaluation findings.

Focus Group:
To identify and generate consensus on the most important components of the FIR program as perceived by facilitators, members of our team conducted a focus group of five experienced FIR facilitators using the Nominal Group Technique (NGT) to support the development of consensus among participants. Facilitators were chosen based on their levels of experience with FIR and to represent a diversity of facilitation settings. This method generated a prioritized list of FIR components that the group agreed were most important to the facilitation of the program.

Quarterly Reports:
With PFSA, we developed a report to collect process metrics and program updates from each implementing site on a quarterly basis. The report will be used for ongoing monitoring and evaluation of the local and contextual factors that may be impacting successful implementation, provides an opportunity for more formalized technical assistance, and will help sites to monitor their progress in recruitment and retention. Quarterly report data was collected during FY22 Q2-Q4 and FY23 Q1-Q3.

Baseline Introduction Calls:
We met with each of the existing implementing sites (n=21) to review the new Quarterly Report template and collect demographic and baseline information regarding implementation plan and progress, challenges, and changes since starting FIR. Meetings occurred between October and March, 2022.

Longitudinal Surveys:
Longitudinal surveys were developed and disseminated at three time points to access program implementation and fidelity. The three surveys were administered as follows:

Table 1: Survey Timeline

Survey	Participant(s)	Baseline	6 months	12 months
FIR Longitudinal Survey	FIR Facilitators & Administrators	**October 2021-March 2022**	**April 2022-July 2022**	**October 2022-January 2023**

The baseline survey set the foundation for evaluating implementation at each site. The questions were completed by facilitators and/or leadership identified by each site. The baseline survey sought information on the activities and programs, both internal and external to FIR implementation. The majority of questions related specifically to implementation and facilitator capacity, while some were included to gather important contextual information about FIR with the potential to inform technical assistance and training efforts. These surveys were guided by the Consolidated Framework for Implementation Research (CFIR), the Center for the Study of Social Policy's Strengthening Families and Protective Factors Framework, and change and implementation readiness principles. The 6- and 12- month surveys included additional questions on fidelity and were informed by the NGT focus group, interviews, PFSA feedback, and FIR curriculum.

Site Observations:
We developed an observation tool to understand how the FIR program is being used, facilitated, and implemented across sites. The tool was designed to specifically observe Session 4 and incorporates key elements of the FIR curriculum, feedback from PFSA and the CAB, best practices review, and findings from earlier evaluation activities including the NGT focus group, facilitator interviews, and longitudinal surveys. The sessions were assessed in four domains: 1) Key Session Components; 2) Facilitation; 3) Physical Space or Virtual Space; 4) Addressing Barriers & Additional Needs. Observations are then scored by fidelity domains. For each item, a score of 3 indicates that there is evidence of at least 75% of listed practices, and a score of 2 indicates that there is evidence of between 51% and 74% of listed practices. A score of 1 indicates that there is evidence between 25%-50% of the listed practices, and a score of zero means there is less than 25% of listed practices. These are then averaged by domain and then averaged to an overall score of "Well Developed," "Moderately Developed," "Minimally Developed," or "Needs Improvement." Sites were chosen based on which were active and implementing groups during the evaluation period. Observations occurred between August 2022-May 2023.

Facilitator & Participant Interviews:
Individual interviews with FIR facilitators were conducted to: 1) assess program barriers and opportunities in implementation; 2) understand perceived program outcomes and mechanisms for impact from their perspective; and 3) explore any content facilitators may not feel comfortable discussing in group settings or during site observations. The interview guide was developed following CFIR to understand the implementation dynamics underpinning stakeholder priorities (i.e., characteristics of the intervention, the outer setting, the inner setting, the characteristics of individuals, and the process). Content explored included core components of the intervention; strengths and challenges to widespread dissemination, program initiation and uptake, program fidelity, and local adaptation; stakeholder perspectives on assessment and measurement; and perceived mechanisms of impact. Interview participants were purposively sampled across implementation factors including site implementation status, small group facilitation experience, and FIR facilitation experience. To be eligible to participate in an interview, facilitators must have completed at least one FIR cohort.

The team also conducted semi-structured interviews with former FIR participants to understand their experiences with the program, including their perceptions of program outcomes and mechanisms for impact, barriers and opportunities for implementation and any other feedback about the program using the CFIR framework and informed by the FIR model.

The interviews were conducted by four PolicyLab researchers trained in qualitative research methods. The interviews were audio-recorded, transcribed verbatim, and de-identified.

To analyze interview data, the study team created a codebook based on a priori themes related to our research aims, joined with de novo codes emerging from a preliminary review of the interviews. A priori codes were based on CFIR, NGT focus group findings, evaluation goals, and best practices review. Our analysis focused on facilitators and barriers to implementation and participate and facilitator experience, expecting that this information would be valuable to future implementation, quality improvement, and evaluation efforts. Three members of the study team trained in NVivo, a software used for qualitative and mixed methods data analysis, then double-coded a subset of transcripts and met to resolve coding discrepancies and adjust the codebook structure or definitions when necessary. The remaining transcripts were then independently coded according to the final codebook.

Best Practices Review

When creating an evaluation plan for assessing FIR, it was important to understand best practices in the following areas: TIC, small group facilitation and programming, and family-centered recovery programming. Selected summary findings that informed our evaluation design are included below.

Small-Group Facilitation and Programming:
Facilitation and the facilitator role heavily influence the impact and success of FIR. As such, much of this implementation evaluation focuses on facilitator experience, perspective, and characteristics. When reviewing the literature to understand facilitation best practices, we identified research that ranked facilitator primary tasks and created a model of small group facilitator competencies.[1] The model, grounded in small group theory, is an interplay between the following competencies: 1) Communication: listens actively, observes nonverbals, uses questions skillfully; 2) Task: helps with purpose and ground rules; 3) Relationship or climate: creates a supportive climate, encourages group involvement, handles disruptive individuals, and adheres to ground rules; 4) and Organization: plans the meeting and completes necessary follow-up. **Our evaluation tools, including surveys, interview guides, and observation guide, assess established competencies of small-group facilitation, including but not limited to: active listening, monitoring group dynamics, encouraging group involvement, and adhering to an established time frame.**

Trauma-Informed Care and Approaches:
A core tenet of the FIR curriculum is TIC. As such, it was important to evaluate site and facilitator use of TIC practices during FIR groups. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies six key principles of a trauma-informed approach, which include: 1) Safety; 2) Trustworthiness and Transparency; 3) Peer Support; 4) Collaboration and Mutuality; 5) Empowerment, Voice and Choice; 6) Cultural, Historical, and Gender Issues.[2] To assess the adoption of these principles and approaches, we utilized the 21-item survey tool, "Knowledge, Attitudes, and Practices of Trauma-Informed Practice," which was validated to assess Knowledge, Attitudes and Practices (KAP) related to TIC among healthcare professionals in a pediatric institution and found to be relevant to FIR facilitators.[3] The KAP method is a reliable and valid method to enhance KAP around a specific theme, establish baseline data, and suggest learner-centric intervention strategies.[4] Additionally, TIC needs to translate and be assessed in the virtual setting. Trauma Informed Oregon, a leading interdisciplinary collaborative promoting evidence-based TIC practices, developed strategies for hosting virtual meetings that promote safety, power, and value, informed by SAMHSA's six TIC principles. These strategies provide best practices for facilitators seeking to foster a space where participants are present and accessible, and their exposure to activation and re-traumatization is mitigated.[5] **These strategies informed the development of evaluation tools to assess trauma-informed care in the virtual delivery of FIR.**

Family-Centered Recovery Programming:
As research and practice have shown that family dynamics can be significantly impacted by substance use disorders, revolving around behaviors of the person who is struggling with some form of addiction.[6] Altered family dynamics due to addiction can cause emotional turmoil, poor communication, and weakened trust.[7] Failing to address these concerns can be harmful to all family members, particularly individuals with substance use disorders. Programming that addresses these specific problem areas and engages all individuals within the family unit can be immensely beneficial for not only recovery, but longstanding change.

Studies show that service providers who adequately understand the addiction experience, system shortcomings, and system success were better equipped to handle the unique challenges of family-centered recovery.[8] More specifically, these providers had a comprehensive emotional understanding of how addiction influences families and awareness of the perceived guilt and shame parents and caregivers facing addiction may experience when dealing with treatment agencies/programs.[8] They also recognized the value of individuals taking leadership or expert roles in structuring their own care with their providers.[8] Through utilizing these specific tools, providers were able to empower and improve self-efficacy of families and patients along their recovery journey.

Additionally, research has shown that group sessions centered around child-appropriate therapeutic models have clear positive findings, as the fear, shame, doubt, and guilt common for parents in traditional therapy models decrease within family-adapted sessions.[9] Family-adapted sessions can empower parents by providing tactics to communicate about addiction and recovery and better understand their children's perspectives.[9] Shifting supports to be more family-focused may be more relevant for caregivers with substance use disorders by addressing environmental stressors, parenting, family growth, and other considerations relevant to this specific subgroup[9-11]

Recovery can be an intergenerational process, even if addiction is specific to only one family member. Many family-centered recovery practices are included in the FIR curriculum and incorporated into the PFSA facilitator training. However, it is important to understand if or how practices are adopted at implementing sites. As such, our evaluation tools were created to assess agency culture and facilitator competencies and perspectives regarding supporting families impacted by SUD.

Focus Groups

The NGT focus group members individually identified 20 components of FIR that they felt were essential to implementing the program and came to a consensus on eight of the 20 as the most important. The top eight components and their definitions as described by the group are listed below alongside their rank by the group.

Table 2: Focus Group Consensus on Essential Components of Implementing FIR

Rank	Component	Definition
1	Location	Program is facilitated in a location that is nearby, comfortable, and accessible for participants.
2	Open Discussions	Facilitators create balance in how much information is shared and opportunities to hear others share. Facilitators support this exchange of information rather than serve as "experts."
3	Creating Safe Space	Facilitators set the stage for the group to be confidential, comfortable, aware of potential triggers, and rooted in honesty.
4	Curriculum Fidelity	Program is implemented with fidelity to what is in the guidebook and trainings.
5	Parallel process	Emphasis on the parallel processes of ending cycles of intergenerational trauma and addiction and creates awareness of intergenerational parenting styles and effects.
6	Reducing barriers to participation	Sites find ways to reduce barriers to participation, for example providing onsite childcare and transportation.
7	Incentives	Sites provide incentives for attending sessions including meals, physical items for families (games for bonding, diapers, etc.), or certificates of completion at the end of the program.
8	Strengths-based	Facilitators are non-judgmental and approach the program with a strengths-based lens.

This table represents qualitative data from a focus group of experienced FIR facilitators using the Nominal Group Technique.

The NGT findings and related discussion informed the development of fidelity tools. Facilitators in the focus group mostly identified key tenets of good facilitation, rather than particulars of the curriculum, as the most important components of implementing FIR. This supports the effort to understand fidelity to program requirements for setting the stage, preparing the physical space, and facilitation techniques. It also suggests that fidelity metrics related to preparing a virtual setting, incorporating trauma-informed practices, and reducing barriers to participation are key to understanding successful implementation of the FIR model.

Session Observations

During the evaluation period, the team observed FIR Session 4 at 9 sites. The types of sites, delivery methods, and scores are included in the table below.

Table 3: FIR Observation Details (n=9)

Site Type	Number
Child Welfare	2
Family Support	6
Behavioral Health	1
Delivery Method	
Virtual	3
In-Person	7
Score	
Well Developed	2
Moderately Developed	6
Minimally Developed	1
Needs Improvement	0

Within the observation guide content areas, sites were most often well developed in trauma-informed care, with 6 of the 9 sites scoring well-developed. Use of the guidebook was consistently found to be moderately developed at 8 of the 9 sites, with 1 minimally developed. The two items within this content area that were not observed at any site included "A facilitator discussed at least one of the additional probes provided in the facilitator workbook" and "Facilitator referenced the resource section of the guidebook". The lack of overlap between the facilitator guidebook and participant guidebook may make it challenging for facilitators to identify and use the additional probes in the facilitator guidebook during a session.

There was also variability in how sites presented the session content. While 100% of the sessions included an ice breaker, 5 of the 9 sessions included an agenda or overview of the session. Most strikingly was the variability in the delivery of the communication and parenting styles activities. Sites delivery of this element of the curriculum ranged from simply having a discussion about the topic to fully recreating the suggested scenario or activity outlined in the guidebook. Only 2 sites conducted both the parenting and communication styles activities as described. The parenting styles activity was conducted as described at 5 sites, while the communication style role play activity was conducted as described at 4 sites.

Overall, sites were well developed in the logistical components that were explicitly suggested or included in the FIR training, including the sessions being co-facilitated, starting on time and lasting 1.5-2 hours. None of the sites had participants complete an exit survey, and only 2 sites provided information about resources after the session. All but 2 sites had FIR sessions that lasted between 1.5-2 hours, and only one session was not co-facilitated or typically co-facilitated.

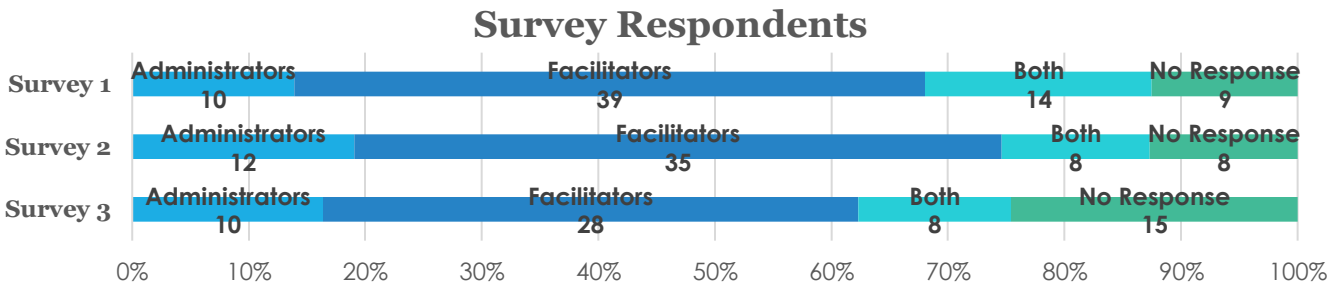
When assessing facilitation best practices, there was a range of levels of development. 2 sites were well developed, 5 moderately developed, and 2 minimally developed in this area. The inclusion and assignment of homework were infrequently utilized, while reflective listening, humor, and engaging all participants were widely adopted.

While those facilitating FIR in person were well developed in incorporating best practices to create a physical space that is welcoming and conducive to learning, there was little incorporation of best practices into virtual FIR delivery. All three sites who delivered FIR virtually scored needs improvement in this domain. During the sessions we observed, there was little discussion of maintaining confidentiality in a virtual space, no use of polling, chat boxes, or breakout rooms, little choice regarding cameras being on or off, and no virtual boundary setting. While we only observed one session at each site, and these elements may have been addressed during earlier sessions, there is an opportunity to provide guidance to sites regarding virtual facilitation best practices.

Surveys

The facilitator and administrator surveys occurred at three time points to provide data on implementation over the course of a year. The baseline and follow-up surveys sought information on the activities and programs, both internal and external to the implementation of FIR. The questions related specifically to implementation and facilitator capacity, and gathered important contextual information about FIR that may shape technical assistance and training efforts. The surveys were guided by CFIR and the Center for the Study of Social Policy's Strengthening Families and Protective Factors Framework. Additional items were informed by baseline survey results, facilitator focus group, facilitator interviews, and a review of FIR resources and documents.

Survey Response:
To begin the first survey, we conducted phone calls with at least one administrator and one facilitator at each of the 21 participating sites between September 2021 and March 2022, as additional sites were added to the evaluation. In some cases, additional key staff members joined the call. Individual surveys were sent to administrators who participated in the call and all facilitators at each site immediately following the baseline call. Survey 1 was sent to 72 facilitators and administrators at 21 sites. 63 individual surveys were completed with a response rate of 88%, representing all 21 sites. This includes 10 administrators, 39 facilitators, and 14 who identified as both administrators and facilitators. %. For survey 2, 51 individual surveys were completed, with a response rate of 79%. Between the dissemination of Survey 1 and Survey 2, 8 respondents discontinued association with the implementing site or facilitation of FIR. Survey 3 was sent to 61 facilitators and administrators. 46 individual surveys were completed with a response rate of 75%, representing all 20 sites. The total number of Survey 3 disseminated declined due to staff turnover and transitions.



Site Context:

To understand site context and readiness to implement the FIR program, we asked sites about their existing program offerings. Every site reported that they also deliver another group program, and 12 sites reported offering other SUD or recovery-focused programming. 17 of the sites offer other programs that incorporate the Strengthening Families Protective Factors Framework, which informed the FIR curriculum, primarily Parent Café, Parents as Teachers, Nurturing Parents Programs, and Positive Parenting Program (Triple P). Sites vary in terms of agency type, as summarized in the table below. During the course of the evaluation, one site discontinued FIR participation and was excluded from Surveys 2 and 3, thus there were 21 sites for the baseline and 20 across all 3 surveys. Sites had to complete FIR training by March 2022 to be included in the survey data collection.

Table 4: Number of Sites by Agency Type (n=20)

Agency Type	Number	Percent
Behavioral Health	**3**	**15%**
Child Welfare Services	**4**	**20%**
Drug and Alcohol Treatment	**2**	**10%**
Family Support	**11**	**52%**

This table represents data from FY 2022 Q2 and Q3 Quarterly Reports and Baseline Survey Calls

Recruitment & Representation:

There are varied recruitment strategies reported by sites. Most frequently, sites are recruiting internally from other programs at their organization or from external partner agencies, rather than recruiting from the broader community through channels like social media or flyers. To better understand the inclusion and accessibility of the groups, we asked about racial, ethnic, and linguistic representation at each site. 18 of the 20 agencies felt their facilitators reflected the racial, ethnic, or linguistic identities of their participants and three said they plan to or have staff who can offer FIR groups in languages other than English. All three noted that Spanish was the secondary language they were looking to offer but that currently the workbooks are only in English.

Facilitator Experience Levels:

To get a baseline understanding of facilitators' experiences and comfort implementing FIR programming, we asked facilitators about their experiences prior to this program. (53 facilitators responded across 20 sites)

Small group facilitation experience:

- 23 facilitators said they had at least 5 years of experience
- 10 facilitators said that this was their first time facilitating a small group
- 14 sites had at least one facilitator with at least 5 years' experience
- 2 sites had only facilitators with no prior small group facilitation experience

Professional SUD and or/recovery experience:

- 27 said they had five or more years' experience with this population
- 7 facilitators said this was their first time working with this population
- 1 reported being a Certified Peer Recovery Specialist
- 1 reported currently participating in other SUD or recovery-focused work outside their role with the implementing organization
- 16 sites had at least one facilitator with at least 5 years' experience
- 0 sites had only facilitators with no prior experience with this population

PFSA Training:

PFSA training was frequently mentioned in the baseline survey call as the most helpful way to prepare to implement FIR. Individual survey responses reiterated this perspective: of the 43 facilitators who reported attending a PFSA training, 37 said they felt "very well prepared," "well prepared", or "prepared" to facilitate the program after attendance. Notably, six said they felt "somewhat prepared" or "not prepared."

