Community Response Program Evaluation Design

Prepared for the Wisconsin Children's Trust Fund

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Program Evaluation
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This evaluation plan was prepared by graduate students at the University of Wisconsin-Madison. The contents of the plan may not reflect the views of the University or the client.

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Executive Summary

In 2006, the Wisconsin Children's Trust Fund (CTF) developed the Community Response Program (CRP), a voluntary program designed to prevent child maltreatment. CRP serves families who have been referred to Child Protective Services (CPS), but whose cases are closed or unsubstantiated. These families remain at higher risk of subsequent re-referral to CPS. The program's interventions are grounded in the theory that addressing household stress factors and cultivating positive family strengths will reduce incidences of child maltreatment. CRP is being evaluated to determine whether the program reduces re-referrals to CPS and strengthens parent-child attachment. To infer a causal link from the program and family outcomes, we recommend using a randomized control trial to evaluate CRP.

Evaluations of similar programs have had design flaws that make it difficult to infer a causal link between the program interventions and reduced incidences of child maltreatment. We recommend using the intent to treat methodology for the randomized control trial, which will estimate the impact of CRP on families who are referred to CRP compared to a control group. A validated survey and state administrative data (eWiSACWIS) will be used to measure outcomes, including re-referrals to CPS and changes in parent-child attachment.

The advantages of this evaluation design are twofold. First, this research design has been used by CTF before in its evaluation of Project GAIN (Gaining Access to Income Now) in Milwaukee. Familiarity with the program design will help buy-in of program staff and CRP's governing board. Second, the evaluation's rigor promises to stand up to scrutiny. Assuming proper implementation, the evaluation should be able to infer a causal link between CRP and the evaluation outcomes. If the evaluation finds positive outcomes, it will allow CTF to make a convincing argument that CRP is worthwhile and should be expanded statewide.

Introduction

A. Program Overview and Purpose of Evaluation

In 2006, Wisconsin Children's Trust Fund (CTF) developed the Community Response Program (CRP), a voluntary program designed to prevent child maltreatment. CRP serves families who have been referred to Child Protective Services (CPS), but whose cases were unsubstantiated and are now closed. Research has indicated that families whose cases are closed after investigation into alleged maltreatment have a similar risk of recidivism as families whose cases are substantiated and investigated further. The program aims to prevent child maltreatment and future referrals to CPS by addressing household stressors and risk factors, such as financial crises, availability of childcare, and access to transportation. Emphasizing building family strengths, the program provides case management, home visits, collaborative goal setting, and access to financial supports to achieve these goals (Bakken et al. 2014).

The main purpose of evaluating CRP at this time is to determine whether the program prevents child maltreatment and strengthens families. This information will be used in determining if CRP would likely have similar outcomes if implemented statewide. CRP has already been studied in terms of implementation by the Institute for Research on Poverty in 2006, and the current eight CRP sites are finalizing a best practices manual and model framework. A similar program providing an economic intervention, Project GAIN (Gaining Access to Income Now) in Milwaukee, is currently being evaluated using a randomized control trial. In addition, a La Follette School Capstone Project gave an overview of what other states are currently doing and recommended the CTF pursue a randomized control trial to effectively evaluate the program in terms of impacts and to generate evidence to support expansion in Wisconsin and nationally (Bakken et al. 2014).

B. Theory of Change and Related Literature Review

a. Risk Factors and Protective Factors

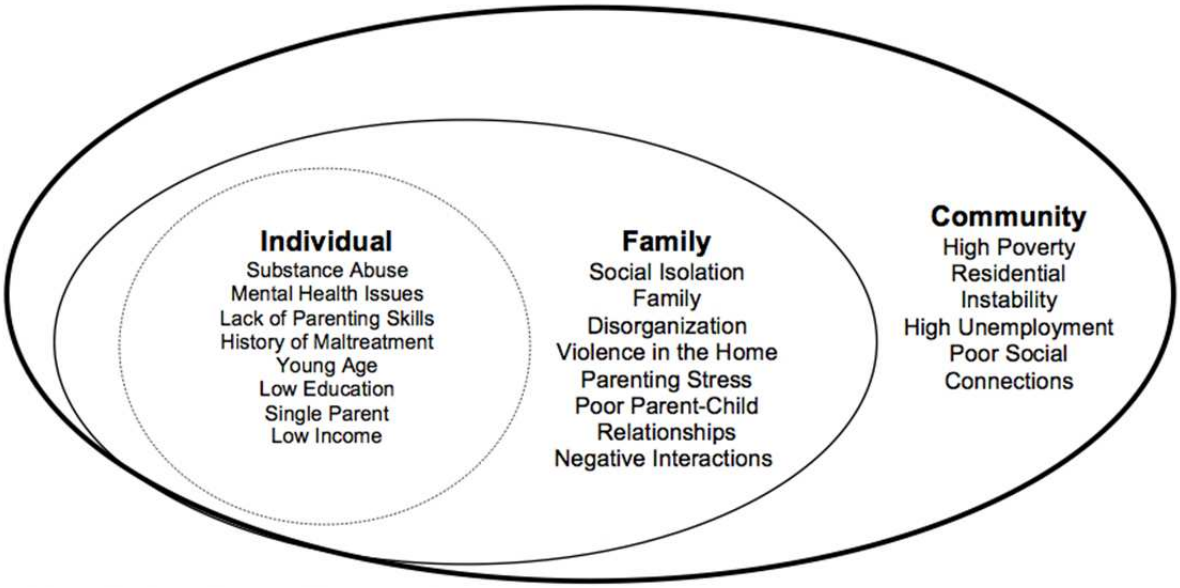
Families that have been referred to CPS have a significantly higher probability of being re-referred to CPS. Of the total cases screened in to CPS, including both those that are substantiated and those that are not substantiated, five percent are re-reported to CPS within six months after the initial investigation (Fluke et al. 1999). Approximately 25 to 30 percent of all families screened in to CPS are re-referred within two years of the initial investigation (Marathon County CRP).