Intended Impacts on Clients:

To better understand sites' varying goals for implementing FIR in their communities, we asked survey respondents to identify the top 3 impacts of FIR on their clients, staff, and organizational cultures. Response choices were informed through a mixed of FIR programmatic goals, PFSA input, interviews with key informants, and the Strengthening Families Protective Factors Framework (SFPFF). While impacts on staff and organizational culture varied across respondents, there were clear leading impacts for clients. **As shown in the table below, there was consistency across all three surveys. Two of the top three intended impacts are related to strengthening families' networks of support and social connections through the program, priorities of the SFPFF framework and of FIR.**

Table 5: Impacts of FIR on Clients as Perceived by Implementing Staff

Rank	Clients	Number of Responses			Percent		
		Survey 1	Survey 2	Survey 3	Survey 1	Survey 2	Survey 3
1	Families with SUD understand their strengths and networks of formal and informal supports	56	36	34	89%	88%	87%
2	Increased Self-Efficacy and Resiliency	46	28	29	68%	68%	74%
3	Increased social connection with other families	41	22	24	65%	54%	61%

Survey 1, Section 3, Question 1, Survey 2, Section 4, Question 1, and Survey 3, Section 4, Question 1

Perceived Impact of Curricular Topics and Self-Reported Mastery of Curricula:

Social connections and knowledge of parenting and child development were consistently rated as highest priority topics.

- In Survey 1, Survey 2 and Survey 3, **over 97% of respondents "strongly agreed" or "agreed" that social connections were a high priority** for clients, while an only average of **34% said they felt they had a mastery-level competency in this area**.
- 92% of respondents agreed or strongly agreed that FIR is effective at increasing participant's peer and/or social support; however, **when asked to how effective, the majority (61%) reported that the program is only slightly or moderately effective.** As building social connections with peers is a key component of the FIR model, this suggests an opportunity for improvement around promoting and supporting peer social connections during and after the 7 sessions.
- **Nearly all respondents "strongly agreed" or "agreed" that knowledge of parenting and child development were a high priority for their clients and an average of 60% felt that they had mastery-level competency in this area.** This higher level of competency likely reflects the professional background of most FIR facilitators as home visitors, parent educators, or other child development and family support specialist roles, and signals the importance of training and support around topics that are outside many facilitators' expertise as well as supplemental training to augment existing professional experience.

Highest priority Strengthening Families Protective Factors topics:

- Social Connections
- Knowledge of Parenting and Child Development

Session Priority and Competency:
Further, we asked facilitators to rate their perceived priority of each session to participating families and their level of competency (mastery) with facilitation.

Highest Priority Sessions:

- Survey 1
  - Session 4- The Bigger Picture: How Family History Influences Parenting and Communication Style
  - Session 6- Healthy Self & Family Wellness
- Survey 2
  - Session 5 – Discipline & Development
  - Session 6- Healthy Self & Family Wellness
- Survey 3
  - Session 3 – The Stages of Change
  - Session 5 – Discipline & Development

Highest Mastery Sessions:

- Survey 1
  - Session 5 – Discipline & Development (47%)
  - Session 4- The Bigger Picture: How Family History Influences Parenting and Communication Style (42%)
- Survey 2
  - Session 5 – Discipline & Development (35%)
  - Session 6- Healthy Self & Family Wellness (29%)
- Survey 3
  - Session 5 – Discipline & Development (48%)
  - Session 4- The Bigger Picture: How Family History Influences Parenting and Communication Style (48%)

In terms of competency, just as facilitators felt most competent with parenting and child development topics in the above findings, facilitators reported mastery in facilitating Session 5, Discipline & Development consistently across all 3 surveys. Session 4, which was considered by most to be high priority for clients, was a close second with a large percentage of facilitators reporting mastery-level competence. **The lowest rate of mastery competence was with Session 2, Serenity & Courage,** for which only 6% of respondents felt they had mastered the session in Survey 1 and 2. However, by Survey 3, the 31% of respondents felt that had mastered the session. **Despite low rates of mastery for some sessions, across all surveys there were at least 89% of facilitators who felt at least competent (rather than not competent or basic competency) for each of the sessions.**

<u>These responses suggest a strong relationship between perceived facilitator competency with a session and perceived strength of the session for participants.</u>

Ranking of Sessions:

Overall, there is a clear consensus that Session 7 is perceived as the weakest and that with least facilitator perceived competency. There was some variability in the selection of the strongest session overtime, with Session 4 narrowly chosen in Survey 2 & Survey 3. The sessions with the most perceived facilitator competency included Sessions 1, 4, and 5. This highlights facilitators' comfort with domains of parenting, child development, and discipline which is consistent with the professional makeup of many FIR facilitators as home visitors, parent educators, or other child development and family support specialist roles.

Ranking of Sessions:

Survey 1
Strongest- Session 1: Strengths & Needs (46% chose as strongest)
Weakest- Session 7: Bridging the Gap: From Here to Home (62% chose as weakest)

Survey 2
Strongest- Session 4: The Bigger Picture: How Family History Influences Parenting and Communication Style (36% chose as strongest)
Weakest- Session 7: (71% chose as weakest)

Survey 3
Strongest- Session 4: The Bigger Picture: How Family History Influences Parenting and Communication Style (24% chose as strongest)
Weakest- Session 7: (58% chose as weakest)

Virtual Facilitation:

Virtual facilitation continues to be a common practice. In Survey 2, of the 30 facilitators surveyed who facilitated at least 1 FIR group, 16 last implemented a group in person and 14 implemented a group virtually. In Survey 3, 10 last delivered FIR virtually and 17 in person. The quarterly reports indicate that between March 2022 and March 2023 31 groups were completed in person and 6 groups were completed virtually. As we know that almost half of the active sites are implementing virtually, we included virtual group best practices into measures of fidelity although none of these items are described in the facilitator guidebook. As also seen in the observations, respondent's answers to methods used virtually varied widely in terms of norm setting and structure of the session. Security measures like a waiting room, secure link, or password were frequently utilized, while proving off camera options and tools to encourage participation were less consistently used. Importantly, session length was particularly varied between in-person and virtual groups. In Survey 2, **13 of the 16 in-person facilitators reported that sessions always lasted 1.5-2 hours, while only 7 of the 14 virtual reported the same.** In Survey 3**, the gap narrowed**, with approximately **70% of all facilitators, in both groups, reporting that sessions always lasted 1.5-2 hours.**

Trauma-Informed Care:

As similarly noted in the FIR Session 4 observations**, facilitators consistently and highly endorse knowledge, attitudes, and practices related to TIC.** Across both Survey 2 and Survey 3, **more than 90% of respondents strongly agreed or agreed with items related to knowledge of TIC**, such as retraumatization can occur unintentionally, trauma affects physical, emotional, and mental well-being, and substance use issues can be indicative of past traumatic experiences or ACES.

Similarly, high agreement with attitudes related to TIC and trauma-informed practices (TIP) such as I have a comprehensive understanding of TIP and I believe and support the principles of TIP showed more than 95% of respondents agreeing or strongly agreeing. When assessing the practice of TIC, **there continued to be high agreement on items such as maintaining transparency, helping participant recognize their strengths, and tailoring interactions to the specific needs of each participant.**

Notably, the one item with less agreement, was "I would like to receive more training on TIP." Only 86% and 71% in Survey 2 and Survey 3, respectively, strongly agreed or agreed with this statement. In looking at responses by site type, the largest decline between Survey 2 and 3 occurred among Family Support sites, where 91% strongly agreed or agreed in Survey 2, while only 68% responded similarly in Survey 3. **These findings, along with the high TIC fidelity seen in the observations, may indicate that the FIR TIC training components and facilitator education, experience and background, sufficiently prepares facilitators to deliver FIR in a trauma-informed manner.**

Measuring Fidelity to the Program Model:

We asked facilitators whose sites had begun implementing the model about the last FIR cohort they facilitated to assess if components of the program were being implemented as intended. A total of 24 facilitators answered these sets of questions in both Survey 2 and Survey 3.

Key group facilitation components:

- 93% formed a group agreement during the first session (develop list of norms and rules)
- 89% provided overview of entire program before the start of the program
- 89% shared their contact info shared with participants
- 56% held orientation session or 1-on-1 meetings for all participants

Facilitators were also asked to indicate how often the following components of FIR occurred across all seven sessions of the last cohort they facilitated, ranking each item as occurring Always, Usually, Sometimes, Rarely or Never.

Key components of session content:

- 75% of facilitators always or usually read aloud from workbook during session
- 92% always or usually use participant workbooks during the session
- 88% always or usually include ice breakers
- 83% always or usually use additional probes provided in the facilitator workbook

We included measurements of fidelity to activities and components of FIR that are provided in the facilitator guidebook. These were also informed by the focus group, where experienced facilitators emphasized the importance of physical space set up and tenets of high-quality small group facilitation.

Key components of session facilitation:

- 54% always or usually provide information about community resources after each group
- 75% always or usually assign participants homework for the next session
- 83% of sessions are always or usually co-facilitated
- 94% always or usually ensure all participants have fair opportunities to share in the group

Interview Findings

Interviews with facilitators and participants provided an opportunity to delve into the perspectives and experiences of those with firsthand knowledge of implementing and experiencing FIR.

Table 6: Facilitator Interviews: Interviewee Background

Site Name	Number of FIR Cohorts Facilitated	Facilitator Small Group Facilitation Experience
Blueprints	1	3-4 years
Centre County Youth Service Bureau	2	none
Champion State of Mind	2	5+ years
Child Inc.	2	5+years
Children's Home Society of Florida	2	5+ years
Columbia County Family Center - Bloomsburg	3	1-2 years
Crawford County Drug and Alcohol Executive Commission Inc.	2	2-4 years
Families First Parent Resource Center	1	5+ years
Family Service Association of Bucks County	5	none
Greene County Human Services- Family Center	7	none
IU 25 - Delaware County	2	5+ years
Lawrence County Children's Advocacy Center	4	none
Monessen Family Center	7	5+ years
Northumberland County Children & Youth Services	1	1-2 years
Wesley Family Services	1	5+ years

This table represents data from Facilitator Interview Demographics Surveys

Table 7: Participant Interviews: Interviewee Background

FIR Site	N (%)
Centre County Youth Service Bureau	1 (7.7%)
Child Inc.	2 (15.4%)
Children's Home Society of Florida	2 (15.5%)
Columbia County Family Center - Bloomsburg	1 (7.7%)
Crawford County	1 (7.7%)
Greene County	2 (15.4%)
Monessen Family Center	1 (7.7%)
Wesley Family Services	3 (23.1%)
Age Range	
18-20	1
21-30	1
31-40	7

41-50	2
51-60	2
Gender	
Man	2
Woman	11
Race	
Black or African American	2
White	11
Hispanic or Latino origin	
Yes	0
No	13
Education {highest level completed}	
11th Grade	1
College Degree	2
High School Diploma	7
Some College	3
Marital Status	
Divorced	2
Legally Separated	2
Married	1
Single	8
Number of Children	
1	4
2	4
3	4
4	1
Age of Children	
Infants (1 month to 12 months)	1
Young Children (1 year through 5 years)	4
School age children (6 years through 12 years)	
Adolescents (13 years through 17 years)	4
Adult	5
No response (question was added after interview)	8

This table represents data from Participant Interview Demographics Surveys

Recruitment

Facilitators highlighted recruitment as a challenge. Facilitators were happy with the FIR curriculum and found it valuable but reaching participants who would be interested and benefit was a key issue with implementation. Site strategy for engaging new participants varied according to organizational culture. Examples of strategies used were online posts, flyers, and use of referral networks. The results of these efforts had varying levels of success, with the use of referrals being a particularly frustrating

experience. Despite sites being connected with referral sources, not all referrals were useful and many did not result in enrollments. Participants also highlighted a lack of awareness of this program's availability.

> *"The issue we struggle with is getting the referrals for the people in class. You know, you might get 10 referrals, but two people show up." F03*

> *"I think it has a lot of potential… I think that it has so much going for it. For me personally, or my center, I think I've struggled to recruit. Recruitment's been a problem to do the group." F07*

> *"I thought people would be really excited about it, so I've been surprised that we haven't gotten more referrals and there hasn't been more interest from the courts in the county in doing this program because I know from being out there that there's lots of families that would benefit from it" F06"*

> *"Maybe they can advertise more. Okay. I think that that would be something to put out stuff. To me there wasn't enough. I thought out for my mom, but they don't advertise more. Like I go to [outpatient] and I told them about it. [They didn't know about the program] …and I was gonna see about getting them. I was gonna see about getting flyers for them." P07*

Facilitators identified a need for greater assistance from PFSA and a greater connection with community partners to improve the quality of referrals and awareness of FIR.

> *"Now we're really lucky because we kind of settled into a beautiful partnership with treatment court and I know that not everyone is able to do that. And so, like with any agency, building those relationships with the other organizations and maybe even having a little bit more help doing that because sometimes having a little bit more clout behind your name with a statewide organization, as opposed to, you know, county families center. Build those relationships and even just kind of put your foot in the door. A lot of times the bigger agencies in the area are more willing to listen to original ideas from the state organizations as opposed to a local community organization." F01*

> *"I think a lot about building relationships with the community partners and really talking with them about working with our community partners in a trauma informed way [has been helpful in recruitment]." F10*

When discussing their recruitment and enrollment experience, participants spoke most positively of interactions that felt personalized. Many participants cited their entry into the program through an existing relationship with the individual recommending the class. Examples include being talked to about it by a case worker or being already connected with the FIR facilitator for other services. Sites that present the program at treatment centers or recovery houses seem to be the most successful with recruitment and participants who entered the program through this method endorsed this as an easy introduction.

> *"I liked it cause I felt like, um, like she chose me <laugh>. Like, I know she, I know it was voluntary and, and she probably asked a lot of people, but like, I felt like when she, I really strongly feel like she only asked people she thought that were truly going to gain, benefit from it. So I really like that she recognized that in me, that she, you know, she, that she took the time to, to offer it to me." P03*

When discussing the process of enrollment prior to beginning class, participants cited organization and communication as key factors in their experience. Participants highlighted positively examples when, upon being connected to FIR, there was follow-though from organizers and clear communication about classes. Participants also noted that the process was smooth when their experience required as little work on their part as possible, with the facilitator doing most of the organizing. Participants noted less ease and comfort with the enrollment process when communication was not clear or the facilitator was disorganized and gave little lead time.

> *"I think it would've been a little bit better if it was just, just a tab more organized, but I know they're just starting or whatever, but like, she had to drop my book off on my front porch and, there just could have been just a tab more communication. Like, I, I heard about it and then a couple months later then she, they called saying, "We wanna start next Thursday. What time's good for you?" And, you know, it was just, I don't know, it, a little bit more communication would've been better." P03*

> *"I would a very easy process, actually. I called, I told, [the facilitator]... She was actually very helpful. Unfortunately, when I had originally called the class had not started yet, she took my name and information, me and my boyfriend's information, and she contacted me as soon as the class was, like, she was, you know, putting people in the class. So she contacted me immediately as soon as they were about to start, and, you know, gave me the information and, and encouraged me and him to both go. So it was, it was really good, actually." P06*

Despite a struggle to get participants to find and attend class, both participants and facilitators reported that once participants began the class, participants became interested and engaged. Facilitators and participants noted an initial reluctance to attend initially particularly among those who were court ordered. Participants reported entering the class with limited expectations of what they would experience with FIR as a program and endorsed the need to publicize the class experience.

> *"The only challenges is your participants. I think it's not on families in recovery. It's just getting them to come to class. Once they come to class and get their curriculum, then they're hooked and they'll stay, but it's trying to get them to come to class" F03*

> *"I mean, I didn't have any expectations. I was just more so I was like, well, maybe this will look better on paper, but then like, getting in the class and actually discussing some things, it peak my interest and it was, it was, I mean, I learned this." P04*

> *"When they first went in there, I expected it to be just like a sit down, read a book, write down answers, you know, like a formal, like being in a classroom. But it was not that at all. It was, they made it, they made it personal, you know what I mean? So that intrigued me and I was like, Hmm, you know what, maybe I'll come back. So I did again and again and again." P06*

Motivation and incentives to participate

Motivation to participate varied, though facilitators and participants noted a difference between participants that had court or custody involvement and participants who took the course voluntarily. While both groups cited gaining guidance and support in their parenting and learning how to parent while in recovery, those with a legal incentive also reported that their initial motivation was to complete

the course for their court record. Obtainment of a certificate was a frequently cited incentive to join and complete the course.

> *"Being able to see my stepdaughter and nobody else beside my girlfriend have anything to say about it. Pretty much that's how it was at first. Then when I started participate in more classes, I noticed that not only it helped me, but it also helped my girlfriend who- she wasn't encouraged by the courts to take it. She came and went cuz she was my ride. So she figured she'd participate and I noticed it made a big difference with her, which made a big difference in mine and her relationship. Which also made the difference with the whole parenting thing. You know what I mean?" P08*

> *"Most of them, um, definitely are very happy with even just a certificate that they completed, something that they can hang up. You know, especially since when they're in substance use, they're not getting a whole lot of those." F04*

> *"[The certificate] made me feel accomplished. I know it's just a piece of paper but it's something." P06*

Other incentives mentioned by participants and facilitators were the presence of food and gift cards for participation. Though both were considered positively, neither were presented as deciding factors for participation. The absence of gift cards was not commented on by participants, but participants did comment on a desire for more food.

Experience with prior programming

Participants cited previous experience with parenting and recovery programming as a key factor in their expectations of FIR. Most participants interviewed had participated in some capacity with other recovery or parenting groups and many had engaged with both. Prior experiences, particularly with parenting classes, were more focused on a traditional class structure where participants were given information and then tested. All participants interviewed endorsed that FIR was as good or better than their past experiences, with this contrast to past educational models being repeatedly endorsed as a positive and something that made this class more exciting and engaging.

> *"Yeah, this one was definitely more interactive. It was guided, you know, it wasn't just a, a reading and, you know, choke and puke. We didn't have to just puke it back up on a test. You know. This one doesn't really a have a test. It's almost like a non-closure. I don't, it's like I don't have the closure. Which is great. Cause I hate tests." P13*

> *"Well, I was expecting more like the parenting classes. Like, I was expecting it to be more like that when it was somewhat like that, you know what I mean? It was somewhat structured and it was material and it was a handbook and all that. And we did have assignments, but it, it felt like groupy as well. So it felt like to half group, half class, but which we all already did. But yeah, I was expecting it to be like, regimented, like just like a parenting class." P03*

> *"When they first went in there, I expected it to be just like a sit down, read a book, write down answers, you know, like a formal, like being in a classroom. But it was not that at all. It was, they made it, they made it personal, you know what I mean? So that intrigued me and I was like, Hmm, you know what, maybe I'll come back. So I did again and again and again." P06*

When discussing experiences with prior parenting programming, participants spoke positively about the class's more general focus with regards to the family structure. Participants noted an existing availability of knowledge about parenting basics, both from classes they had taken and from their own life experiences, and liked that this class did more than give information on infant and child care.

> *"It just felt, I felt more informative. It didn't feel like they were going over stuff. I already know, like, I've taken two of the parenting classes again, voluntary on top of the one that I was court ordered to take. So I've taken three voluntary parenting classes. Two of 'em I didn't complete because I finished with CYS and they were, it's just, it's just a repetitive thing that I have a 21-year-old daughter who's amazing. I know how to keep 'em alive. You know what I mean?" P03*

> *"Families in recovery was different cause we got more in depth of different scenarios different aspects of life where you're at, where you have been, where you come from, and things like that. The other parenting class that I took was very, like, generalized. Like, this is like something that you need to do." P12*

In comparison to prior program experiences, participants noted an appreciation for a focus on how a parent fits into the family as a whole. Participants noted that previous experiences had felt very individual-focused and they appreciated learning about how parental mindset and substance use related to the family as a whole.

> *"Like that I know how to do. It's the stuff that they touched on in this particular class that nobody else had touched on, that I really was grateful, knowledge, I was grateful to get. ... Like, me time, the, the, the reminding myself that I can't take care of him properly unless I'm taking care of myself. And, and yeah. Just focus a lot on me and not a child where most parenting classes are focused on the child. This, a lot of this, a lot of it had to do with how, you know, how to Yeah. Dealing with myself so that I can be a better mom." P03*

> *"[Families in Recovery] kind of targets everything. Other parenting classes- they only target from like newborn to toddler age." P01*

> *"It involved more than just me. [Families in Recovery was better than other recovery programming I have participated in] because in everyday life, it's not just me, you know, I have a family and I do have to interact with them, and I know that, that working on me is great, but ultimately the reality is working on me and then being able to work within my family." P10*

FIR was noted by participants to be more relatable to their situation than prior experiences with programming. This relatability contributed to a feeling of lack of judgment and a usability of the knowledge they were gaining.

> *"Well, it was similar [to AA or NA] because obviously the focus is recovery and how to maintain the recovery in everyday lives. So everybody's situation, you go today, everybody's situation different. Um, you got single people, you got family people, you got all kinds of different walks of life and different situations. And sometimes you can get lost in the, the herd there, but in families and recovery itself, families that are in recovery. So we all have like, you know, it's very relatable. Everybody, you don't feel like you get, you're, you're lost. You don't feel like, Oh, I'm not working into this has nothing to do with me. You know what I mean? Like, it's all relatable." P03*

"[In other parenting classes] like, it's almost as if like you're, you're, you are crit- like, I, I don't wanna say criticized, but almost as if like you were criticized for things of where you came from and what you did in your path and where, you know what I mean? Things like that. Right. Like, I would've told my own starting class that I was an addict you know, and I was in recovery. They would say, oh my gosh, you need to have CYS involved in your life and your kids need to be taken. Like, no." P12

Though most participants who had previous experience with a 12-steps program spoke of and noted similarities with FIR neutrally, two participants endorsed a negative perception of that program. No one mentioned any similarities between FIR and 12-step programs as a negative.

"Personally I feel like AA and NA is kind of cultish. Like, they're very like, you know, there's the steps and there's stringent and there's the rules and there's the 13 steps, but all that stuff. But, and that's what they're, it's like, that's what they focus on most." P03

"NA classes are not for me. I got counselor who told me the only way that someone can stay sober is by going to meetings. And I think that's horses shit. <laugh>, I, I, I get it. That, that, like, that's the preferred method. And like, typically proven like yes, 100%. But like, I'm sorry, I don't, I'm not into the meeting. I, I did some online and I did some in person, and the in person were definitely better than the online in one respect. The online I didn't have to speak or, or even acknowledge that like it was a thing. So that was cool. But, so I'm not speaking, like, what's the point in being here? <laugh>... It's just not for me. Okay. It's just not for me." P13

Barriers to Participation

Beyond recruitment difficulties associated with awareness of the program, facilitators and participants both noted the existence of logistical barriers to participation for participants. These barriers included finding transportation, childcare, and fitting the class into their schedule. Having time for the class while taking care of other life demands was a particularly important hurdle reported by participants.

"Just my, just my issue is just like, I'm, I'm going, going, going, going. I work overnight and then I've got groups and I've got therapy and I've got doctors cause I've got medical issues too. And it's like, I don't get to sleep very much. So it was nearly just my issue was just, you know, just trying to make sure that I'm, you know, was able to make it, which I did at eight every week. ... Like, there was one time I didn't miss it, but I was, I got caught up and I didn't get home in time. And so I, but when I got, when I got to the house, I got on the, I missed like 30 minutes of it, then they stayed, she stayed on afterwards with me and went over what they went over that first 30 minutes, which she basically, our homework and all that stuff. But, yeah, she was very accommodating." P03

"I was little overwhelmed, yeah, and I think tired. The class was later at night and my boyfriend worked early, early in the morning, and he works all day, does construction, but he was very tired. And, um, also, I have an eight year old to the class wasn't done until, you know, nine o'clock. And I didn't get home until nine 30. So that's one complaint I have- the time. The time of the class, not how long it was, but, but when they had it, because, you know, by the time I got home it was nine 30, I needed to get her ready for bed she had school the next day. It was just, it wasn't good, you know what I mean? Yeah." P06

"No, I guess, just the barriers that I would probably put up for some people, not specifically for myself, but some other people as transportation. Some people had a hard time transportating. Because you have to, you have to, you know, think about it, they're coming from addiction. Most of us have lost a lot of things in our life and our license being one of 'em. So we have to rely on other people for transportation. This is one of the barriers that I've seen a lot in, in, in just my group." P12

One participant shared a barrier for other participants to completing all seven sessions of FIR. Though the participant interviewed completed all seven classes, they were the only participant to do so. All other participants in the class were told that the number they had to attend to be counted as complete was five and all but the participant interviewed stopped attending after that fifth session.

"I know that it was voluntary, but it felt like something I had to do versus something I chose to do, but then, like the last two, two sessions they were fully 100% voluntary, like, you know what I mean. Cause I was, technically from what I was told, after five sessions, you technically did a completion of the class. Cause it's like, basically like, and I asked [facilitator], I said, you know, [my partner] did it, did the five sessions. The other couple that was in it did the five sessions, and then they all, everybody quit." P13

Length and number of sessions

Participants were asked their opinion about the number and length of classes. No participants felt that seven classes were too many. Opinion about length of class varied between participants, as did their experiences. While some participants felt that the class length was too long, other participants didn't feel that it was enough time to cover every topic. One participant suggested that the number of sessions should be broken up to better digest the material and help bridge their memory between sessions. Some participants cited logistical and life barriers when suggesting that classes were too long and when praising a shorter class.

"Yeah, like they could have added more to the subject that we were talking about but it was, you know, due to time or whatever they were trying to stay within time restraints or whoever provided the material as well, could have went into more detail or whatever. But like, I think that it was designed, you know, obviously the way it was designed for the program to run this way. So, I just think it could have been a little bit more similar. You, you're like, read a question, answer. Okay. Like, trying to get it all done in that hour and a half, you know what I mean? But that was like, yeah. So that's what it is. I just feel like it could have been like, okay, so we didn't get to like, the last two questions this week. We didn't pick 'em up next week. It wasn't like that. It was like, we're finishing and then this week, that's it." P03

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to like, the last two questions this week. We didn't pick 'em up next week. It wasn't like that. It was like, we're finishing and then this week, that's it." P03

"Really the only thing I, only thing I didn't like was how long the classes were, two and a half hours and how late they were. Because I work a construction job. I wake up at five thirty in the morning and I have to drive all the way from [my home] every Thursday, two and a half hours. And I was always tired and exhausted in the middle of the class." P08

One participant felt the class was too long but revealed that often much of the class time was spent sitting without instruction until they reached the required time.

"I guess sometimes, when like this session, it would be like an hour and a half, but the session would be done early and so it was just, it, you know, just sit there. Sometimes she would let us go early, but sometimes she wouldn't. And it was just kind of, I don't know. It made it, I think that's what made it like, seem extra long. … I think it was like with like time sheets and insurance issues and that kind of thing. So they had to keep you for so long." P05

Virtual Implementation

For participants and facilitators, virtual implementation of FIR presented an opportunity to overcome barriers to participation. Virtual classes were easier for participants to fit into their schedule and did not require travel. One participant who took the class in-person suggested having an option to attend classes virtually for participants who had difficulty finding time for the class.

"[Taking Families in Recovery virtually] was convenient. It was, it was good… I didn't have to like go to wherever the location was. It's conservative on gas I guess you could say." P01

"I'd say the [biggest barrier was] time of day they had it and how long the classes are. Two and a half hours from 6:30 to nine. And I think if somebody couldn't make it to the class, I say it should offer to have them on video so that they can still get that participation." P08

"I have a very hectic with what I, with my case plan, what I am working and you know, all this by myself. So this, as I mentioned, it was something additional that I chose to and [taking the class virtually] was very convenient, so …I didn't have to get dressed, do my makeup." P03

Facilitators who pivoted to virtual groups during the initial phase of the COVID-19 pandemic struggled with the switch from in-person to virtual. Facilitators noted that the course was created with in-person attendance in mind, and the coursework was not created with consideration for virtual implementation. As a result, each site adapted to a virtual model independently, with different interpretations of the coursework.

"So we kind of tried to roll with it virtually, you know, when nobody like, knew what they were doing. And it was, uh, it was terrible… So when they went virtual, they would like set up their camera in a conference room. So we would be on their big screen TV, but the camera is looking into the room at like six to eight guys at a big table who all had masks on… So we would constantly miss like the first two words of every sentence… I think just really being able to not, I mean, how can you really like make a connection with somebody when you are, when you constantly have to say, like, who said that? Or what's your name again? Yeah. It was just, it was, it was bad." F05

"Honestly, I don't think that we really reached out for support. I don't wanna just say none. Because that indicates like, well, they wouldn't help us, but I don't, I don't know that we

necessarily reached out to them. Um, as much as we just kind of troubleshot on our own and brainstormed over this way and, and kind of figured it out." F02

Though most participants who took the course virtually did not state a preference for taking the class in-person, both in-person and virtual participants endorsed that taking classes virtually came with drawbacks. Ability to connect with other participants and to pay attention were two issues frequently brought up by participants as barriers when taking courses virtually.

"I think, I think that you get more out of it whenever you attend in person than you do virtually. You're not paying attention whenever you're, you're not giving your full attention when you're just over video or phone calls." P02

"I probably would've been a little bit closer with them before I had met in person, maybe everything. I mean, we just finally meet in person at the end, but, um, maybe just did a little bit more. But, now everything is, now everything is so digital and everybody texts and, and emails anyway. So I don't know if it made much of a difference. It made, it would've made a little bit of a difference, I think for me. I'm a little older than rest of the group though." P03

"It's more personal than being on phone, you know what I mean? You get to see people's faces and their expressions and, you know, just, it's just better than being on phone on the screen. … I don't think it would've been as good [if the class was virtual]. Yeah. I just don't think that, I don't think I would've connected as well with people over the phone as I did in person. You know what I mean?" P06

Group experience of Families in Recovery

When discussing needs of participants, facilitators identified the need for peer support as a key unmet need in this population.

"I think that most of their [remaining] needs is just having a support system. You know, Families in Recovery is only seven weeks, so then we have to fill in that gap once FIR is over. So I think it puts the foundation in that we're here as the support system, but then, you know, families and recovery is over." F03

"I think that, like the one thing that I've noticed, with parents that are in recovery is they don't have a whole lot of peer support. Peer support that they had before is not, you know, the support that they should be hanging out with anymore. And I do try and like make those connections during groups, but it still doesn't quite seem to… So, our plan always as case workers is like looking at the end game, who's gonna be there to support my client when we close our case. But that always seems to be an issue at the end." F05

"Well, I mean, I think they're typical of the substance use population. You know we still have these people who don't always have a lot of supports. They burned a lot of bridges in their years in substance use. So, you know support is not always there." F04

When asked, participants overall did not identify with wanting or needing a stronger support system and none reported increasing the amount of social support as a motivation to participate. Despite this, taking the class as a group was one of the most cited benefits of taking FIR, especially in contrast with other programming. Participants frequently described Families in Recovery as a group therapy hybrid

and found value in a relatable space to work together. Participants repeatedly credited being in FIR with making them feel less alone.

> *"Well yeah, we talked about parenting skills but it was more about like a group therapy rather than parenting. Cause everybody in the class, including ourselves, we found it beneficial and helpful to each individual as like I said, it's like as an individual pretty much saying in order to become a parent you need to be good and you need to be true to yourself to be true to your kid, if that makes sense." P08*

> *"It definitely makes the group setting just makes you feel not so singled out and not so alone. Like, I, this is in a very lonely process for me." P03*

> *"When I saw the material that was being presented and kinda looked through the book more, and the ability to open up and share with a group of women that were also in recovery, it allowed me a feeling of unity and a safe space to connect with other parents in recovery, you know, that we normally would not talk about with people that are not in recovery and don't understand our emotional challenges." P10*

Building Lasting Peer and Social Support Networks

Though participants found benefit in the class setting and facilitators endorsed the need for stronger support networks in this population, maintaining support after the class concluded was a known hurdle.

> *"You know, Families in Recovery is only seven weeks, so then we have to fill in that gap once FIR is over. So I think it puts the foundation in that we're here as the support system, but then, you know, families and recovery is over." F03*

Facilitators and participants cited several barriers to building new and lasting peer relationships. These included not having the space and time in their lives to cultivate new friendships, a hesitance to connect with others in different stages of recovery, existing familiarity and sometimes history of substance use with other participants, and differing participant genders.

> *"It can be helpful to have other parents that are in a very similar situation and part of the process. That's hard in our community to have that, because what we see a lot of times in the variety of recovery groups in our community is that people really need to get out of here to be successful with recovery because they know the people that that could offer peer support are often people they've used with in the past and that can create some significant triggers when they're in class together. So that peer support is a little bit challenging here" F10.*

> *"Other parents? Honestly I have them in a group chat but I haven't like reached out to them. Honestly, I have so much on my plate I can't really. I mean I can socialize. But it's a lot." P01*

> *"I think because most people that are in those groups have to go there, it's a requirement. So not all of those people are clean. They're just doing it because they're required to do it. … I don't think that they necessarily want the support right now, but also, if you're staying clean and trying to do what's right, you're not getting to want to keep them in your life if they're still actively using." P02*

> *"They were all women and yeah, I have no reason to talk to other women like that." P08*

Despite some facilitators and participants citing differences between participants as barriers to building lasting relationships, for other participants the differences between them as an incentive to create a relationship. Some participants saw their differences as an opportunity to mentor or be mentored by those with either children of different ages or who were in different stages of recovery.

> *"What made [me want to stay in touch and make friends]? Because I wanted to help them to, a lot of them were just starting for recovery and I gave them meetings they could go to, all kinds of stuff." P07*

> *"You see that [knowing that people were at different stages] is a bad thing? You know, like, peoples are different way than them. We can, like, I guess we can like for real for real like we, when we was in there people, you know, I've seen that people that was at different stages. It's like, I mean, it, it is not even just the parenting, people that just, you know, that can teach them something, they can be us too. Give them, you know, to build them, you know, make 'em feel better about theyself and like, you know, they can build on what, you know, what we had to like offer, you know." P10*

Facilitators employed a few strategies to build relationships between participants. An important component of building relationships during sessions was encouraging and creating opportunities for participants to open up and share about their experiences and lives. Facilitators also encouraged participants to share numbers with each other and created familiarity by partnering participants together for coursework. Class activities like icebreakers and role play were cited by participants as useful in getting to know other participants and building bonds.

> *"Oh we paired off several times, and each time we did pair off to work on a certain part of the chapter or book. We changed partners, so it wasn't always the same, you know, two people at different parts of the book. But she was, she actually allowed us to interact with each individual in that class." P10*

> *"They would have this blow-up beach ball and he had different questions written all that with us from that marker. And we would play this game to where we would throw past the ball over to, He would all throw the ball for me. And whatever question my right thumb lands on, I have to answer that question like what was your favorite movie as a child or whatever. I would answer that question. And sometimes the other parents, they would also put the two stamps into it, answer the question too. And then I would throw the ball. I would pick whoever I want to go ball do. And same thing, whatever they write thumb lands on, they would answer the question. And that got us to build a bond and relate to each other in a way." P08*

Although facilitator-led efforts were an important component of attempting to build lasting relationships, the most frequently cited structural reason for lasting relationships was the ability to socialize outside of the coursework. Facilitator intervention was useful in introducing and creating an opportunity these relationships, but participants credited being able to converse with other participants during breaks and while eating meals as the times when real friendships were built.

> *"Oh, yeah, like I said, I just, like, when we got to know, we got to know each other a little bit. We would talk, you know, even like when we got our 10-minute break in between the two hours when we went outside or whatever, we would even talk out there, just the parents, you know what I mean? Yeah. How comfortable we were, which was cool. Really cool. And I actually got one of the girl's phone numbers. She was so sweet, so sweet. And we told each*

other that we would text and keep in contact, you know, and, and keep each other, um, keep our heads up and if we needed something to call each other, which I think is awesome because I don't have a lot of sober friends. I don't have a lot of friends because I can't, you know what I mean? Yeah. But she is, and, and I just think that's really cool that I found somebody, you know what I mean?" P06

When discussing what would encourage lasting relationships, two participants had suggestions for things that they would like to see. One participant took the class virtually and felt that an in-person meal or gathering would have been useful in building a connection to other participants. The other participant found that class ending left a social gap in their lives and suggested a semi-organized group after FIR concluded to allow participants to continue to gather.

"I think that it, if we could done like a welcoming, like an opening in-person meeting and then a at the end like, oh, let's celebrate and have like cupcakes or whatever that would've been, that could have been nice. Or, or Yeah. I can, I could see myself going to, you know, maybe a few more classes if like once in a while we did something all together, you know?" P13

"I missed [the social aspect of the class] now that I don't have it. Like I was so sad that classes ended. I honestly think that they might wanna follow it up afterwards with a group. Like, you know, try to arrange the participants to like have their own little, like, you know, church, I don't know if you go to church, but I go to church. And at church we have a small group where everyone is tied into these small groups. Almost like, um, almost like that, like where they would, you know, you know, appoint somebody in charge and then they would have these, you know, continue the group on amongst ourselves with the peers." P03

Despite mixed success in developing lasting peer relationships through the class, participants frequently noted that participating in FIR had a positive impact on their existing relationships. Participants endorsed that taking the class and implementing the lessons into their lives was noticed positively by their support system and was felt in some cases to be a step in repairing trust.