The basic theory of change in CRP and related programs is that addressing household stress factors and cultivating positive family strengths will reduce incidences of child maltreatment. This reduced incidence of child maltreatment could then be measured by the comparative rates of families' re-referrals to CPS.

There is significant evidence from the fields of psychology, social work, and sociology that household risk factors influence rates of child maltreatment. Economic resources, economic hardship, parenting, and parent well-being are all related to the treatment of children (Slack et al. 2011). For example, parental depression has a statistically significant association with an increased rate of child maltreatment (Slack et al. 2011). Low-income households and communities with higher unemployment also experience higher rates of reported child maltreatment (Wadfogel 2005). Children with special needs are at a higher risk of maltreatment, which is often associated with the effects of an increased caregiver burden (Centers for Disease Control and Prevention 2013). Young children also experience higher rates of maltreatment, and a third of all reported victims of child maltreatment are younger than three years old (U.S. Department of Health and Human Services 2012). The Center for Disease Control and

Prevention (CDC) identifies several significant risk factors at the individual, family, and community levels illustrated in Figure 1:

Figure 1. Risk Factors for Perpetration within the Social-ecological Model



Source: Bakken et al. 2014, 4.

Approximately 80 percent of child maltreatment cases involve a child's parent, which means that the characteristics and well-being of parents are particularly significant in addressing risk factors (U.S. Department of Health and Human Services 2012).

Protective factors within families and households can serve as mechanisms to both buffer the effects of childhood maltreatment and to prevent child maltreatment. Social support, including other family members and friends, can help mitigate the long-term effects of cumulative child maltreatment, such as depression and anxiety (Folger and O'Dougherty Wright 2013). The promotion of education and adaptive coping strategies among children who have experienced maltreatment is associated with a reduced rate of personality disorders in adulthood (Hengartner et al. 2013). The development of family strengths and attachment may also prevent the occurrence, or recurrence, of child maltreatment. Emotionally responsive, supportive, and

protective relationships allow children to thrive (Lawler et al. 2011). Interventions that can repair or create these relationships within families would allow children to thrive in safe, stable, and permanent homes (Lawler et al. 2011). For example, programs that specifically address parental substance abuse can not only have the effect of reducing substance use, but also reducing parental depression and reducing parental psychological aggression towards their children (Schaeffer et al. 2013). These outcomes can result in fewer substantiated cases of child maltreatment, fewer out-of-home placements, and reduced experiences of anxiety among children and youth (Schaeffer et al. 2013). Cultivating attachment between parents and children reduces incidences of child maltreatment, and can also allow children to development stable friendships outside of the home (Lawler et al. 2011). Both types of relationships can help to prevent child maltreatment (Lawler et al. 2011). CRP, and programs like it, may cultivate these types of protective family strengths.

b. Evaluations of Similar Programs

Wisconsin is one of a number of states with a program that responds to screened-out referrals from CPS. These programs are often called differential or alternative response programs (Bakken et al. 2014). Currently, nine states have a formal, statewide response to screened out referrals (Child Welfare Information Gateway 2008). Wisconsin is one of five states that have formal implementation in part of the state. Several other states have varying types of alternative response programs, though many use a different program design than CRP. Though there is widespread implementation of different types of alternative response, only a few states have a published evaluation backing up the effectiveness of their program. This lack of evaluation is likely caused by the relative newness of alternative response programs. A

Wisconsin evaluation could contribute strong evidence to the body of literature on programs that respond to screened-out referrals from CPS.