"I was avoiding, I was avoiding my support system prior to recovery... [After participating in family's recovery] I was able to realize that even though I am an addict, I can still be in recovery and be a parent and it's not too late." P10

"I, I was happy with the support I already had. I have a huge, I have huge, huge, huge, huge support system. And then they just added more, more to my support system. So it was nice. ... Actually it got better because you know, they're, they were probably looking at us like, Hey, look, this girl's doing what she needs to do. She's getting all the resources she needs to get, she's doing all the, you know, all the things that we recommend for her. We're proud of her." P12

For participants who took FIR alongside a partner, the experience was noted to be one that strengthened this relationship.

"Well, it didn't change anything with my mother or the child's father, really. I try to get along with the child's father as much as I can. Me and my mother, I have too much trauma. Her, I can't, I'm not even gonna get into that. But as for me and my boyfriend, yes it has changed because I see how much effort he has put into trying to fix things. And I realize how much he does love both me and my daughter because he didn't have to do this. He could've just gave up and he did it. He went above and beyond. You know what I mean?" P06

"It helped us to work better as a team. She, before she had a problem with how I disciplined and I had a problem with her lack of discipline. But we ended up learning, especially cause we took together learning how to co-parent better together with communication and everything also helped me communication and have a better understanding of my stepdaughter. And I still coach my girlfriends on some shit sometimes." P08

Facilitator "soft skills"

Almost universally, participants praised the work of facilitators and credited their personalities, humor, lack of judgment, and particularly their relatability, as key components of what made participating in FIR a positive experience. Participants cited relatability as an important component in perceiving their facilitator to be knowledgeable and in creating a comfortable environment in which to learn. When facilitators took the time to convey genuine interest and knowledge of their individual lives, participants noticed and appreciated this effort.

"The people instructing it were so knowledgeable about us. Like, it made, like, I felt like I was absolutely benefiting. Like it was geared for me, like they were gearing for me. ...like me individually actually. And all of, yeah, there's only like four or five of us in the group. They seem to know about all of us. Like all of our situations, they were up to the date and every time when they taught a lesson, they would, they would be like, they would know like who to like would be relating to it, you know what I mean? Like, they were very, very knowledgeable, our situations." P03

"They were knowledgeable and they were, they were easy going and they were down earth, they weren't monotoned or without experiences and stuff. They were able to relate pretty well. And being by hands on experience and actually what goes on that sometimes... They tell me their experiences and how they get through their stuff, and being that were roughly around the same age, the same problems, they were pretty good ideas on how to do it. ... In it, being that the instructors were more so on the same level with their experiences, they could relate to whole the course when just based off of experience, knowing it's not as bad as you think, because I mean, to go through a kid and being around the same age, it felt like I wasn't what I go through alone." P04

"They treated us like human beings, that we weren't bad people, you know, they never made us feel like, you know, we did something wrong and we were being punished or anything like that. We were just treated normally like humans, which I greatly appreciate. Cause that doesn't happen a lot. And, you know, we weren't treated any different. I really appreciated that." P06

"They, they understood where, like, they understood us. It almost felt like as if like they, I don't know how to put it. Like, it's like they had compassion, they wanted to, it's like, they like, like they wanted to listen to us. Not that they had to listen to us. They wanted to listen to us. That's a big difference." P06

When asking participants about social supports gained while in the class, participants frequently brought up the support offered by facilitators rather than support from their peers. Facilitator contact information sharing and their willingness to assist in connecting them to resources was seen as a strengthening of their support system.

"I have great support system. I, I could still call the people that were in the group for families in recovery. I can call them today if I ever need anything. Actually, I, I still speak to them. They call and check up on us and see how we're doing. And I, I have their phone number if I could call them at any time." P12

"Even afterwards, after the class, they're still helping me, um, with my case because, you know, they feel like I've been railroaded. But, um, they were, they actually took an interest. Like, and I could, I felt like I could call them anytime I had a question or if I needed something, I feel like I could call them." P03

Only one participant felt that their facilitator was not a good match for their personality.

"My, I, [Facilitator 1] is my, my case worker, my, my parent educator. She is the disgustingly happiest person I've ever met. And like, I've been called Mary Effing Sunshine many times. So I mean, it's pretty, it's pretty bad if I'm like, you know, saying that about somebody else and I see how annoying that can be. I think [Facilitator 2] is a better fit for the class. She seems more realistic. So I don't know. And I don't know if that's anything what you wanna, you know, hear about this kinda thing. I like [Facilitator 1], don't get me wrong, like I said, she's my parent educator. I do, you know, I like her. I have a different opinion, or view, of her than, than other people do probably. But like, I like her. I just dunno that she's necessarily the guy for the class or like, you know, a good, a good person for the class." P13

Reception of Families In Recovery

The overall response to FIR amongst facilitators and participants has been positive. For facilitators and their agencies, FIR fills an unmet gap in services and is a class they enjoy teaching. Participants found the class to be a benefit in their lives.

"I think it's great, honestly. I really like everything that it talks about, and I love the fact that it is geared towards parenting, and it has all these little aspects that are kind of interwoven through it, but it's not like in-your-face recovery." F01

"I love it. It's my favorite curriculum that I facilitate. I think they're all good, but I just love this. And I've seen this to be the most impactful of all the curriculums really on the families that, especially the moms that we serve." F02

"How would I describe it? It was a good experience. I'd say it's very helpful. It's more than just going to a couple classes just to waste taxpayers money. I think depending on the judge and his perspective, some judges they don't care, people that need to go to the classes just to make a couple bucks. But it can be helpful. But it's also up to the person if they wanna let it be helpful or not. If you wanna go to the class and just do the bare minimum just to do certificate, whatever, but you actually participate and it can be very helpful." P08

The guidebook served as an important component of FIR for participants. In class, the book served as a jumping off point for discussions. Participants highlighted the flexibility of the book's use in and out of class. Participants liked that it had interactive use as a workbook on top of providing information. The ability to work through the lessons using the book was a benefit in helping participants internalize an understand the lessons.

"I think it was just, um, going through the, just seeing the workbook maybe. I think that really helped because, um, none of the other courses I don't think had a, a workbook like that. Mm. And, um, I have my, like, I have a horrible memory and I just, I have a, like, it was nice at the very end of it to have something to take home with me." P05

Though some participants liked that the book was light on information, other participants expressed a desire for more information that they could use after the course concluded.
Some participants did continue to use the guidebook after the conclusion of FIR. Those who used the guidebook outside of the FIR setting did so in reference to skills they found relatable their situation.

"The handbook allowed me to break down my feelings and emotions and working through that workbook, I was able to go back and reflect, write and read what I had written down previously, and really internalize it. Think about it, come back with other solutions and apply those things in my daily life." P10

"I still use [the guidebook] actually. Cause my son should be becoming a homeowner soon. I'm trying to keep my mind fresh of what I learned. Cause I don't wanna, you know, forget. So I just read over it and refer back to it sometimes. Cause I still, I visit with him on the phone on Zoom three times a week. And I see him in person and I'm still parenting 'em, just, I'm parenting 'em from a distance. Yeah. So I do refer back to them getting frustrated or aggravated or there's a situation I don't know how to handle." P03

Overall, the guidebook was viewed as easy to understand, though some participants pointed to struggles in their class with understanding certain words and concepts.

"At first I didn't understand it, but <laugh>, yeah. After a little bit? Yeah I understood it. Because like, certain things I would get mixed up with, emotionally and spiritually. Like, like say for instance like, um, you know, uh, spending time with your baby, right? So they will say that's spiritually, but like, how I would think of it, I will think of it as like emotionally or physically or, or mentally, there it is, mentally. You know what I mean?" P11

"Yeah. Most of [the guidebook was easy to understand]. Once in a while, like some of those activities, I'm like, wait, what? How do I put this in my own words? That that was, I can't even think of a good example. Let me like flip through the book real quick and see if I can come up with an actual example of one that I had some problems comprehending. The perspective, I think. Pages 18 and 19. I think those were hard for me to, to, to put into my own life. That was one that was hard for me." P13

When asked about favorite sessions, all sessions were mentioned by at least one person as useful or a highlight. All participants were able to share a specific activity or lesson that they found relatable and useful. The three sessions that were mentioned most frequently were Session 5, Discipline and Development, Session 6, Healthy Self & Family Wellness, and Session 1, Strength and Needs.

"So there was a time she talked about passive aggressive, aggressive and assertive, you know instead of giving her children their way all the time, like she, she, she taught us boundaries. You know, of them not using this from the guilt and also, you know, to not holler at our kids, but to talk to them and tell them why they're going on time out and tell 'em why they, or, or, you know, allowing our kids to, to talk and us to listen. You know, it's important to listen to our children and sometimes, and there's a difference between punishment and discipline, you know and abuse. So, you know, so that really helped. Yeah. You know, cuz a lot of us didn't

know that, you know, you punish your kids and then they're, you don't, you know, there's a, a different difference in discipline and punishment, especially after they've been through abusive things, you punishment that's like abuse on top of abuse, you know? So that really, really helped to, you know, know the difference between that and when you discipline, I tell 'em why, you know, in a love and compassionate way and, you know, things like that nature. So that really, really helped." P09

Several participants highlighted the last few sessions as being memorable ones. This was credited to the emotional impact of those sessions as well as their place in the order of the course. At that point, participants were open and comfortable with each other and willing to share personal information about their experiences.

"[In the last three classes] we started to getting, getting into personal, personal things, which is when people started to open up and you got to know people and understand, you know, like what they've been through a little bit and maybe why they are the way that they are. Some of their triggers, you can compare them to some of yours. And, then the last class was very emotional. I cried. I did, I'm not gonna lie. It's not in a bad way. It wasn't a bad way. It was actually good and bad tears. It was emotional. I was actually kind of, that was over <laugh> I sounds crazy, But I think they were more a lot of information. You know what I mean? The first few classes were just a lot of information and that's really just the only thing I would say. It wasn't terrible. It was just, you know, they weren't my favorites. That's all I'm saying." P06

"The last session was my favorite... Everybody was more on the personal level where people, they got emotional and we would write on three different pieces of paper about somebody in the classroom. Give one person a gift, you give one person the word of advice, give one persons something nice. And we would go around and pick random ones and be it out loud and would know it was a more of emotional connection and people were like, Oh I'm gonna miss you. Yeah, it was more, yeah, the most personal emotional one, et cetera." P08

One participant's reported experience deviated from other participants and did not feel that the class was as useful as it could have been. The reasoning for this was that the class did not feel relatable to their situation. The participant felt that the class was geared towards parents who did not have custody and were working towards reunification. This participant had custody of their child. They also felt that the class did not present enough of the consequences of parenting while using substances and felt that that kind of messaging would have been more effective for their learning style.

"Like some people are better with the, the positive. Like, this is what can real, this is where we're heading. This is the good thing. This is, this is where, you know, where being sober is gonna take you. And some people benefit better from seeing, seeing the nitty gritty. Like, hey, if you don't get sober, this is what is gonna happen. I guess that, that, that it's more designed for the fact that like, we've already gone through not living with our children or not having custody of our children, and like, it's, it's more designed for that, which isn't necessarily my situation. So that's probably why I didn't get the same or get that that much out of it. I know, I don't wanna say I didn't get much outta it, but like, there are probably, probably two, two actual lessons where I was like, oh, okay. Wow. Alright. Yeah. That makes sense. I do like that it broke, it was broken down and then it, like, every, every lesson had a hands-on kind of, not exactly hands-on, but like, you know, the participant had had to do. I think that some of them were a little harder to understand than others of like, what exactly, but you, you gave examples, which was really nice. Still was a little hard to, to make it into my own my own life. Make relevant in my own life." P13

Though most participants did not offer criticism of specific sessions, two did. They provided feedback for Session 3, Stages of Change and Session 7, From Here to Home.

> *"Like just some, the redundant ones, like the five stages of recovery. Like we do that every class, every group, every, you know what I'm saying? Like that, that's kind of like the basics. Like I think by the time you would get to the class, you would already have, most people already have that down. So I just found that a little redundant." P03*

> *"[From here to home] was kind of like, okay, well this is the wrap up and there's a couple of resources which were great. And that's kind of it. It was a couple, I think it was a story or two of how it impacted other people, which was fine, but it was almost like, oh, that's it. … More stories of the, of, yeah. Like more printing of other people's experiences [would have made it more impactful for me]." P10*

Participant Impact

For participants of FIR, participants praised being able to gain tangible skills with practical applications. Other than the ability to come together as a group, the relatability and utility of the material were the areas of the course they most enjoyed and found most impactful.

> *"After every session in between sessions, if you were to have a session that were helpful, I would use what we learned in the last session, in the meantime for the next session. And then it ended up becoming the way, I didn't really have to think about it much to make it self-conscious. Well not, I was self-conscious as an instinct and pretty much I don't look at it as something I was taught. I look at as knowledge and of, you know what I mean by subconscious? Whenever, if you're trained in a certain sport or thought, you have to think about the certain skills at first, right? But then the more you practice at it, the more it just becomes the instinct." P08*

After completing FIR, participants highlighted several useful takeaways in their mindset. The course helped participants understand their family's point of view and how they as an individual had an impact on their family. The course also helped participants learn to cope with their feelings of guilt. Participants both learned that it was sometimes important to take a step back to deal with their own emotions and were given the tools to put that knowledge into practice.

> *"I don't think I, when people always talk about self-care, but I don't think that I realized until, you know, we talked about it and everybody talked about it. Like how, just how impactful it is… But then I realized, you know, I realized through the group that like, I really need to do this. Like, I better start doing this. Cause I wasn't, I'm working seven days a week. I'm doing classes, I'm doing groups, I'm doing therapy. Like I don't do anything for myself. So I definitely know in order to be a better person or better mother, that I have to take some time for myself so I feel better. And then the guilt is something that is still stressing me out. Even though I learned tactics on how to deal with it when he comes home, I just, I'm gonna, I feel it now already. He's not here yet and I just know when he gets home, it's, you know, I have to remember, not that I gotta be his mother and not just cuz I feel guilty. Like that was really huge for me. Cause I still don't even know how, I mean, I have some guidelines now to go by and I, you know, remind myself that, you know, I'm still, I'm his parent. I gotta be your parent. Shit happens. Stuff happens <laugh> and now we need to move on and I need to be his*

parent. So, Cause I've been, I found myself already, like, I visit him in person once a week and I'm like freaking out every week. And like, I can't, I gotta, I got parent him." P02

"We're talking about knowing the time to take space or feel like when just a minute to take that minute, that everything doesn't have to stressful the whole time when you could a five-minute breather and it was alright if you did that… When I was as child I would just keep going and going, I wouldn't just take a breather. This was good to know I could just take that break." P04

"I didn't know that, like, by not being encouraging, you know, when I was in my active addiction, it, it had a huge impact on how they will feel later on in their life and I don't want them to feel like that… Like being supportive or like how they like, you know, like discipline for one… Like, you know, having that, setting that boundary to where like… if you're parenting outta guilt, that's not gonna work out… Like, you still have to think of yourself as the same mother you would be, you know, if you wasn't in that addiction… Like, you can't become vulnerable to, you know, to a situation. You gotta be strong for your children. …You can't beat yourself up and like… you know what I'm trying to say, I guess." P11

When reflecting on FIR and their recovery, how sessions taught participants to think about their substance use and its impact on their family resonated.

"It just made me not ever want to use again. If I want a relationship, if I wanna live and have a relationship with my children. Thank you so much. I appreciate you. Okay. Make me want to live so I could be a good mother for my children." P09

"It just gave me more courage to stay sober. … Because like I said, one of my strongest things was writing a letter to my kids. And it just made me think, like, it makes me think of my kids daily." P12

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Appendix

Timeline

Proposed aims, activities, and deliverables to achieve project outcomes and results		Proposed timeline	Status/Progress
Start-up and Administration	Execution of Contract	By September 2021	**Completed.**
	IRB Approval		
	Develop Partnerships with Key Community Stakeholders		
	Deliverable: Draft analytic plan and submit protocol to CHOP IRB by September 30, 2021.		
Aim 1 – Understand Best Practices	Best Practices Review	By December 2021	**Completed.**
	Engage Community Expert Panel	Ongoing	**Completed**
	Meeting Participation	Monthly PFSA-PolicyLab Meetings	**Ongoing**.
Aim 2 – Stakeholder perspectives on concepts of fidelity and program components	Quantitative Data Collection	By March 2021	**Completed.**
	Develop Longitudinal Survey Instrument	By December 2021	**Completed.**
	Develop Focus Group and Interview Guides	By December 2021	**Completed.**
	Deliverable: Develop longitudinal survey instrument and interview guides and provide mid-year update memo by December 31, 2021.	By December 2021	**Completed.**
	Disseminate Longitudinal Surveys	First survey by December 2021	**Complete.**
	Deliverable: Complete focus group and provide an update reviewing survey recruitment, participation and preliminary findings in quarterly meeting by March 31, 2022.	By March 2022	**Completed.**
	Conduct Focus Group	By December 2021	**Completed.**
	Conduct Interviews	By December, 2022	**Completed.**
	Deliverable: Deliver year 1 interim report with findings from all evaluation activities completed to date and refined scope of work for Year 2 by June 30, 2022.	By June, 2022	**Completed.**
	Deliverable: Disseminate second round surveys and provide recruitment and outreach plan for outstanding data collection efforts in quarterly update meeting by September 30, 2022.	By September, 2022	**Completed.**

	Deliverable: Provide mid-year update memo with preliminary interview and observation findings by December 31, 2022.	By December, 2022	**Completed.**
Aim 3 – Assess Fidelity	Observations	By December, 2022	**Completed.**
	Deliverable: Finalize data collection efforts and provide update on final analysis plan in quarterly update meeting by March 31, 2023.	By March, 2023	**Completed.**
Reporting and Dissemination	Analyze and Aggregate Findings	By June, 2023	**Completed**
	Research and Policy Brief	By June, 2023	**In progress.**
	Deliverable: Deliver final report by June 30, 2023.	By June, 2023	**Completed.**

Appendix A: Implementation Evaluation Baseline Survey

The following assessments will provide insight into each site's capacity and process throughout implementation of the Families in Recovery (FIR) Program.

The Baseline Survey will set a foundation for evaluating implementation at each site. These questions will be completed by the facilitator and/or leadership identified by each site. The Baseline Survey seeks information on the activities and programs, both internal and external to the implementation of FIR. The majority of these questions relate specifically to implementation and facilitator capacity, while some are included to gather important contextual information about FIR that may shape technical assistance and training efforts. These surveys were guided by the Consolidated Framework for Implementation Research (CFIR) [1] and the Center for the Study of Social Policy's Strengthening Families and Protective Factors Framework[2]. Subsequent iterations of the survey will include items relevant to the focus group findings.