Minnesota conducted an evaluation of their Parent Support Outreach Program (PSOP) to provide evidence that the program should be expanded statewide (Loman et. al. 2009). At the time, the program served screened out families in 38 counties. The evaluation divided families into groups with high levels of poverty needs and low levels of poverty needs. A dosage model was used in order to compare the number and timing of CPS reports during and after PSOP participation. The evaluation found that higher needs families whose needs were addressed by PSOP had the same level of re-referral to Minnesota's Child Welfare Agency as lower needs families. The evaluation also found that participating parents rated their child care abilities higher after the program and believed that they had benefitted from the program. Caseworkers also believed that the needs of families were addressed through the program, allowing parents to focus on caregiving. The main weakness of the PSOP evaluation was the lack of a control group. Without a control group, there is no way draw a causal link between PSOP and the associated positive program impact.

North Carolina operates a type of alternative response program called the Multiple Response System (MRS) (Loman and Siegel 2004). Participating counties respond to reports of child maltreatment with one of two tracks: investigative assessment (traditional investigation) or family assessment (alternative response). The family assessment track uses a strengths-based approach that engages the family in finding solutions to their needs. It differs from Wisconsin's CRP in that the family assessment track includes a further recommendation of services needed, services recommended and services not recommended. The MRS program conducted an implementation evaluation from 1996 to 2003. The evaluation matched ten pilot counties with

nine control counties with similar sizes and similar child welfare caseloads (one pilot county was excluded from comparison due to the fact that it was impossible to find a matching control county). The evaluation used surveys, focus groups, and administrative databases to collect data. Caseworkers chose the families to participate in surveys, potentially introducing bias into the evaluation. The evaluation found that MRS did not affect the level of children's safety, but that it helped human services agencies coordinate better.

The research design of the MRS evaluation had a few flaws that affect the strength of its results. The use of comparison counties, while valuable in providing a comparison group, may have introduced bias into the evaluation. Counties were not matched based on demographic or economic characteristics, which likely influence the risks to child safety in each county. In addition, allowing caseworkers to choose the families who complete the survey is problematic. It is possible that caseworkers wish for the program to be seen as successful and, therefore, choose the most successful families to complete the survey. Flaws such as these temper the results of the MRS evaluation.

c. Previous Evaluations of Wisconsin's CRP

In addition to evaluations of similar programs in other states, there have been evaluations of CRP in Wisconsin using several vantage points and a variety of methods. Slack, Berger, and Maguire-Jack (2012) conducted an implementation study of the CRP pilot sites and next cohort of sites (Slack 2012). They examined the fidelity of sites to their proposed service models, factors that predict family engagement, characteristics of families and their needs, factors that predict progress toward service goals, and families' experiences of CRP. Slack and colleagues gave recommendations for which families to target in the CPS system, using a simple, pre-established protocol for referrals, ensuring participation is voluntary, process of assessment

before comprehensive goal setting, meeting in the home of the family, and maintaining the program as a short intervention.

Using a quasi-experimental design, Maguire-Jack (under review) compares the outcomes of re-referrals to CPS of CRP participants to eligible, wait-listed families in Marathon County, WI. Marathon County started as a site under CTF and has since been independently implementing CRP with county funds. Comparing means of the treatment group and the comparison group, the study found that families who participated in CRP compared to families who were waitlisted had a mean difference of -0.28 for new referrals, -0.19 for new neglect referrals, and -0.113 for any out-of-home placement, all of which are statistically significant at a $p < 0.05$. At a $p < 0.10$, participant families also had lower rates of screened in referrals, substantiated referrals, and cases opened for ongoing services (Maguire-Jack under review).

Currently, Project GAIN in Milwaukee, a similar program that focuses on economic factors only, is currently being evaluated using a randomized control trial by Slack and Berger (Bakken et al. 2014). This study is the first of its kind to "experimentally test the potential role that economic factors may play in child maltreatment prevention" (Bakken et al. 2014, 5). Initial findings indicate that participating families are 39 percent less likely than the control group to have investigated reports by CPS, 45 percent less likely to have a substantiated report, and 12 percent less likely to have an out-of-home placement over the year following participation.

Finally, Bakken and colleagues (2014), as part of a La Follette School of Public Affairs workshop project, overviewed the CRP and its current heterogeneity across sites and recreated a national survey of corollary programs in other states. The authors surveyed states using the same survey as created by Morley and Kaplan (2011) and found that states are moving to develop and expand systems to meet the needs of families who interact with the CPS system but do not reach

the point of out-of-home placement. They recommended conducting a randomized control trial to as the best means to establish whether there is a causal link between participating in CRP and the rate of CPS re-referrals.

While there have been some studies estimating the effects of CRP in certain contexts, there are still questions remaining that could benefit from a rigorous evaluation design, which will be addressed in Section D: Research Questions, Hypotheses and How Evaluation Will Contribute to Knowledge. Before addressing remaining questions, it is important to understand the program purpose, interventions, and population.

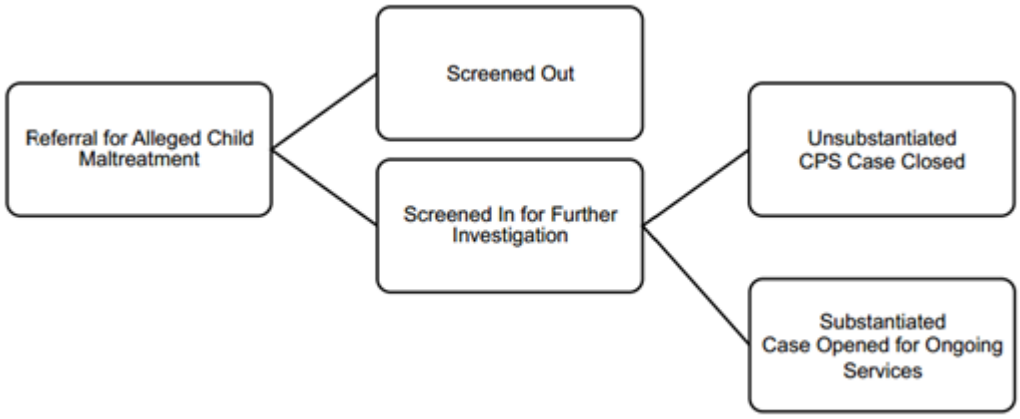
C. Program Purpose, Interventions, Population

The purpose of CRP is to prevent child maltreatment by serving families who have been referred to Child Protective Services (CPS), but whose cases were unsubstantiated and are now closed. Families whose cases are closed after investigation into alleged maltreatment have a similar risk of recidivism as families whose cases are substantiated and investigated further (Bakken et al. 2014). A voluntary program, CRP offers services to families who would otherwise not receive intervention services after leaving the CPS system. CRP staff work with families to address household risk factors and cultivate family strengths. CRP places an uncommon emphasis among child maltreatment prevention programs on improving family economic situations to decrease stress and provide children with necessities (Slack 2009).

The CRP model provides case management via home visitation, collaborative goal setting, referrals for services, and small flexible funds for urgent needs. CRP is run at the county level by either a community organization or the county CPS. Each program receives referrals from CPS cases that have been screened out at the initial phase or when the case was screened in

but then closed due to being unsubstantiated. Caseworkers receive contact information for these families and through a series of different types of communication, then offer program enrollment to these eligible families. Figure 2 demonstrates the processes that families go through in the CPS system. Both families who are screened out or families whose cases are unsubstantiated and the CPS case is closed are eligible for CRP services.

Figure 2. Child Protective Services Process



Source: Bakken et al. 2014.

After agreeing to participate, CRP caseworkers meet with families in their homes (unless the family requests a different setting) and complete the initial assessment. The initial assessment/intake process includes the CRP intake form (general information about the family composition and demographics), financial intake form (identify family economic needs), income and benefits inventory, economic self-assessment (identify family strengths and goals), and the Family Support Tool (FaST) tool (assessing strengths and risk areas of parent-child interactions). Families work with caseworkers to evaluate strengths and work on achieving three to five (Wisconsin Children's Trust Fund 2014c) collaboratively set goals over a three to five month period (Wisconsin Children's Trust Fund 2014a). Overall, for CRP, the goal-setting process "should empower the family to advocate for change, encourage family self-determination,

educate families on their options, and recognize a family's expertise in meeting needs," (Bakken et al. 2014, 8). Figure 3 below outlines CRP service areas and provides examples of each.

Figure 3. Community Response Program Service Areas

Service Area	Examples
Domestic violence services	Assistance with transportation to appointments, connection to benefits, advocating for services and a safety plan, etc.
Employment/Job assistance	Connect with job center; assist with filling out applications; job counseling; education (complete GED, assist with technical college or trade school, etc.); assist with certification or license completion (completing paper work, assisting with fees, etc.)
Family medical needs	Assistance with transportation to appointments, connection to benefits, advocating for services (immunizations, well-baby check-ups, dental care, etc.)
Financial support	Financial decision-making skills (budgeting, prioritizing, bill paying, etc.); public benefits (assessing potential eligibility; assisting with renewal process; liaison with county economic support, etc.); taxes; utilities; child care or head start assistance, etc.
Household or family needs	Connection to community resources, assistance with transportation to community resources, advocating for the family's needs, etc.
Housing	Working with landlords; connecting to housing/rental assistance; assistance with relocating to a more economical location (rental cost or proximity to employment, etc.)
Mental health services	Assessments, assistance with transportation to appointments, connection to benefits, advocating for services, etc.
Parent education and child development	Assessments, assistance with transportation to appointments, connection to benefits and services, advocating for services, parent education classes, etc.
Substance abuse services	Assessments, assistance with transportation to appointments, connection to benefits, advocating for services, etc.

Source: Wisconsin Child Abuse and Neglect Prevention Board 2013, retrieved from Bakken et al. 2014.