To further understand implementation at each site, the Change and Implementation Readiness Assessment[3] tool will assess each organization's capacity and culture around implementing FIR.

FIR Evaluation Domains

To be assessed baseline, 6 months, and 12 months

I. Organizational Infrastructure & Culture
II. Target Population & Community Needs
III. Change and Implementation Readiness
    a. Motivation
    b. Organizational Capacities
    c. Innovation-Specific Capacities
IV. Facilitator training & experience
V. Perceived facilitator ability to effectively deliver services
VI. Fidelity

[1] https://cFiRguide.org/
[2] https://cssp.org/our-work/project/strengthening-families/
[3] https://capacity.childwelfare.gov/states/focus-areas/cqi/change-implementation/readiness/

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FIR Implementation Baseline Survey

OVER PHONE WITH EACH SITE (1 ADMIN, 1 FACILITATOR)

I. Organization Infrastructure and Resources	
What is the name of your organization?	Choose from list
In what settings are you currently delivering FIR?	Check all that apply 1. In Person – Small Groups 2. In Person – Individually 3. Virtual – Small Groups 4. Virtual – Individually 5. Other
How do you structure the spacing of the 7 sessions?	1. Weekly 2. Bi-weekly 3. Monthly 4. Other, please explain
Did you consider other programs in your selection of FIR?	YES/NO
What were the factors that led you to choose to implement FIR?	Open ended
Have there been significant changes to the leadership or staffing of your organization since starting FIR?	YES/NO/UNSURE, please explain
Have there been significant changes to the facilitation of FIR since you started (setting, location, etc.)?	YES/NO/UNSURE, please explain
Have there been any other significant changes to FIR since you started?	YES/NO/UNSURE, please explain
Does your organization offer any other small group programs?	YES/NO, please explain

Children's Hospital of Philadelphia℠
2716 South Street
Roberts Center, 10th Floor
Philadelphia, PA 19146
P 267-426-5300
F 267-426-0380
PolicyLab@email.chop.edu
policylab.chop.edu

Does your organization offer any other programs or services for individuals with SUD and/or in recovery?	YES/NO, please explain
Does your organization offer any other programs that incorporate the Strengthening Families Protective Factors?	A. Parent Café B. Parents as Teachers C. Nurturing Parent Programs D. Triple P E. Other, please describe
II. Target Population & Community Needs	
How would you describe the community your organization serves?	a. Urban b. Suburban c. Rural d. Other, please explain
How does your organization recruit FIR participants?	Check all that apply 1. Flyers 2. Social media 3. From other programs within our organization 4. Referrals from external agencies 5. Other, please explain
	[If answer to 7 is referrals from external agencies, please describe which external agencies refer participants to you]
Please describe the selection or hiring process for FIR facilitators. Where do you recruit, what credentials do you look for, etc.?	Open ended
Do FIR facilitators at your organization reflect the racial, ethnic, or linguistic identities of participants?	Yes/No, please explain
Does your organization offer FIR groups in any language other than English?	Yes/No, please explain

Please describe the onboarding or training process for FIR facilitators.	Open ended

Baseline Administrator Survey- Online

I. Administrator Details	
What is the name of your organization?	Choose from list
What is your role with the Families in Recovery program?	1. Facilitator 2. Administrator 3. Both facilitator and administrator
What is your current role at your organization?	Open response
How long have you been at the organization in your current role?	1. 0-1 year 2. 2-3 years 3. 4-5 years 4. 5+ years
Has your site begun implementing FIR as of now?	1. Yes 2. No
Does your site use a train the trainer model?	1. Yes 2. No
Please describe the process for training facilitators at your site.	Open response
II. Change and Implementation Readiness	
FIR aligns with the agency's mission, values, and guiding principles.	1. Strongly agree (fully ready to go) 2. Partially agree (somewhat ready) 3. Disagree (not yet ready) 4. Not sure (need more information)

	FIR supports existing programs and initiatives and fits with how the agency does things.	
	FIR is compatible with the values of individuals who will deliver it (e.g., caseworkers, service providers).	
	FIR is compatible with the values of the agency's target population (e.g., families receiving services).	
	Leadership, staff, and stakeholders clearly understand FIR.	
	FIR is viewed as "doable."	
	There are buy-in and support for FIR.	
	FIR is embraced as a priority.	
	FIR is perceived as being better than other alternatives to address the problem and current practice.	
	The expected outcomes of FIR are apparent to leadership, staff, and stakeholders.	
	The agency has appropriate resources (e.g., staff, facilities, materials, and technology) to implement and sustain FIR.	
	Program champions are willing to advocate for FIR and devote efforts to ensure its success. (Program champion is the primary person at your organization who advocates for or leads the implementation of FIR)	
	The agency has staff recruitment and selection systems and processes in place to secure appropriate staff (or contractors)	

	to deliver FIR.	
	The agency has training systems in place that can support competency needs for FIR.	
	The agency has coaching systems in place that can support the application of skills in practice.	
	The agency has processes in place to monitor fidelity to FIR (performance assessment).	
	The agency has data systems and processes in place to track and monitor FIR outputs and outcomes that inform decision-making.	
	The agency has policies and procedures in place to support FIR.	
	Managers and staff have knowledge, skills, and abilities to deliver FIR.	
	There is leadership and organizational support for FIR (including state, county, local, leaders, as relevant).	
	Agency leaders, staff, and stakeholders have a shared vision of the plans and desired outcomes for FIR.	
III. FIR Impact		
	What do you see as the impact of FIR for your clients? (select top three)	• Families with SUD understand their strengths and networks of formal and informal supports • Increased self-efficacy and resilience • Increased social connection with other families • Increased participation in community activities • Increased concrete support in times of need from our program

		• Increased referrals to treatment or SUD programs • Increased enrollment in treatment or SUD programs • Other: Specify _____
	What do you see as the impact of FIR on your organization's staff? (select top three)	• Staff are actively engaged in discussions regarding needs of SUD community, gaps in services, and capacity to serve families with SUD • Staff use a family-centered approach when coordinating SUD services with clients • Staff are competent in the Strengthening Families and Protective Factors Framework • Staff have more resources and tools to support families affected by substance use Other: Specify _____
	What do you see as the impact of FIR on your organizational culture? (select top three)	• Honor the strengths and needs of individuals and families with SUD or in recovery • Clear expectations of our organization's role in the community and the role of community organizations on issues related to SUD • Expand organization's capacity to support individuals with SUD or in recovery • Increased participation in community health planning activities • Other: Specify _____
	What resources from the curriculum have been most helpful for implementation?	Open response
	What resources from PFSA have been most helpful for implementation?	Open response

	Please give an example of a significant success with a client enrolled in FIR	Open response
	Please give an example of a significant challenge with a client enrolled in FIR	Open response

FIR Facilitator Baseline Survey

To be completed online by each facilitator

II. Facilitator Training & Experience		
1.	What is the name of your organization?	Choose from list
2.	What is your role with the Families in Recovery program?	1. Facilitator 2. Administrator 3. Both facilitator and administrator
3.	What is your current role at your organization?	Open response
4.	How long have you been at the organization in your current role?	1. 0-1 year 2. 2-3 years 3. 4-5 years 4. 5+ years
5.	What is your highest level of education?	1. Some high school 2. High school 3. Some college 4. Associates degree 5. Bachelor's degree 6. Master's degree 7. Ph.D. or higher 8. Prefer not to say 9. Other _____
6.	What was your experience in small-group facilitation prior to facilitating FIR?	1. FIR was my first experience in small-group facilitation 2. 1-2 years 3. 3-4 years 4. 5+ years

7.	How many years of experience do you have working with individuals with SUD and/or in recovery?	1. FIR was my first experience 2. 1-2 years 3. 3-4 years 4. 5+ years
8.	Have you received training as a Certified Peer Recovery Specialist?	YES/NO
9.	Do you currently participate in other SUD or recovery-related work outside of your role at your organization?	YES/NO, please describe
10.	Has your site begun implementing FIR as of now?	YES/NO
11.	How many FIR groups have you facilitated?	Open response (numbers only)
12.	How many FIR groups are you currently facilitating?	Open response (numbers only)
13.	If you are facilitating FIR individually, how many individuals are you serving (does not include those in groups)?	Open response (numbers only)
14.	Does your site use a train the trainer model?	YES/NO
15.	Have you attended a FIR training hosted by PFSA?	YES/NO/UNSURE, please explain
16.	If yes, please indicate your level of preparedness to facilitate FIR after completing the training	1. Not prepared 2. Somewhat prepared 3. Prepared 4. Well prepared 5. Very well prepared
17.	If no, please describe how you were trained before beginning FIR group facilitation	Open response

18.	Please tell us about any additional skills or expertise that you bring to FIR facilitation	Open ended
III. Change and Implementation Readiness		
1.	FIR aligns with the agency's mission, values, and guiding principles.	1. Strongly agree (fully ready to go) 2. Partially agree (somewhat ready) 3. Disagree (not yet ready) 4. Not sure (need more information)
2.	FIR supports existing programs and initiatives and fits with how the agency does things.	
3.	FIR is compatible with the values of individuals who will deliver it (e.g., caseworkers, service providers).	
4.	FIR is compatible with the values of the agency's target population (e.g., families or individuals receiving services).	
5.	Leadership, staff, and stakeholders clearly understand FIR.	
6.	FIR is viewed as "doable."	
7.	There are buy-in and support for FIR.	
8.	FIR is embraced as a priority.	
9.	FIR is perceived as being better than other alternatives to address the problem and current practice.	
10.	The expected outcomes of FIR are apparent to leadership, staff, and stakeholders.	

11.	The agency has appropriate resources (e.g., staff, facilities, materials, and technology) to implement and sustain FIR.	
12.	Program champions are willing to advocate for FIR and devote efforts to ensure its success.	
13.	The agency has staff recruitment and selection systems and processes in place to secure appropriate staff (or contractors) to deliver FIR.	
14.	The agency has training systems in place that can support competency needs for FIR.	
15.	The agency has coaching systems in place that can support the application of skills in practice.	
16.	The agency has processes in place to monitor fidelity to FIR (performance assessment).	
17.	The agency has data systems and processes in place to track and monitor intervention outputs and outcomes that inform decision-making.	
18.	The agency has policies and procedures in place to support FIR.	
19.	Managers and staff have knowledge, skills, and abilities to deliver FIR.	
20.	There is leadership and organizational support for the selected intervention (including state, county, local, leaders, as relevant).	
21.	Agency leaders, staff, and stakeholders have a shared vision of the plans and desired outcomes for FIR.	

IV. FIR Impact		
1.	What do you see as the goal of FIR for your clients? (select top three)	• Families with SUD understand their strengths and networks of formal and informal supports • Increased self-efficacy and resilience • Increased social connection with other families • Increased participation in community activities • Increased concrete support in times of need from our program • Increased referrals to treatment or SUD programs • Increased enrollment in treatment or SUD programs • Other: Specify _____
2.	What do you see as the impact of FIR on your organization's staff? (select top three)	• Staff are actively engaged in discussions regarding needs of SUD community, gaps in services, and capacity to serve families with SUD • Staff use a family-centered approach when coordinating SUD services with clients • Staff are competent in the Strengthening Families and Protective Factors Framework • Staff have more resources and tools to support families affected by substance use Other: Specify _____
3.	What do you see as the impact of FIR on your organizational culture? (select top three)	• Honor the strengths and needs of individuals and families with SUD or in recovery • Clear expectations of our organization's role in the community and the role of community organizations on issues related to SUD • Expand organization's capacity to support individuals with SUD or in recovery • Increased participation in community health planning

		activities • Other: Specify _____
4.	What resources from the curriculum have been most helpful for implementation?	Open response
5.	What resources from PFSA have been most helpful for implementation?	Open response
6.	Please give an example of a significant success with a client enrolled in FIR	Open response
7.	Please give an example of a significant challenge with a client enrolled in FIR	Open response

V. Families in Recovery Competency and Fidelity			
1.	The following questions refer to the Strengthening Families Protective Factors domains:		
1a.	Parental Resilience	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent 4. Mastery
1b.	Social Connections	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent 4. Mastery

1c.	Knowledge of Parenting and Child Development	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent 4. Mastery
1d.	Concrete Support in Times of Need	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent 4. Mastery
1e.	Social and Emotional Competence of Children	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent 4. Mastery
2.	Please rank your competency facilitating the 7 FIR sessions: [most to least competent]		1. Session 1: Strengths & Needs 2. Session 2: Serenity & Courage 3. Session 3: The Stages of Change 4. Session 4: The Bigger Picture: How Family History Influences Parenting & Communication Style 5. Session 5: Discipline & Development 6. Session 6: Healthy Self & Family Wellness 7. Session 7: Bridging the Gap: From Here to Home
3.	Please rank the strength of each FIR session: [strongest to weakest]		1. Session 1: Strengths & Needs 2. Session 2: Serenity & Courage

			3. Session 3: The Stages of Change 4. Session 4: The Bigger Picture: How Family History Influences Parenting & Communication Style 5. Session 5: Discipline & Development 6. Session 6: Healthy Self & Family Wellness 7. Session 7: Bridging the Gap: From Here to Home
1.	The following questions refer to the Families in Recovery Sessions:		
1a.	Session 1: Strengths & Needs	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
1b.	Session 2: Serenity & Courage	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 5. None 1. Basic 2. Competent 3. Mastery
1c.	Session 3: The Stages of Change	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
1d.	Session 4: The Bigger Picture: How Family History Influences	This session is a high priority for FIR participants:	My personal level of competency with this session is:

	Parenting & Communication Style	1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	1. None 2. Basic 3. Competent 4. Mastery
1e.	Session 5: Discipline & Development	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
1f.	Session 6: Healthy Self & Family Wellness	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
1g.	Session 7: Bridging the Gap: From Here to Home	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
Session Length & Supervision			
	How often do you meet with a supervisor to discuss your FIR work?		1. None 2. Multiple times a week 3. Weekly 4. Bi-weekly 5. Monthly 6. Other, please explain
	On average, how long is a typical FIR session?		1. 30-45 minutes

		2. 1 hour 3. 1.5 hours 4. 2 hours 5. More than 2 hours

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Appendix B: Families in Recovery Facilitator CFIR Interview Guide

Thank you for taking the time to talk with me. Our conversation today will include questions about your experience implementing and facilitating the Families in Recovery program. We hope to understand the barriers and facilitators to administering this program and its impact on families.

As discussed during the consent process, I will audio-record our conversation today. This will allow me to focus on our conversation and not forget any important information you share with me. Everything you share with me will be kept private; when our recorded conversation is typed up, we will remove anything that could identify you as the person on the recording. Finally, as a reminder, your participation is completely voluntary - you may skip any question that you choose not to answer and may stop the conversation at any time.
Finally, if there is a question that I ask that you would like me to clarify, please just ask.

Do you have any questions before we get started?

Version A: Currently implementing/planning to begin implementing

Intervention Characteristics

1) How would you describe where you are with implementing Families in Recovery at in your organization? (e.g., just getting started, doing it for a while, but still figuring it out, stopped the program/thinking of stopping the program)
    - How do you think the program is going?
        - Why do you say that?
    - What did you learn when you were first starting the program? *
    - How it is being delivered? (e.g. in person, virtual, both?)
        - What modifications did you have to make for this to be successful in your setting? (Explore virtual, curriculum, facilitation approach/style, timing of sessions, pitch to potential participants)
            - ◊ How was PFSA involved in supporting changes needed at your site? What could PFSA have done differently to be more helpful?
    - How has your agency recruited participants?
        - What has worked well?
        - What has been challenging?
2) What material things do you need to be able to deliver Families in Recovery? (E.g. online resources, marketing materials, a toolkit),
    - Do you have or expect to have sufficient resources to implement and administer Families in Recovery?
        - What has PFSA provided?
        - What resources will be easy to get?
        - [If no] What resources will not be available?
3) How well does FIR fit with your organization's mission or culture (general beliefs, values, assumptions that people embrace)?
    - What level of involvement has leadership at your organization had so far with the intervention?
    - How does FIR fit in with the other programs you offer to families and how they are staffed?

- Tell me about any changes you made to materials or approach so that FIR fit with your organization's culture or setting?

4) How receptive has your organization and staff been to implementing Families in Recovery?
   - How about clients?
5) What gaps does FIR fill in meeting the needs of your agency that weren't met before?
   - What needs do clients have that are still challenging to meet?
6) If you have attended the PFSA FIR training, describe how the training prepared you to carry out the roles and responsibilities expected of you?
   - What was the most helpful or impactful part of the training?
     - Tell me what you took away from the training about…
       - ◊ What it means to be trauma informed
       - ◊ The recovery process
       - ◊ The way family can influence recovery
       - ◊ The Strengthening Families Protective Factors
   - What needs did you have that were not met by the training?
   - What kind of continued training is planned?
     - If you have you attended a PFSA Refresher Course, what were your reactions to that training?
     - What do you think is still needed from trainings?
     - If you have you attended a cohort call, what were your reactions to the call?

Individual

7) What is your experience with small group facilitation?
   - If there was little, how did you prepare to facilitate FIR?
   - Please describe your experience working with individuals with substance use disorders
     - How did you prepare to work with this population?
8) How do you approach facilitation of Families in Recovery groups?
   - What do you bring or do as a facilitator that helps a session to be successful?
   - How do you prepare for each session?
   - What have you learned as a facilitator that has helped you succeed in doing this work? Probe: What advice would you give to someone who was learning to be a facilitator of FIR (to help them be successful)?
9) In your opinion, what do facilitators need to feel prepared and comfortable facilitating in a trauma informed way?
   - What if they have little experience?
10) Please describe the parts of the curriculum that seem to be the most impactful for clients.
   - What needs to work better in the curriculum? What client needs aren't met or need additional support?
   - How does the curriculum address or incorporate peer and social support?
11) How is co-facilitation of FIR utilized at your site?
     - Probe: If not used, why not? What are some of the benefits of co-facilitation? What are the challenges?
12) What kinds of incentives for participants does your organization offer?
   - Probe: Meals? Childcare? Certificates? Gifts?
13) Who do you ask if you have questions about Families in Recovery or its implementation?
   - How available are these individuals?

14) Can you describe any changes you are considering/anticipating/planning for the program in the year ahead?

Outer Setting

15) What are the needs of clients that are impacted by FIR? (probe: improved access to services? Help with parenting? What story would a client tell if they were describing what they got out of FIR?)
    - What needs do clients have that are not met by FIR?
    - What types of families/clients are not a good fit for FIR?
16) Are there any special populations that your agency tries to provide services for? (LGBTQ, Immigrant community, etc.)
    - [If yes] Can you describe any adaptations you've made to the program to meet the needs of this population?
17) What makes it hard for individuals to participate in FIR?
    - Describe any ways you have tried to overcome these barriers with clients?