Throughout the program, the frequency and duration of meetings depends on the families' needs, but, at a minimum, caseworkers check in with families every two weeks (Wisconsin Children's Trust Fund 2014a). Defined by (but not limited to) CRP service areas, goals range from stabilizing housing to connecting to benefits to facilitating access to medical, mental health, and substance abuse treatment. Another key aspect includes flexible funds that

caseworkers can use as a last resort form of emergency assistance to families to maintain or establish stability. Flexible funds can be used for a variety of goods or services, including buying essential household items, paying rent or a security deposit, child care expenses, energy bills, education or training expenses (Wisconsin Children's Trust Fund. 2014a). Of families that receive flexible funds, the dollar amount averaged $222 (Wisconsin Children's Trust Fund 2014b).

CRP addresses the household stress factors that individual families identify, so every intervention is unique. Thus, the types of CRP interventions vary by household needs. The method and type of CRP interventions also vary by the available community resources and the resources of the organization that operates CRP in that specific location (Bakken et al. 2014). However, all sites are required to have these four elements: strengths-based engagement and assessment; assessment of income-related needs; linkage to income and benefits; and the provision of flexible funding to assist with immediate material concerns (e.g., food, clothing, shelter, transportation) (Slack 2009).

The target population for CRP is families who have been reported to CPS whose cases are not substantiated. For July 2013-June 2014, CRP served 482 families in Wisconsin (Wisconsin Children's Trust Fund 2014c). Of those served, 70 percent had a high school degree or less, over 60 percent were not working, and nearly 65 percent made $20,000 or less per year. In addition, over 20 percent of caregivers had an identified disability. By racial and ethnic composition, 73.3 percent of participants were white, 9.9 percent were African American, 8.1 percent were Hispanic, 3.1 percent were American Indian, and the remaining percentage were multiracial, Asian American, or unknown. Almost 12 percent of primary caregivers were pregnant. Over 60 percent of families reported it would be difficult to come up with $100 in an

emergency, and almost 30 percent of families reported concerns about losing their housing within three months (Wisconsin Children's Trust Fund 2014c).

The population of families in the next iteration of CRP is expected to be relatively similar to families who have previously received Wisconsin CRP services. However, there may be a few significant differences. Wisconsin counties vary by demographic characteristics, rural and urban characteristics, and socio-economic characteristics. The counties included in the next iteration of CRP associated with this evaluation will be determined by the request for proposals (RFP) process, which will be discussed further in Section C: Target Population, Power Analysis, Sample Size, and Minimizing Sampling Bias.

D. Research Questions, Hypotheses and How Evaluation Will Contribute to Knowledge

The Community Response Program (CRP) is being evaluated at this time to find answers to the following research questions:

1. Do families who have previously been reported to CPS who participate in CRP have significantly lower rates of re-referrals to CPS compared to eligible families who do not participate in CRP?
2. Do families who participate in CRP improve significantly more on measures of family strength (measured by the Family Support Tool) compared to eligible families who do not participate in CRP?

Families screened out of CPS will be divided into control and treatment groups. The treatment group will be offered services by CRP, and control group families will not. Key outcomes, including rates of re-referral to CPS and markers of family strengths, will be measured in both groups and compared.

Based on initial evidence from implementation and the program's theory grounded interventions, we expect overall that the group of families who are offered CRP to have

significantly lower rates of re-referrals to CPS compared to the group of families who are not offered CRP. Because decreasing the rate of re-referral to CPS is a goal of CRP, this outcome would mean that CRP is attaining its goals and would lend strength to the argument that CRP is a worthwhile public program. In addition, we expect that families who participate in CRP will improve significantly more on measures of family strength, based on the assumption that the interventions used in CRP have a positive impact on family strength.

Evaluation Design

A. Logic Model

The logic model for the Community Response Program outlines the resources (inputs) that facilitate the outputs (activities and participation) that lead to the outcomes (short-, medium-, and long-term impacts) that operate to prevent future child maltreatment for participating families. See Appendix A for the visual illustration.

Using funding and evidence-based practices and tools from CTF, CRP agencies receive referrals from CPS, hire and direct CRP caseworkers, and form and maintain community partnerships. Caseworkers use funding for transportation and case management, office space, and the practices and tools to work with families. The families who opt to participate work with the caseworker to identify needs and determine service goals. To achieve these goals, caseworkers build on families' strengths and support them through case management, direct service provision, referrals to community partners, emergency funding, and home visitation. Caseworkers report the results of assessments and goal progress to their CRP site, who then reports to CTF. CTF monitors sites' adherence to the CTF model of the CRP service delivery. These activities by participating families and CRP staff facilitate families' achievement of their service goals, which

both parties agree were completed. Achievement of these goals leads to greater family strengths (as measured by the FaST tool) by reducing stress, increasing stability, and providing education. Increasing strengths and decreasing stress levels of participating families leads to decreased re-referrals to CPS, decreased substantiated re-referrals, fewer out-of-home placements, and increased long-term strength of parent-child relationships.