Process

18) What has been harder than you anticipated about implementing FIR?
    - What are some challenges you think you will be facing moving forward?
19) Is there anything else you would like to add about your experience facilitating or implementing Families in Recovery?

Version B: Sites that stopped/plan to stop implementing

Intervention Characteristics

1) You described how your site either stopped implementing the program or plans to stop implementing the FIR program.
    - Why are you choosing to not implement or discontinue the program?
    - Could you describe what you thought the program would deliver for your site/community?
        - Where did it fall short?
    - How is/was it being delivered? (e.g. in person, virtual, both?)
        - If any, what modifications did you make to try to make this program successful in your setting? (Explore virtual, curriculum, facilitation approach/style, timing of sessions, pitch to potential participants)
            - How was PFSA involved in supporting changes needed at your site? What could PFSA have done differently to be more helpful?
    - How did your agency recruit participants?
        - How successful were you at recruiting participants?
        - What worked well?
        - What has been challenging?
2) What material things did you need to be able to deliver FIR? (E.g. online resources, marketing materials, a toolkit)
    - Do you or have you had sufficient resources to implement and administer FIR?
        - What did PFSA provide?
        - What resources were easy to get?

    - [If no] What resources need to be available?
3) How well does FIR fit with your organization's mission or culture (general beliefs, values, assumptions that people embrace)?
    - What level of involvement did leadership at your organization have with the intervention?
    - How does FIR fit in with the other programs you offer to families and how they are staffed?
    - Tell me about any changes you made to materials or approach so that FIR fit with your organization's culture or setting?
4) How receptive was your organization and staff to implementing Families in Recovery?
    - How about clients?
5) What gaps did FIR fill in meeting the needs of your agency that weren't met before?
    - What needs do clients have that are still challenging to meet?
6) If you attended the PFSA FIR training, describe if and how the training prepared you to carry out the roles and responsibilities expected of you?
    - What was the most helpful or impactful part of the training?
        - Tell me what you took away from the training about…
            - ◊ What it means to be trauma informed
            - ◊ The recovery process
            - ◊ The way family can influence recovery
            - ◊ The Strengthening Families Protective Factors
    - What needs did you have that were not met by the training?
    - What kind of continued training was planned?
        - If you have you attended a PFSA Refresher Course, what were your reactions to that training?
        - What do you think is still needed from trainings?
        - If you have you attended a cohort call, what were your reactions to the call?

Individual

7) Before FIR, what was your experience with small group facilitation?
    - If there was little, how did you prepare to facilitate FIR?
    - Please describe your experience working with individuals with substance use disorders
        - How did you prepare to work with this population?
8) How did you approach facilitation of Families in Recovery groups?
    - What do you bring or do as a facilitator that helps a session to be successful?
    - How did you prepare for each session?
    - What have you learned as a facilitator that has helped you succeed in doing this work? Probe: What advice would you give to someone who was learning to be a facilitator of FIR (to help them be successful)?
9) In your opinion, what do facilitators need to feel prepared and comfortable facilitating in a trauma informed way?
    - What if they have little experience?
10) Please describe the parts of the curriculum that seem to be the most impactful for clients.
    - What needs to work better in the curriculum? What client needs aren't met or need additional support?
    - How does the curriculum address or incorporate peer and social support?
11) Did you co-facilitate the sessions at your site?

    - Probe: If not used, why not? If so, what were some of the benefits of co-facilitation? What are the challenges?

12) What kinds of incentives for participants did your organization offer?
    - Probe: Meals? Childcare? Certificates? Gifts?
13) Who did you ask if you have questions about FIR or its implementation?
    - How available are these individuals?

Outer Setting

14) What are the needs of clients that are impacted by FIR? (probe: improved access to services? Help with parenting? What story would a client tell if they were describing what they got out of FIR?)
    - What needs do clients have that are not met by FIR?
    - What types of families/clients are not a good fit for FIR?
15) Are there any special populations that your agency tries to provide services for? (LGBTQ, Immigrant community, etc.)
    - [If yes] Can you describe any adaptations you've made to the program to meet the needs of this population?
16) What made it hard for individuals to participate in FIR?
    - Describe any ways you have tried to overcome these barriers with clients?

Process

17) What was harder than you anticipated about implementing FIR?
18) Are there other programs you plan to implement to meet client needs in place of FIR?
    - Explain why you chose another program or how to will meet these needs.
19) Is there anything else you would like to add about your experience facilitating or implementing FIR?

Appendix C: FIR Survey II

Families in Recovery Implementation Evaluation Survey 2

The following assessments will provide insight into each site's capacity and process throughout implementation of the Families in Recovery (FIR) Program.

Survey 2 will provide insight into implementation at each site six months after the baseline survey. These questions will be completed by the facilitator and/or leadership identified by each site. This survey seeks information on the activities and programs, both internal and external to the implementation of FIR. The majority of these questions relate specifically to implementation and facilitator capacity, while some are included to gather important contextual information about FIR that may shape technical assistance and training efforts. These surveys were guided by the Consolidated Framework for Implementation Research (CFIR) [4] and the Center for the Study of Social Policy's Strengthening Families and Protective Factors Framework[5]. Additional items on this survey were informed by baseline survey results, a facilitator focus group, facilitator interviews and a review of FIR resources and documents.

To further understand implementation at each site, the Change and Implementation Readiness Assessment[6] tool will assess each organization's capacity and culture around implementing FIR.

FIR Evaluation Domains

To be assessed baseline, 6 months, and 12 months

VII. Organizational Infrastructure & Culture
VIII. Target Population & Community Needs
IX. Change and Implementation Readiness
    a. Motivation
    b. Organizational Capacities
    c. Innovation-Specific Capacities
X. Facilitator training & experience
XI. Perceived facilitator ability to effectively deliver services
XII. Fidelity

[4] https://cFiRguide.org/
[5] https://cssp.org/our-work/project/strengthening-families/
[6] https://capacity.childwelfare.gov/states/focus-areas/cqi/change-implementation/readiness/

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FIR Implementation Survey 2

To be given 6 months after site's completion of the first survey (Facilitator & Administrator)

I. Organization Infrastructure and Resources	
What is the name of your organization?	Choose from list
Has your site held at least one FIR session?	YES/NO
Is your site currently delivering FIR programming?	YES/NO
Have there been significant changes to the leadership or staffing of your organization since [date of Survey 1]?	YES/NO/UNSURE, please explain
Have there been significant changes to the facilitation of FIR since [date of survey 1] (setting, location, etc.)?	YES/NO/UNSURE, please explain
Have there been any other significant changes to FIR since [date of first survey]?	YES/NO/UNSURE, please explain
Are there any changes to FIR you plan to make in the next six months?	YES/NO/UNSURE, please explain
II. Target Population & Community Needs	
Has your organization changed who you are recruiting to participate in FIR since [date of first survey] (for example, parents in active addiction, parents at a particular treatment center, parents in long-term recovery, etc.)	YES/NO/UNSURE, please explain
Have there been any significant changes for the broader community you serve since [date of first survey]	YES/NO/UNSURE, please explain
Have there been any policy changes (federal, regional, local, or at your broader organization) that have impacted implementation of FIR?	YES/NO/UNSURE, please explain

Children's Hospital of Philadelphia℠
2716 South Street
Roberts Center, 10th Floor
Philadelphia, PA 19146
P 267-426-5300
F 267-426-0380
PolicyLab@email.chop.edu
policylab.chop.edu

Survey 2- Online (ADMINISTRATORS ONLY)

	III. Change and Implementation Readiness [Same questions as baseline survey]	
	FIR aligns with the agency's mission, values, and guiding principles.	5. Strongly agree (fully ready to go) 6. Partially agree (somewhat ready) 7. Disagree (not yet ready) 8. Not sure (need more information)
	FIR supports existing programs and initiatives and fits with how the agency does things.	
	FIR is compatible with the values of individuals who will deliver it (e.g., caseworkers, service providers).	
	FIR is compatible with the values of the agency's target population (e.g., families receiving services).	
	Leadership, staff, and stakeholders clearly understand FIR.	
	FIR is viewed as "doable."	
	There are buy-in and support for FIR.	
	FIR is embraced as a priority.	
	FIR is perceived as being better than other alternatives to address the problem and current practice.	
	The expected outcomes of FIR are apparent to leadership, staff, and stakeholders.	
	The agency has appropriate resources (e.g., staff, facilities, materials, and technology) to implement and sustain FIR.	

	Program champions are willing to advocate for FIR and devote efforts to ensure its success. (Program champion is the primary person at your organization who advocates for or leads the implementation of FIR)	
	The agency has staff recruitment and selection systems and processes in place to secure appropriate staff (or contractors) to deliver FIR.	
	The agency has training systems in place that can support competency needs for FIR.	
	The agency has coaching systems in place that can support the application of skills in practice.	
	The agency has processes in place to monitor fidelity to FIR (performance assessment).	
	The agency has data systems and processes in place to track and monitor FIR outputs and outcomes that inform decision-making.	
	The agency has policies and procedures in place to support FIR.	
	Managers and staff have knowledge, skills, and abilities to deliver FIR.	
	There is leadership and organizational support for FIR (including state, county, local, leaders, as relevant).	
	Agency leaders, staff, and stakeholders have a shared vision of the plans and desired outcomes for FIR.	
IV. FIR Impact [Same questions as baseline survey]		

	What do you see as the impact of FIR for your clients? (select top three)	• Families with SUD understand their strengths and networks of formal and informal supports • Increased self-efficacy and resilience • Increased social connection with other families • Increased participation in community activities • Increased concrete support in times of need from our program • Increased referrals to treatment or SUD programs • Increased enrollment in treatment or SUD programs • Other: Specify _____
	What do you see as the impact of FIR on your organization's staff? (select top three)	• Staff are actively engaged in discussions regarding needs of SUD community, gaps in services, and capacity to serve families with SUD • Staff use a family-centered approach when coordinating SUD services with clients • Staff are competent in the Strengthening Families and Protective Factors Framework • Staff have more resources and tools to support families affected by substance use Other: Specify _____
	What do you see as the impact of FIR on your organizational culture? (select top three)	• Honor the strengths and needs of individuals and families with SUD or in recovery • Clear expectations of our organization's role in the community and the role of community organizations on issues related to SUD • Expand organization's capacity to support individuals with SUD or in recovery • Increased participation in community health planning activities • Other: Specify

		_____
	What resources from the curriculum have been most helpful for facilitation of FIR sessions? (select top 3)	• Apps noted in the manual • Mindfulness and CBT techniques • Stages of change activity • Ice breakers • Group discussion • Journaling activities • Other (explain)
	What resources from PFSA have been most helpful for implementation? (select top 3)	• New Facilitator Training • Quarterly Cohort Calls • Annual Refresher Calls • One-on-one Technical Assistance • Foundations of Group Facilitation Training (monthly offering) • Links to online help/reading resources and apps • Other
	What resources do you not have, but feel would help you support implementation of FIR?	• Open ended
	Please give an example of a significant success with a client enrolled in FIR [from the past 6 months]	• Open ended
	Please give an example of a significant challenge with a client enrolled in FIR [from the past 6 months]	• Open ended

FIR Survey 2 (FACILITATORS ONLY)

To be completed online by each facilitator

I. Change and Implementation Readiness		
1.	FIR aligns with the agency's mission, values, and guiding principles.	1. Strongly agree (fully ready to go) 2. Partially agree (somewhat ready) 3. Disagree (not yet ready) 4. Not sure (need more information)
2.	FIR supports existing programs and initiatives and fits with how the agency does things.	
3.	FIR is compatible with the values of individuals who will deliver it (e.g., caseworkers, service providers).	
4.	FIR is compatible with the values of the agency's target population (e.g., families or individuals receiving services).	
5.	Leadership, staff, and stakeholders clearly understand FIR.	
6.	FIR is viewed as "doable."	
7.	There are buy-in and support for FIR.	
8.	FIR is embraced as a priority.	
9.	FIR is perceived as being better than other alternatives to address the problem and current practice.	

10.	The expected outcomes of FIR are apparent to leadership, staff, and stakeholders.	
11.	The agency has appropriate resources (e.g., staff, facilities, materials, and technology) to implement and sustain FIR.	
12.	Program champions are willing to advocate for FIR and devote efforts to ensure its success.	
13.	The agency has staff recruitment and selection systems and processes in place to secure appropriate staff (or contractors) to deliver FIR.	
14.	The agency has training systems in place that can support competency needs for FIR.	
15.	The agency has coaching systems in place that can support the application of skills in practice.	
16.	The agency has processes in place to monitor fidelity to FIR (performance assessment).	
17.	The agency has data systems and processes in place to track and monitor intervention outputs and outcomes that inform decision-making.	
18.	The agency has policies and procedures in place to support FIR.	

19.	Managers and staff have knowledge, skills, and abilities to deliver FIR.	
20.	There is leadership and organizational support for the selected intervention (including state, county, local, leaders, as relevant).	
21.	Agency leaders, staff, and stakeholders have a shared vision of the plans and desired outcomes for FIR.	
II. FIR Impact		
1.	What do you see as the impact of FIR for your clients? (select top three)	• Families with SUD understand their strengths and networks of formal and informal supports • Increased self-efficacy and resilience • Increased social connection with other families • Increased participation in community activities • Increased concrete support in times of need from our program • Increased referrals to treatment or SUD programs • Increased enrollment in treatment or SUD programs • Other: Specify _____
2.	What do you see as the impact of FIR on your organization's staff? (select top three)	• Staff are actively engaged in discussions regarding needs of SUD community, gaps in services, and capacity to serve families with SUD • Staff use a family-centered approach when coordinating SUD services with clients • Staff are competent in the Strengthening Families and Protective Factors Framework • Staff have more resources and tools to support families affected by substance use

		Other: Specify _____
3.	What do you see as the impact of FIR on your organizational culture? (select top three)	• Honor the strengths and needs of individuals and families with SUD or in recovery • Clear expectations of our organization's role in the community and the role of community organizations on issues related to SUD • Expand organization's capacity to support individuals with SUD or in recovery • Increased participation in community health planning activities • Other: Specify _____
4.	What resources from the curriculum have been most helpful for facilitation of FIR sessions? (select top 3)	• Apps noted in the manual • Mindfulness and CBT techniques • Stages of change activity • Ice breakers • Group discussion • Journaling activities • Other (explain)
5.	What resources from PFSA have been most helpful for implementation? (select top 3)	• New Facilitator Training • Quarterly Cohort Calls • Annual Refresher Calls • One-on-one Technical Assistance • Foundations of Group Facilitation Training (monthly offering) • Links to online help/reading resources and apps • Other
6.	What resources do you not have, but feel would help you support	• Open ended

	implementation of FIR?	
7.	Please give an example of a significant success with a client enrolled in FIR [from the past 6 months]	• Open ended
8.	Please give an example of a significant challenge with a client enrolled in FIR [from the past 6 months]	• Open ended

III. Families in Recovery Competency and Fidelity			
1.	The following questions refer to the Strengthening Families Protective Factors domains:		
1a.	Parental Resilience	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent 4. Mastery
1b.	Social Connections	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent 4. Mastery
1c.	Knowledge of Parenting and Child Development	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent

		4. Strongly Agree	4. Mastery
1d.	Concrete Support in Times of Need	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent 4. Mastery
1e.	Social and Emotional Competence of Children	This topic is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this topic is: 1. None 2. Basic 3. Competent 4. Mastery
2.	Please rank your competency facilitating the 7 FIR sessions: [most to least competent]		1. Session 1: Strengths & Needs 2. Session 2: Serenity & Courage 3. Session 3: The Stages of Change 4. Session 4: The Bigger Picture: How Family History Influences Parenting & Communication Style 5. Session 5: Discipline & Development 6. Session 6: Healthy Self & Family Wellness 7. Session 7: Bridging the Gap: From Here to Home
3.	Please rank the strength of each FIR session: [strongest to weakest]		1. Session 1: Strengths & Needs 2. Session 2: Serenity & Courage 3. Session 3: The Stages of Change 4. Session 4: The Bigger Picture: How Family History Influences Parenting & Communication Style 5. Session 5: Discipline & Development

			6. Session 6: Healthy Self & Family Wellness 7. Session 7: Bridging the Gap: From Here to Home
1.	The following questions refer to the Families in Recovery Sessions:		
1a.	Session 1: Strengths & Needs	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
1b.	Session 2: Serenity & Courage	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
1c.	Session 3: The Stages of Change	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
1d.	Session 4: The Bigger Picture: How Family History Influences Parenting & Communication Style	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery

1e.	Session 5: Discipline & Development	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
1f.	Session 6: Healthy Self & Family Wellness	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
1g.	Session 7: Bridging the Gap: From Here to Home	This session is a high priority for FIR participants: 1. Strongly Disagree 2. Disagree 3. Agree 4. Strongly Agree	My personal level of competency with this session is: 1. None 2. Basic 3. Competent 4. Mastery
IV. Fidelity to the program model			
The next few sets of questions will refer to the last FIR cohort your facilitated. *This section includes many possible components of the FIR groups. They may not all apply to your site or setting. Your site will not be "graded" on your answers to this survey, it is for informational purposes only. Please answer as honestly as possible.*			
	Thinking back to the last FIR cohort you facilitated, please identify if this cohort was primarily virtual or in-person.	• Virtual, • In-person	
Thinking back to the last FIR cohort you facilitated, please identify if the following elements were present (to the best of your ability)			
	Orientation session or 1-on-1 meetings for all participants before the start of the program	YES/NO/UNSURE	

	Form a group agreement during the first session (develop list of norms and rules)	YES/NO/UNSURE
	Facilitator's contact info shared with group	YES/NO/UNSURE
	Overview provided of entire program	YES/NO/UNSURE
Thinking back to the last FIR group you facilitated (sessions 1-7), please indicate how often each of the following key components occurred		
Content		Likert scale of occurrence: always, usually, sometimes, rarely, never
	Ice Breaker	
	Agenda/overview of each session (topic, motive, and goals)	
	Use of Workbook during session	
	Appropriate facilitation tools (post-it easels, markers, pens, pencils)	
	Facilitator reads aloud from workbook during session	
	Use of additional probes provided in facilitator workbook	
	Use of additional resources section of the facilitator guidebook	
Physical Space (for in-person groups only)		Likert scale of occurrence: always, usually, sometimes, rarely, never
	Food provided	
	Incentives for attending- diapers, gift cards, or other material items	
	Signage for how to get to meeting space, bathrooms, exits, etc. or someone posted at the front entrance to greet and direct participants	

	Chairs arranged with respect to space (arm's length distance)	
	Participants have table, clipboard, or other writing surface	
	Room arranged in a horseshoe or semi-circle arrangement	
	Childcare provided during session	
	Transportation vouchers provided	
Virtual Setting (visible only to virtual sites)[7]		Likert scale of occurrence: always, usually, sometimes, rarely, never
	Utilize security measures, such as a secure link, password, and/or wait room, in order to ensure that only those invited to the meeting are in attendance.	
	Setting of virtual boundaries and expectations, with explanation (camera on/off, "hand raising", muting when not speaking, popcorn, call-on, etc.)	
	Remind participants that the meeting may not be entirely confidential, especially if there are others in the home who are able to listen in on the meeting	
	Remind participants that they can have fidget toys, water, etc. to make the space more comfortable	
	Invite participants to customize name and pronouns if they would like	
	Discuss and normalize screen fatigue and other common issues with virtual meetings (silence, calling on others, use of chat box)	

[7] Adapted from Trauma-informed Oregon guidelines on virtual group best practice

	Provide a forum for feedback about the session (polls, email, private chat box, etc.)	
	Utilize polling, chat box, or breakout rooms to encourage voice and equal participation	
	Choice regarding camera being on/off	
Facilitation		Likert scale of occurrence: always, usually, sometimes, rarely, never
	Preparation for the session (questions, discussion probes, activities)	
	Session is co-facilitated	
	Sessions start on time (within 20 minutes of the intended start time)	
	Provide information about resources after each group (food pantries, volunteer opportunities, childcare etc)	
	Ensure all participants have fair opportunities to share in the group	
	Enforcement of the group agreement norms and values	
	Modifies workbook content or activities to meet the literacy level of participants	
	All participants engage in discussion or activities at least once during the session	
	Session lasts 1.5-2 hours	
	Participants complete an exit survey	
	Participants have homework assigned for the next session	

Additional Implementation Questions		
	How often do you meet with a supervisor to discuss your FIR work?	1. None 2. Multiple times a week 3. Weekly 4. Bi-weekly 5. Monthly 6. Other, please explain
	On average, how long is a typical FIR session?	1. 30-45 minutes 2. 1 hour 3. 1.5 hours 4. 2 hours 5. More than 2 hours
	How often do you request feedback from participants about their satisfaction with the program?	1. Never 2. Weekly 3. Bi-weekly 4. Monthly 5. Other, please explain
Knowledge, Attitude, and Practice Related to Trauma-Informed Practice Tool [8]		
	Knowledge	Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree
	1. Exposure to trauma is common.	
	2. Trauma affects physical, emotional, and mental well-being.	