B. Research Methodology

We recommend that CTF use a randomized control trial (RCT) to evaluate the effectiveness of CRP. An RCT lets researchers infer a causal link between the program and the observed effects. This causal link can be ascertained because treatment and control groups are equated, making any other explanation for observed effects unlikely. This design will allow researchers to obtain effect size estimates free of selection bias. The CRP program model does not naturally create a comparison group that could be used as the counterfactual without the use of RCT. For example, using the group of families who do not agree to participate in CRP as the comparison group may introduce selection bias into the evaluation due to potential unobserved differences between those who agree to participate and those who do not.

Another decision is the point at which to randomize families into treatment and control groups. When randomization occurs determines the type of population the evaluation measures outcomes for. Two options for CRP include randomizing at the point of referral, which evaluates CRP outcomes for the eligible population, and randomizing after families agree to participate, which evaluates CRP outcomes for families who are motivated to participate. We recommend randomizing eligible families at the point of referral. Randomizing at this point means that the only difference between the treatment and control group should be that the

treatment group is offered CRP and the control group is not. The treatment group will include families who choose to participate and those who will choose not to participate, mirroring the take-up rate for a voluntary program. To randomize for the evaluation, researchers will receive a list of eligible families from CPS and then randomize these families into treatment and control groups. Only researchers will have knowledge of the control group families and will be in charge of collecting the control group data. For the treatment group, researchers will send the list of treatment group clients to the CRP agencies.

Another option for when to implement randomization is after families have agreed to participate. We decided against this option for two main reasons, including decreasing the likelihood of agency interference with randomization and objections to families accepting and then not receiving programming. Randomizing at referral instead of after families agree to participate helps to avoid the possibility of adding selection bias by program administrators into the evaluation. As randomization will be done by researchers before CRP agencies receive the list of clients to contact, CRP agencies will have no knowledge of or control over the families selected into the control group.

The process of contacting families to offer them CRP is resource intensive. Referred families have been in contact with CPS recently and may have a lower trust in government programs. If the research design is such that families agree to participate and then may be randomized into the control group (not offered CRP), this process may further decrease their trust and willingness to participate in government services, including CPS and CRP. These factors would likely make randomization after acceptance of services difficult to justify to CRP grantees. For these reasons, we favor randomizing families into treatment and control groups before contacting families in either group.

One potential issue with randomizing at eligibility is that families willing to participate in the program (treatment group) might be different than families who are willing to participate in the evaluation (control group). Randomizing at this level in the program may not yield an exact match in terms of treatment and control groups as the two groups are agreeing to participate in slightly different processes. As with any RCT, researchers will have to conduct robustness checks to verify that the randomization process successfully created two similar groups.

Using an RCT, the "gold standard" of program evaluation, this program design promises to be highly rigorous. An RCT has been previously used by CTF in the evaluation of Project GAIN. Implementing the evaluation of Project GAIN means that the Child Abuse and Neglect Prevention Board has already approved a similar type of evaluation. Though the specific board members have likely changed in the intervening time, it is likely that they will see the value in a randomized control trial once the advantages are explained. A possible point of contention may be the decision over how many CRP agencies must participate. This decision has implications for the statistical power of the study, and will be discussed further in the power analysis section.

Agencies that currently implement CRP are likely to be mixed in their response to an evaluation. Some of these agencies will see the value in evaluating the program, and others believe that the program works and does not need evaluation, and will understandably resist the extra work that comes with an evaluation. It is important to stress that because there is currently not enough funding to offer the program to every eligible family in Wisconsin, the RCT is ethically sound. Because not every family can receive CRP services, an RCT only formalizes the group which does receive services and the group that does not. Offering information and opportunities to ask questions about the evaluation and what it offers may help to demonstrate to reluctant agency staff the value of participating in the evaluation.

a. Other Evaluation to Complement Impact Evaluation: Cost-Benefit Analysis

We recommend that the results of the CRP evaluation be used to conduct a cost benefit analysis. Assuming that the estimated impact of CRP is possible, a cost benefit analysis would allow CTF to ascertain the cost savings to society of implementing CRP statewide. Such savings include the value of preventing child maltreatment, the value of reducing re-referral to CPS, and the value of fostering stronger parent-child bonds on the child's development. These savings would be weighed against the cost of CRP. A positive benefit-cost ratio would provide convincing evidence that CRP should be implemented statewide.

C. Target Population, Power Analysis, Sample Size, and Minimizing Sampling Bias

The target population is families that have been reported to CPS, with cases closed after being either screened out or screened in but then not substantiated after investigation. Researchers will collect the list of names and contact information of families whose cases have been closed. This information will be received on a daily to weekly basis. Researchers will then randomly assign families to the treatment and control groups. Treatment group names and contact information will then be given to program implementers so that caseworkers can contact treatment group families. Using past evaluation participation rates, we anticipate a program uptake rate among treatment group families of 60 percent (Slack 2009). This uptake rate means that program implementers will need to contact more families than they plan to serve, assuming that approximately 40 percent of families will either not be reachable or will choose not to receive services.

The program will have the capacity to serve approximately 200 to 400 families per year. We choose a threshold of minimum detectable effect size of 0.35, which approximates a

moderate effect size of 0.60 multiplied by the expected take up rate of 60 percent of eligible families (Slack 2009). Assuming an alpha (the probability of a false positive) of 0.05 and a beta (the probability of a false negative) of 0.80, the evaluation will need a total number of about 150 families in the treatment group to reach our chosen effect size. The total sample size, including control group families, should be at least 300 families. However, as gaining results for different populations and contexts is important, we recommend aiming for a larger total sample size such as 600 families. A larger sample size gives researchers the flexibility to examine the differences in results between urban and rural counties, for example. In addition, we recommend including a range of four to eight implementation sites (Slack 2009; Optimal Design). At a minimum, to ensure an adequate effect size, the implementation should include four sites, with at least two rural-based sites and two urban-based sites. Rural-based sites will likely include multiple counties.

Sites for the next grant period when the evaluation will occur will be selected through a request for proposals (RFP) process. The sample composition and size will depend on which counties submit RFPs and are awarded funding. Ideally, the sample of counties would include geographic and demographic variation, including the racial composition of the counties. We recommend that each of the four minimum sites are located in different regions of the Wisconsin Child Welfare Regions. We also recommend including at least two urban and two rural-based sites. The US Census Bureau defines a rural county to have a population between 2,500 and 50,000 people, and urban counties have populations exceeding 50,000 people (U.S. Census Bureau 2010). Variation in county characteristics between sites will help to estimate effect sizes that might be generalized to other parts of the state. Counties that want services but only have a few cases may receive CRP but not be included in the evaluation or may be grouped as regional

sum of a few small counties. Including one or two counties that have an existing alternative response program may be preferred for inclusion in the CRP evaluation. Alternative response in Wisconsin offers an alternative to traditional CPS interventions, and providing CRP and alternative response programs in one county may change the outcomes of CRP.

D. Data Sources, Collection Procedures, and Descriptions of Tools

The main sources of data in this program evaluation will come from surveys sent to participants, the FaST tool, and a Department of Children and Families administrative database. Further information about each of the specific outputs and short, medium, and long-term outcomes being measured is contained in Appendix C.

Outputs of CRP will be measured by caseworkers for the treatment group. These outputs will include the treatment group's self-identified needs and service goals, number of case management contacts and home visits, service referral data, and funds spent by CRP for emergent family needs. These outputs are measured in order to evaluate the implementation of CRP for each family at each site. While this information is not necessary to answer the main research questions, it will help in evaluating implementation and is already collected by CRP sites to report to CTF. Short-term outcomes data describing whether service goals are met and whether service use is increasing will also be collected for the treatment group by caseworkers. This data could also potentially be used in a cost-benefit evaluation of CRP.

For the treatment group, surveys will be collected by caseworkers, and for the control group, surveys will be mailed to them. Surveys will be sent out or collected at four points after a family is eligible for CRP. For the treatment group, the survey will be collected: the first week after enrolling, at least once after the start of participation around 2-2.5 months in, at the end of

the program, and six months after the end of the program. The control group will be mailed the survey on a similar time frame: the first week after the date of program eligibility, 2-2.5 months after the date of program eligibility, 4-5 months after the date of program eligibility, and 11 months after the date of program eligibility (mirroring the six months after the end of the program for the treatment group). A mid-point evaluation is done due to the transient nature of some CRP families; sending multiple evaluations over a shorter time span will ensure that data is collected from as many participants as possible.

The surveys will include the CRP intake form and the FaST tool. The intake form collects demographic information and data needed for program administration purposes, and will be included in the first survey. Data collected by survey at each site will be reported to CTF and the researchers. Included will be the FaST tool data, data describing service referrals done by the caseworkers, and information about the goals set by clients and caseworkers and the client's progress toward those goals.

CRP caseworkers will use a newly created and validated tool, the Family Support Tool (FaST) to measure change in family strengths and parenting. This outcome will be measured in the medium- and long-term. The FaST tool will be used to measure change in both the treatment and control group. The FaST tool was developed by UW Madison researchers with the goal of assessing the whole family ecology and strengths rather than just parenting. It has been tested and is internally valid. The tool has several additional advantages. First of all, it can be self-administered, meaning that a caseworker does not have to physically observe the client (Slack 2014). Secondly, it uses a nonthreatening, strength-based framework for asking questions. For example, asking whether the parent had role models growing up is a positive way to gather information about adults that influence their parenting. This emphasis on strengths helps to

reinforce the perception of the program and program facilitators as positive, which encourages continued participation. Thirdly, the tool is focused on risk/protective factors, which predict the immediate risk context and are potentially malleable. This aspect allows the tool to be used over time to observe changes in families (Slack 2014).