[8] King, Simmy DNP, MS, MBA, RN-BC, NE-BC*; Chen, Kuan-Lung Daniel DrPH(c), MPH†; Chokshi, Binny MD‡,§ Becoming Trauma Informed: Validating a Tool to Assess Health Professional's Knowledge, Attitude, and Practice, Pediatric Quality and Safety: September/October 2019 - Volume 4 - Issue 5 - p e215 doi: 10.1097/pq9.0000000000000215 https://journals.lww.com/pqs/Fulltext/2019/09000/Becoming_Trauma_Informed__Validating_a_Tool_to.10.aspx

	3. Substance use issues can be indicative of past traumatic experiences or ACES. (adverse childhood experiences)	
	4. There is a connection between mental health issues and past traumatic experiences or ACES.	
	5. Distrusting behavior can be indicative of past traumatic experiences or ACES.	
	6. Retraumatization can occur unintentionally.	
	Attitude	
	7. Recovery from trauma is possible.	
	8. Paths to healing/recovery from trauma are different for everyone.	
	9. People are experts in their own healing/recovery from trauma.	
	10. Informed choice is essential in healing/recovery from trauma.	
	11. TIP (trauma informed practice) is essential for working effectively with our participants and their families.	
	12. I have a comprehensive understanding of TIP.	
	13. I believe in and support the principles of TIP.	
	14. I share my expertise and collaborate effectively with colleagues regarding the use of TIP.	
	15. I would like to receive more training on TIP.	
	Practice	

	16. I maintain transparency in all interactions with participants.	
	17. I offer participants' choices and respect their decisions.	
	18. I help participants and peers to recognize their own strengths.	
	19. I inform all participants of my actions before I perform them.	
	20. My interaction with each participant is unique and tailored to their specific needs.	
	21. I practice self-care (taking care of my own needs and well-being).	

PolicyLab

Appendix D: FIR Participant Interview Guide

Thank you for taking the time to talk with me. Our conversation today will include questions about your experience participating in the Families in Recovery program. We hope to learn more about your expectations, experiences, and thoughts on what types of changes might help the program improve.

As discussed during the consent process, I will audio-record our conversation today. This will allow me to focus on our conversation and not forget any important information you share with me. Everything you share with me will be kept private; when our recorded conversation is typed up, we will remove anything that could identify you as the person on the recording. As a reminder, your participation is completely voluntary - you may skip any question that you choose not to answer and may stop the conversation at any time.

Finally, if there is a question that I ask that you would like me to clear up, please just ask.

Do you have any questions before we get started?

1. Tell me about how you came to the Families in Recovery Program.
2. Can you share what went into your decision to enroll in Families in Recovery?
    a. Did anyone/anything in particular influence your decision to enroll in Families in Recovery? (CYS, Drug Court, family/friends, etc.)
        i. [If court or CYS ordered]
            1. Did you believe it was fair to be ordered to attend?
            2. What other feelings did you have at the beginning about participating in the program?
    b. What did you like/dislike about how your program involvement began?
        i. What could have been better?
    c. What did you expect to get out of participating in Families in Recovery?
3. Think back to your first Families in Recovery session, what was it like for you?
    a. What were you feeling?
        i. Probe: nervous, excited, not caring one way or the other? Overwhelmed? Resentful or angry?
    b. What happened during that session that made you want to come back?
        i. Did anything happen during the session that made you not want to return?
4. Did you attend Families in Recovery in person or virtually?
    a. How did you feel about attending [virtually or in person] during the COVID-19 pandemic?
    b. What did you like about attending virtually or in person? What did you not like?
    c. Do you think your experience would have been different had you attended (in person/virtually)?
5. What did you appreciate about your Families in Recovery facilitator/leader?
    a. What did they do well?
    b. What could they have done better?
    c. What stands out to you about them?
6. How do you feel about the material/information or skills shared during the Families in Recovery Program?
    a. If you have taken other parenting classes, how was Families in Recovery different?

        i. What made it better or worse?
    b. If you have been a part of other support group programs, how was Families in Recovery different?
        i. What made it better or worse?
        ii. How did you interact with your peers in the course?
            1. What did you learn from them?
            2. What were some of the benefits of the group setting?
                a. Any negatives of the group setting?
7. Please describe the parts of the course that were the most impactful for you? What about Families in Recovery didn't you like or what could be better?

8. What are your thoughts on the participant guidebook?
    a. Did you feel like it was easy to read and understand?
    b. What in the guidebook worked well?
    c. What would you change about it?
    d. How was it used during the sessions?
    e. How did you use it after the sessions?
9. What parts of the Families in Recovery Program were the most valuable to you?
    a. What parts were least valuable?
10. If you could change anything about your experience in the Families in Recovery Program, what would it be?
11. Which session was your favorite?
    a. What about that session made it so good?
    b. Were there any sessions that stood out as less useful than others?
        i. What made them less useful?
12. What, if anything, made it harder for you to participate in Families in Recovery? (probe: transportation, childcare, time of the session)
    a. What support did you have in getting past these barriers?
13. What was your biggest takeaway from the Families in Recovery program?
    a. What lessons do you carry with you today?
14. How did this program change your relationship or interactions with your children?
15. How did this program change your relationship or interactions with your partner, co-parent, or other people who take care of your child?
16. Would you or have you recommended Families in Recovery to friends or family members?
    a. Could you describe why you would or would not?

Appendix E: FIR Survey III

The following assessments will provide insight into each site's capacity and process throughout implementation of the Families in Recovery (FIR) Program.

Survey 3 will provide insight into implementation at each site 12 months after the baseline survey. These questions will be completed by the facilitator and/or leadership identified by each site. This survey seeks information on the activities and programs, both internal and external to the implementation of FIR. The majority of these questions relate specifically to implementation and facilitator capacity, while some are included to gather important contextual information about FIR that may shape technical assistance and training efforts. These surveys were guided by the Consolidated Framework for Implementation Research (CFIR) [1] and the Center for the Study of Social Policy's Strengthening Families and Protective Factors Framework[2]. Additional items on this survey were informed by baseline survey results, survey 2 results, session observations, a facilitator focus group, facilitator interviews and a review of FIR resources and documents.

To further understand implementation at each site, the Change and Implementation Readiness Assessment[3] tool will assess each organization's capacity and culture around implementing FIR.

FIR Evaluation Domains

I. Organizational Infrastructure & Culture
II. Target Population & Community Needs
III. Change and Implementation Readiness
IV. Families in Recovery Impact
V. Families in Recovery Competency and Fidelity
VI. Fidelity to the program model
VII. Trauma Informed Care Assessment Tool

To be given 12 months after site's completion of the first survey (Facilitator & Administrator)

I. Organization Infrastructure and Resources	
What is the name of your organization?	Choose from list
Has your site held at least one FIR session?	YES/NO
Is your site currently delivering FIR programming?	YES/NO
If no, please explain. (When you plan to start, any barriers to beginning the program)	
Have there been significant changes to the leadership or staffing of your organization in the past 6 months?	YES/NO/UNSURE, please explain
Have there been significant changes to the facilitation of FIR since [date of survey 1] (setting, location, etc.)?	YES/NO/UNSURE, please explain
Have there been any other significant changes to FIR in the past 6 months?	YES/NO/UNSURE, please explain
If yes, please explain	
Are there any changes to FIR you plan to make in the next six months?	YES/NO/UNSURE, please explain
II. Target Population & Community Needs	
Has your organization changed who you are recruiting to participate in FIR in the past 6 months (for example, parents in active addiction, parents at a particular treatment center, parents in long-term recovery, etc.)	YES/NO/UNSURE, please explain
If yes, please explain	

Have there been any significant changes for the broader community you serve in the past 6 months?	YES/NO/UNSURE, please explain
If yes, please explain	
Have there been any policy changes (federal, regional, local, or at your broader organization) that have impacted implementation of FIR?	YES/NO/UNSURE, please explain
If yes, please explain	

Survey 3- Online (ADMINISTRATORS ONLY)

III.	**Change and Implementation Readiness [Same questions as baseline survey and survey 2]**	
	FIR aligns with the agency's mission, values, and guiding principles.	9. Strongly agree (fully ready to go) 10. Partially agree (somewhat ready) 11. Disagree (not yet ready) 12. Not sure (need more information)
	FIR supports existing programs and initiatives and fits with how the agency does things.	
	FIR is compatible with the values of individuals who will deliver it (e.g., caseworkers, service providers).	
	FIR is compatible with the values of the agency's target population (e.g., families receiving services).	
	Leadership, staff, and stakeholders clearly understand FIR.	
	FIR is viewed as "doable."	
	There are buy-in and support for FIR.	
	FIR is embraced as a priority.	
	FIR is perceived as being better than other alternatives to address the problem and current practice.	

	The expected outcomes of FIR are apparent to leadership, staff, and stakeholders.	
	The agency has appropriate resources (e.g., staff, facilities, materials, and technology) to implement and sustain FIR.	
	Program champions are willing to advocate for FIR and devote efforts to ensure its success. (Program champion is the primary person at your organization who advocates for or leads the implementation of FIR)	
	The agency has staff recruitment and selection systems and processes in place to secure appropriate staff (or contractors) to deliver FIR.	
	The agency has training systems in place that can support competency needs for FIR.	
	The agency has coaching systems in place that can support the application of skills in practice.	
	The agency has processes in place to monitor fidelity to FIR (performance assessment).	
	The agency has data systems and processes in place to track and monitor FIR outputs and outcomes that inform decision-making.	
	The agency has policies and procedures in place to support FIR.	

	Managers and staff have knowledge, skills, and abilities to deliver FIR.	
	There is leadership and organizational support for FIR (including state, county, local, leaders, as relevant).	
	Agency leaders, staff, and stakeholders have a shared vision of the plans and desired outcomes for FIR.	
IV.	**FIR Impact [Same questions as baseline survey and survey 2]**	
	What do you see as the impact of FIR for your clients? (select top three)	• Families with SUD understand their strengths and networks of formal and informal supports • Increased self-efficacy and resilience • Increased social connection with other families • Increased participation in community activities • Increased concrete support in times of need from our program • Increased referrals to treatment or SUD programs • Increased enrollment in treatment or SUD programs • Other: Specify _____
	What do you see as the impact of FIR on your organization's staff? (select top three)	• Staff are actively engaged in discussions regarding needs of SUD community, gaps in services, and capacity to serve families with SUD • Staff use a family-centered approach when coordinating SUD services with clients • Staff are competent in the Strengthening Families and Protective Factors Framework

		• Staff have more resources and tools to support families affected by substance use Other: Specify _____
	What do you see as the impact of FIR on your organizational culture? (select top three)	• Honor the strengths and needs of individuals and families with SUD or in recovery • Clear expectations of our organization's role in the community and the role of community organizations on issues related to SUD • Expand organization's capacity to support individuals with SUD or in recovery • Increased participation in community health planning activities • Other: Specify _____
	What resources from the curriculum have been most helpful for facilitation of FIR sessions? (select top 3)	• Apps noted in the manual • Mindfulness and CBT techniques • Stages of change activity • Ice breakers • Group discussion • Journaling activities • Other (explain)
	What resources from PFSA have been most helpful for implementation? (select top 3)	• 1, New Facilitator Training • 2, Quarterly Cohort Calls • 3, Annual Refresher Calls • 4, One-on-one Technical Assistance • 5, Foundations of Group Facilitation Training (monthly offering)

		• 6, Links to online help/reading resources and apps • 7, Other
	What resources do you not have, but feel would help you support implementation of FIR?	• Open ended
	Please give an example of a significant success with a client enrolled in FIR [from the past 6 months]	• Open ended
	Please give an example of a significant challenge with a client enrolled in FIR [from the past 6 months]	• Open ended

FIR Survey 3 (FACILITATORS ONLY)

To be completed online by each facilitator

III.	Change and Implementation Readiness	
22.	FIR aligns with the agency's mission, values, and guiding principles.	5. Strongly agree (fully ready to go) 6. Partially agree (somewhat ready) 7. Disagree (not yet ready) 8. Not sure (need more information)
23.	FIR supports existing programs and initiatives and fits with how the agency does things.	
24.	FIR is compatible with the values of individuals who will deliver it (e.g., caseworkers, service providers).	
25.	FIR is compatible with the values of the agency's target population (e.g., families or individuals receiving services).	
26.	Leadership, staff, and stakeholders clearly understand FIR.	
27.	FIR is viewed as "doable."	
28.	There are buy-in and support for FIR.	
29.	FIR is embraced as a priority.	

30.	FIR is perceived as being better than other alternatives to address the problem and current practice.	
31.	The expected outcomes of FIR are apparent to leadership, staff, and stakeholders.	
32.	The agency has appropriate resources (e.g., staff, facilities, materials, and technology) to implement and sustain FIR.	
33.	Program champions are willing to advocate for FIR and devote efforts to ensure its success.	
34.	The agency has staff recruitment and selection systems and processes in place to secure appropriate staff (or contractors) to deliver FIR.	
35.	The agency has training systems in place that can support competency needs for FIR.	
36.	The agency has coaching systems in place that can support the application of skills in practice.	
37.	The agency has processes in place to monitor fidelity to FIR (performance assessment).	

38.	The agency has data systems and processes in place to track and monitor intervention outputs and outcomes that inform decision-making.	
39.	The agency has policies and procedures in place to support FIR.	
40.	Managers and staff have knowledge, skills, and abilities to deliver FIR.	
41.	There is leadership and organizational support for the selected intervention (including state, county, local, leaders, as relevant).	
42.	Agency leaders, staff, and stakeholders have a shared vision of the plans and desired outcomes for FIR.	
IV.	**FIR Impact**	
8.	What do you see as the impact of FIR for your clients? (select top three)	• Families with SUD understand their strengths and networks of formal and informal supports • Increased self-efficacy and resilience • Increased social connection with other families • Increased participation in community activities • Increased concrete support in times of need from our program

		• Increased referrals to treatment or SUD programs • Increased enrollment in treatment or SUD programs • Other: Specify _____
9.	What do you see as the impact of FIR on your organization's staff? (select top three)	• Staff are actively engaged in discussions regarding needs of SUD community, gaps in services, and capacity to serve families with SUD • Staff use a family-centered approach when coordinating SUD services with clients • Staff are competent in the Strengthening Families and Protective Factors Framework • Staff have more resources and tools to support families affected by substance use Other: Specify _____
10.	What do you see as the impact of FIR on your organizational culture? (select top three)	• Honor the strengths and needs of individuals and families with SUD or in recovery • Clear expectations of our organization's role in the community and the role of community organizations on issues related to SUD • Expand organization's capacity to support individuals with SUD or in recovery • Increased participation in community health planning activities • Other: Specify _____
11.	Families in Recovery is effective at increasing participants' peer and/or social support.	• Strongly Disagree • Disagree

		• Agree • Strongly Agree
12.	Please give an example of a significant success with a client enrolled in FIR [from the past 6 months]	• Open ended
13.	Please give an example of a significant challenge with a client enrolled in FIR [from the past 6 months]	• Open ended
14.	What FIR resources have been the most helpful for facilitation?	• Open ended
15.	What resources do you not have, but feel would help you support implementation of FIR?	• Open ended

V.	**Families in Recovery Competency and Fidelity**		
1.	The following questions refer to the Strengthening Families Protective Factors domains:		
1a.	Parental Resilience	This topic is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this topic is: 5. None 6. Basic 7. Competent 8. Mastery

1b.	Social Connections	This topic is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this topic is: 6. None 7. Basic 8. Competent 9. Mastery
1c.	Knowledge of Parenting and Child Development	This topic is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this topic is: 5. None 6. Basic 7. Competent 8. Mastery
1d.	Concrete Support in Times of Need	This topic is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this topic is: 5. None 6. Basic 7. Competent 8. Mastery
1e.	Social and Emotional Competence of Children	This topic is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this topic is: 5. None 6. Basic 7. Competent 8. Mastery
2.	Please rank your competency facilitating the 7 FIR sessions: [most to least competent]		8. Session 1: Strengths & Needs 9. Session 2: Serenity & Courage 10. Session 3: The Stages of Change 11. Session 4: The Bigger Picture: How Family History Influences Parenting

			& Communication Style 12. Session 5: Discipline & Development 13. Session 6: Healthy Self & Family Wellness 14. Session 7: Bridging the Gap: From Here to Home
3.	Please rank the strength of each FIR session: [strongest to weakest]		8. Session 1: Strengths & Needs 9. Session 2: Serenity & Courage 10. Session 3: The Stages of Change 11. Session 4: The Bigger Picture: How Family History Influences Parenting & Communication Style 12. Session 5: Discipline & Development 13. Session 6: Healthy Self & Family Wellness 14. Session 7: Bridging the Gap: From Here to Home
1.	The following questions refer to the Families in Recovery Sessions:		
1a.	Session 1: Strengths & Needs	This session is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this session is: 5. None 6. Basic 7. Competent 8. Mastery
1b.	Session 2: Serenity & Courage	This session is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree	My personal level of competency with this session is: 10. None 4. Basic

		7. Agree 8. Strongly Agree	5. Competent 6. Mastery
1c.	Session 3: The Stages of Change	This session is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this session is: 5. None 6. Basic 7. Competent 8. Mastery
1d.	Session 4: The Bigger Picture: How Family History Influences Parenting & Communication Style	This session is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this session is: 5. None 6. Basic 7. Competent 8. Mastery
1e.	Session 5: Discipline & Development	This session is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this session is: 5. None 6. Basic 7. Competent 8. Mastery
1f.	Session 6: Healthy Self & Family Wellness	This session is a high priority for FIR participants: 5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	My personal level of competency with this session is: 5. None 6. Basic 7. Competent 8. Mastery
1g.	Session 7: Bridging the Gap: From Here to Home	This session is a high priority for FIR participants:	My personal level of competency with this session is:

		5. Strongly Disagree 6. Disagree 7. Agree 8. Strongly Agree	5. None 6. Basic 7. Competent 8. Mastery
VI.	**Fidelity to the program model**		
1.	Was the group mostly virtual or in-person?		Virtual, In-person
2.	**Overall Fidelity** Thinking back to the last FIR cohort you facilitated, please identify if the following elements were present (to the best of your ability) *This section includes many possible components of the FIR groups. They may not all apply to your site or setting. Your site will not be "graded" on your answers to this survey, it is for informational purposes only. Please answer as honestly as possible.*		
	Orientation session or 1-on-1 meetings for all participants before the start of the program		YES/NO/UNSURE
	Form a group agreement during the first session (develop list of norms and rules)		YES/NO/UNSURE
	Facilitator's contact info shared with group		YES/NO/UNSURE
	Overview provided of entire program		YES/NO/UNSURE
3.	**Content** Thinking back to the last FIR group you facilitated (sessions 1-7), please indicate how often each of the following key components occurred.		Likert scale of occurrence: always, usually, sometimes, rarely, never

	Ice Breaker	
	Agenda/overview of each session (topic, motive, and goals)	
	Use of Workbook during session	
	Appropriate facilitation tools (post-it easels, markers, pens, pencils)	
	Facilitator reads aloud from workbook during session	
	Use of additional probes provided in facilitator workbook	
	Use of additional resources section of the facilitator guidebook	
	Role play activities were conducted as described	
4.	**Physical Space (for in-person groups only)** Thinking back to the last FIR group you facilitated (sessions 1-7), please indicate how often each of the following key components occurred.	Likert scale of occurrence: always, usually, sometimes, rarely, never
	Food provided	
	Incentives for attending- diapers, gift cards, or other material items	
	Signage for how to get to meeting space, bathrooms, exits, etc. or someone posted at the front entrance to greet and direct participants	
	Chairs arranged with respect to space (arm's length distance)	
	Participants have table, clipboard, or other writing surface	

	Room arranged in a horseshoe or semi-circle arrangement	
	Childcare provided during session	
	Transportation vouchers provided	
5.	**Virtual Setting (visible only to virtual sites)** Thinking back to the last FIR group you facilitated (sessions 1-7), please indicate how often each of the following key components occurred.	Adapted from Trauma-informed Oregon guidelines on virtual group best practices: https://traumainformedoregon.org/wp-content/uploads/2020/06/TIP-Hosting-a-Virtual-Meeting-Using-Trauma-Informed-Principles.pdf Likert scale of occurrence: always, usually, sometimes, rarely, never
	Utilize security measures, such as a secure link, password, and/or wait room, in order to ensure that only those invited to the meeting are in attendance.	
	Setting of virtual boundaries and expectations, with explanation (camera on/off, "hand raising", muting when not speaking, popcorn, call-on, etc.)	
	Remind participants that the meeting may not be entirely confidential, especially if there are others in the home who are able to listen in on the meeting	
	Remind participants that they can have fidget toys, water, etc. to make the space more comfortable	
	Invite participants to customize name and pronouns if they would like	

	Discuss and normalize screen fatigue and other common issues with virtual meetings (silence, calling on others, use of chat box)	
	Provide a forum for feedback about the session (polls, email, private chat box, etc.)	
	Utilize polling, chat box, or breakout rooms to encourage voice and equal participation	
	Choice regarding camera being on/off	
6.	**Facilitation** Thinking back to the last FIR group you facilitated (sessions 1-7), please indicate how often each of the following key components occurred.	Likert scale of occurrence: always, usually, sometimes, rarely, never
	Preparation for the session (questions, discussion probes, activities)	
	Session is co-facilitated	
	Sessions start on time (within 20 minutes of the intended start time)	
	Provide information about resources after each group (food pantries, volunteer opportunities, childcare etc)	
	Ensure all participants have fair opportunities to share in the group	
	Enforcement of the group agreement norms and values	

	Modifies workbook content or activities to meet the literacy level of participants	
	All participants engage in discussion or activities at least once during the session	
	Session lasts 1.5-2 hours	
	Participants complete an exit survey	
	Participants have homework assigned for the next session	
7.	**Supervision and Implementation**	
	How often do you meet with a supervisor to discuss your FIR work?	1. None 2. Multiple times a week 3. Weekly 4. Bi-weekly 5. Monthly 6. Other, please explain
	Please explain	
	On average, how long is a typical FIR session?	1. 30-45 minutes 2. 1 hour 3. 1.5 hours 4. 2 hours 5. More than 2 hours
	How often do you request feedback from participants about their satisfaction with the program?	1. Never 2. Weekly 3. Bi-weekly 4. Monthly Other, please explain

	Please explain	
VII.	**Trauma Informed Care Assessment Tool**	
1.	**Knowledge**	Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree
	Exposure to trauma is common.	
	Trauma affects physical, emotional, and mental well-being.	
	Substance use issues can be indicative of past traumatic experiences or ACES. (adverse childhood experiences)	
	There is a connection between mental health issues and past traumatic experiences or ACES.	
	Distrusting behavior can be indicative of past traumatic experiences or ACES.	
	Retraumatization can occur unintentionally.	
2.	**Attitude**	Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree
	Recovery from trauma is possible.	
	Paths to healing/recovery from trauma are different for everyone.	
	People are experts in their own healing/recovery from trauma.	
	Informed choice is essential in healing/recovery from trauma.	

	TIP (trauma informed practice) is essential for working effectively with our participants and their families.	
	I have a comprehensive understanding of TIP.	
	I believe in and support the principles of TIP.	
	I share my expertise and collaborate effectively with colleagues regarding the use of TIP.	
	I would like to receive more training on TIP.	
3.	**Practice**	Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree
	I maintain transparency in all interactions with participants.	
	I offer participants' choices and respect their decisions.	
	I help participants and peers to recognize their own strengths.	
	I inform all participants of my actions before I perform them.	
	My interaction with each participant is unique and tailored to their specific needs.	
	I practice self-care (taking care of my own needs and well-being).	

Appendix F: FIR Fidelity Observation Guide
Session 4: The Bigger Picture: How Family History Influences Parenting & Communication Style

V. Domain I: Key Session Components		
Use of the Guidebook	A facilitator read aloud from the workbook during the session.	Yes/No
	A facilitator used at least one of the additional probes provided in the facilitator workbook. - Provided probe: *Ask individuals how their spouse or co-parent might answer these questions. Does it cause conflict or balance to co-parent with someone who perceives discipline and parenting skills differently.*	Yes/No
	A facilitator used the Parenting Styles Character handouts and resources section of the facilitator guidebook.	Yes/No
	A facilitator used the workbook during the session.	Yes/No
Session Content	An agenda/overview of the session (topic, motive, and goals) was provided. - Topic: How Family History Influences Parenting and Communication Style - Objective: To reflectively approach and understand the ways in which role modeling, culture, and family dynamics influence parenting and communication styles. - Goals: Gain insight about family dynamics, understand how a shift to the recovery process impacts the family, gain an understanding of communication styles, develop healthier communication and strengthen parenting approach	Yes/No

	The session included the "My Hero & My Superhero" ice breaker.	Yes/No
	Facilitation tools such as post-it easels, markers, pens, pencils were available and utilized. - For this session: small/medium ball for ice breaker, post-it easel, yellow star stickers or cut outs of varying sizes, pens	Yes/No
	Facilitator(s) refrained from telling participants what is good vs. bad in regard to parenting or communication.	Yes/No
	Facilitator(s) communicated the message that there are no perfect parents, children, or families.	Yes/No
	Communication Style Role Play Activity was conducted	Yes/No
	Parenting Styles Character activity was conducted	Yes/No
VI. Domain II: Facilitation		
Logistics	Session was co-facilitated.	Yes/No
	Sessions started on time (within 20 minutes of the intended start time).	Yes/No
	Session lasted 1.5-2 hours.	Yes/No
	A facilitator provided information about resources after the session (food pantries, volunteer opportunities, childcare etc).	Yes/No
	Participants completed an exit survey.	Yes/No

Best Practices	The facilitator(s) ensured that all participants engaged in the discussion or activities at least once during the session.	Yes/No
	The facilitator(s) enforced the group agreement norms and values.	Yes/No
	The facilitator(s) modified the workbook content or activities to meet the literacy level of participants.	Yes/No
	The facilitator(s) used humor during the session.	Yes/No
	Participants were assigned homework for the next session.	Yes/No
Trauma-Informed Care	Facilitator(s) maintained transparency in interactions with participants	Yes/No
	Facilitator(s) offered participants choices and respected their decisions.	Yes/No
	Facilitator(s) helped participants recognize their own strengths.	Yes/No
	Facilitator(s) informed all participants of their actions before performing them.	Yes/No
	Facilitator(s) tailored interactions with each participant to their unique and specific needs.	Yes/No
VII. Domain III: Physical Space (in-person session)		
Physical Space	There was signage for how to get to meeting space, bathrooms, exits, etc. or someone posted at the front entrance to greet and direct participants.	Yes/No

	Chairs were arranged with respect to space (arm's length distance).	Yes/No
	Participants had table, clipboard, or other writing surface.	Yes/No
	Room was arranged in a horseshoe or semi-circle arrangement.	Yes/No
VIII. Domain IV: Addressing Barriers & Additional Needs		
Barriers & Additional Needs	Childcare provided during session.	Yes/No
	Transportation vouchers provided.	Yes/No
	Facilitator(s) provided information or connection to community or agency resources	Yes/No
IX. Domain V: Virtual Setting		
Virtual Best Practices	Security measures, such as a secure link, password, and/or wait room, were utilized to ensure that only those invited to the meeting are in attendance.	Yes/No
	Facilitator(s) set virtual boundaries and expectations, with explanation (camera on/off, "hand raising", muting when not speaking, popcorn, call-on, etc.)	Yes/No
	Facilitator(s) reminded participants that the meeting may not be entirely confidential, especially if there are others in the home who are able to listen in on the meeting.	Yes/No

	Facilitator(s) reminded participants that they can have fidget toys, water, etc. to make the space more comfortable.	Yes/No
	Facilitator(s) invited participants to customize name and pronouns if they would like.	Yes/No
	Facilitator(s) discussed and normalized screen fatigue and other common issues with virtual meetings (silence, calling on others, use of chat box).	Yes/No
	Facilitator(s) provided a forum for feedback about the session (polls, email, private chat box, etc.).	Yes/No
	Facilitator(s) utilized polling, chat box, or breakout rooms.	Yes/No
	Facilitator(s) provided a choice regarding camera being on/off.	Yes/No

Appendix G: FIR Fidelity Observation Tool

Families in Recovery Session 4 Observation Tool

Agency:					
Observer:		0	Overall Score:	0%	
Date:		21		Needs Improvement	
Number of Participants:					

Domain I: Key Session Components				SCORE 3- Well Developed 2- Moderately Developed 1- Minimally Developed 0- Needs Improvement		COMMENTS
		Overall Score in Domain I		0%	0	
Use of the Guidebook	☐	A facilitator read aloud from the workbook during the session.	16.7%	0	50%	
	☐	A participant read aloud from the workbook during the session.	16.7%			
	☐	A facilitator discussed at least one of the additional probes provided in the facilitator workbook. *Provided probe: Ask individuals how their spouse or co-parent might answer these questions. Does it cause conflict or balance to co-parent with someone who perceives discipline and parenting skills differently.*	16.7%			
	☐	A facilitator referenced the workbook during the session.	16.7%			
	☐	A facilitator reviewed the Parenting Styles Character handouts.	16.7%			
	☐	A facilitator referenced the resources section of the guidebook.	16.7%			
			0			
Session Content	☐	An agenda/overview of the session (topic, motive, and goals) was provided. *-Topic: How Family History Influences Parenting and Communication Style* *-Objective: To reflectively approach and understand the ways in which role modeling, culture, and family dynamics influence parenting and communication styles.* *-Goals: Gain insight about family dynamics, understand how a shift to the recovery process impacts the family, gain an understanding of communication styles, develop healthier communication and strengthen parenting approach.*	10%	0	50%	
	☐	The session included the "My Hero & My Superhero" ice breaker.	10%			
	☐	Facilitation tools such as post-it easels, markers, pens, pencils were available and utilized. *-For this session: small/medium ball for ice breaker, post-it easel, yellow star stickers or cut outs of varying sizes, pens*	10%			**Parenting Styles Role Play Activities Notes:**
	☐	Facilitator(s) refrained from telling participants what is good vs. bad in regard to parenting or communication.	10%			
	☐	Facilitator(s) communicated the message that there are no perfect parents, children, or families.	10%			**Communication Role Play Activities Notes:**
	☐	Communication Style Role Play Activity was conducted as described *(add notes describing how the activity was conducted)*	25%			
	☐	Parenting Styles Character activity was conducted as described *(add notes describing how the activity was conducted)*	25%			
			0			

Domain II: Facilitation				SCORE 3- Well Developed 2- Moderately Developed 1- Minimally Developed 0- Needs Improvement		COMMENTS
		Overall Score in Domain II		0%	0	
Logistics	☐	Session was co-facilitated.	20%	0	20%	
	☐	Sessions started on time (within 20 minutes of the intended start time).	20%			
	☐	Session lasted 1.5-2 hours (+ or - 5 minutes).	20%			
	☐	A facilitator provided information about resources after the session (food pantries, volunteer opportunities, childcare etc).	20%			
	☐	Participants completed an exit survey.	20%			
			0			
Best Practices	☐	The facilitator(s) ensured that all participants engaged in the discussion or activities at least once during the session.	11%	0	20%	
	☐	The facilitator(s) referenced and/or reinforced the group agreement norms and values.	11%			
	☐	The facilitator(s) provided examples when asking questions or giving activity instructions.	11%			
	☐	The facilitator(s) modified the workbook content or activities to meet the literacy level of participants.	11%			
	☐	The facilitator(s) adeptly moderated participants' differences of opinions or parenting styles *(comment in notes section if this item occurred*)	11%			
	☐	The facilitator(s) used reflective listening during the session.	11%			
	☐	The facilitator(s) used humor during the session.	11%			
	☐	The facilitator(s) checked on or asked about homework from the previous session	11%			
	☐	Participants were assigned homework for the next session.	11%			
			0			

Trauma-Informed Care	☐	Facilitator(s) provided reminders or advance notice of upcoming transitions during the session.	12.5%	0	40%	
	☐	Facilitator(s) offered participants choices and respected their decisions.	12.5%			
	☐	Facilitator(s) helped participants recognize their own strengths.	12.5%			
	☐	Facilitator(s) provided time at the end of the session to debrief or check in about the session.	12.5%			
	☐	Facilitator(s) informed all participants of their actions before performing them.	12.5%			
	☐	Facilitator(s) used statements that validated or affirmed participants' experiences or feelings.	12.5%			
	☐	Facilitator(s) adjusted content to meet clients where they are (shifting content, focus, or duration based on client needs)	12.5%			
	☐	Facilitator(s) demonstrated cultural humility by doing some or all of the following: being curious about participant experiences, asking open-ended questions, allowing differences of opinion between participants to remain unresolved and emphasizing that differences not needing to be resolved is a good thing, hearing all perspectives without judgment or feeling the need to place value (good versus bad) on these experiences	12.5%			
			0			

Domain III: Physical Space (in-person session)				**SCORE** **3- Well Developed** **2- Moderately Developed** **1- Minimally Developed** **0- Needs Improvement**		**COMMENTS**
Physical Space		**Overall Score in Domain III**		0%	0	
	☐	There was signage for how to get to meeting space, bathrooms, exits, etc. or someone posted at the front entrance to greet and direct participants.	20%	0	100%	
	☐	Chairs were arranged with respect to space (arm's length distance).	20%			
	☐	The space was free of any items that may be triggering or potentially perceived negatively towards SUD or parenting.	20%			
	☐	Participants had table, clipboard, or other writing surface.	20%			
	☐	Room was arranged in a horseshoe or semi-circle arrangement.	20%			
			0			

Domain III: Virtual Space			SCORE 3- Well Developed 2- Moderately Developed 1- Minimally Developed 0- Needs Improvement		COMMENTS
Virtual Space		**Overall Score in Domain III**	0%	0	
		Security measures, such as a secure link, password, and/or wait room, were utilized to ensure that only those invited to the meeting are in attendance.	0	100%	
		Facilitator(s) set virtual boundaries and expectations, with explanation (camera on/off, "hand raising", muting when not speaking, popcorn, call-on, etc.)			
		Facilitator(s) reminded participants that to maintain confidentiality, they should be in a private space.			
		Facilitator(s) reminded participants that they can have fidget toys, water, etc. to make the space more comfortable.			
		Facilitator(s) invited participants to customize name and pronouns if they would like.			
		Facilitator(s) discussed and normalized screen fatigue and other common issues with virtual meetings (silence, calling on others, use of chat box).			
		Facilitator(s) provided a forum for feedback about the session (polls, email, private chat box, etc.).			
		Facilitator(s) utilized polling, chat box, or breakout rooms.			
		Facilitator(s) provided a choice regarding camera being on/off.			

Domain IV: Addressing Barriers & Additional Needs				SCORE 3- Well Developed 2- Moderately Developed 1- Minimally Developed 0- Needs Improvement		COMMENTS
Barriers & Additional Needs		**Overall Score in Domain IV**		0%	0	
		Childcare provided during session.	33%	0	100%	
		Transportation vouchers provided.	33%			
		Facilitator(s) provided information or connection to community or agency resources	33%			
			0			