Data measuring the rate of re-referral, screen-in, and out-of-home placement to CPS will be included as long-term outcomes. This data will be collected at least yearly from the start of the evaluation (following randomization of each family) to the end of the evaluation. The Wisconsin Department of Children and Families (DCF) maintains the Wisconsin Statewide Automated Child Welfare Information System (eWiSACWIS), an administrative database containing information about children referred to Child Protective Services. A data-sharing agreement will need to be formed between CTF and DCF in order to gather data about the rate of re-referral and screen-in among the treatment and control groups at least once per year. Data describing if and what date treatment and control group participants are re-referred to CPS, and why they were referred to CPS will be needed. In addition, data describing whether or not those clients who are re-referred are screened in, and the reason for screen-in, and whether children are placed in out-of-home care, and why they are placed in out-of-home care will also be collected. Researchers involved in the evaluation will need expertise in working with eWiSACWIS, and will need to spend time with child welfare staff at DCF to understand the data and ensure that CTF is getting the correct data.

a. Validity and Reliability of Measures

While survey responses are the most cost effective and feasible method for collecting data about family characteristics and strengths, there are some significant limitations common in survey data. Individuals are not always truthful in their survey responses, particularly when

answering questions about sensitive subjects (Preisendorfer and Wolter 2014). When responding to sensitive questions, people often want to provide the socially desirable answer (Tourangeau and Yan 2007). This behavior in surveys is particularly common if the respondents are worried that they will embarrass themselves in front of an interviewer or if they are worried about third party repercussions (Tourangeau and Yan 2007). This weakness to surveys may be particularly relevant to CRP as these families have recently had an interaction with CPS and may worry that their answers might have repercussions for their CPS cases. The wording and framing of questions, and the survey itself, can have significant impacts on how truthful respondents are in their answers (Preisendorfer and Wolter 2014). The length and order of questions, as well as the inclusion of "don't know" or "indifferent" response options, are important factors to consider on a case by case basis for each question and survey (Lietz 2010). Allowing individuals to fill out surveys alone, without a researcher or caseworker present, can also increase the number of truthful or accurate responses (Tourangeau and Yan 2007).

Surveys, particularly mailed and control group surveys, tend to have low response rates, but there are methods to increase response (Willcox et. al. 2010). Prior notification that a survey will be coming in the mail increases survey response rates (Tepper and Jacob 2012). Most significantly, cash incentives increase the response rate of mailed surveys (Dykema et. al. 2012). For example, a recent pregnancy risk assessment among African American women in Wisconsin found that the distribution of $10 prepaid gift cards increased the number of survey responses by 13 percent (Dykema et. al. 2012). When deciding what amount of money to use as an incentive, it is also important to ensure that the cash incentives do not put a household above the cutoff or means-tested programs. In similar programs, $20-$25 incentives are common, because those amounts are large enough to significantly incentivize response without being so large as to push

a household out of a means-tested program (Murray 2014). We recommend including $20 prepaid debit cards in each of the initial, middle, end of program, and long-term survey mailings for the control group families, and in the long-term survey mailing for the treatment group. This incentive will help make it seem worthwhile for the families to spend time filling out the survey.

Another aspect to consider for the validity and reliability of measures is the potential for a range of differences in implementation across sites. Each selected site may differ in the services offered in the area and may differ in what type of organization administers the program. These differences complicate planning and could be a threat to the internal validity of the evaluation. Some counties will be beginning CRP for the first time, and will not be up and running smoothly right away. We recommend allowing counties three months after the time funds are distributed before beginning the evaluation process. This time will allow counties time to prepare, train, and start implementation but will allow enough time to gather a large enough sample.

In order to ensure an accurate evaluation of the impacts of CRP, researchers will also need to verify that the randomization has been successful. Researchers will randomly assign families into two groups: to be contacted by CRP (treatment) and to not be contacted by CRP (control), and counties will only receive the names of families assigned to the treatment group. Researchers will need to create support from stakeholders, especially with regard to using a randomized control method. Researchers should also compare observable characteristics gathered by the initial survey of the treatment and control groups as a check to ensure that the randomization process is adequately randomizing characteristics between the two groups.

Which counties are included in the program and evaluation will have significant implications for whether the results of the study can be reasonably applied to other parts of the

state. Counties will be selected based on their responses to the RFP process. Criteria for evaluating RFPs cannot directly exclude counties, even if their participation may complicate the study. The selection of counties may be furthered complicated because some counties may want to administer CRP but not want to participate in a randomized control trial. So that the results may be used to estimate potential statewide effects of CRP, participating counties will need to be representative of other regions in Wisconsin. Ideally, the study will need to include both rural and urban counties, and counties with a range of socioeconomic and demographic characteristics. Because of their low population, it may prove challenging to gain the necessary sample sizes to ensure adequate statistical power in rural counties. Urban counties are limited in number in Wisconsin and differ in demographic makeup. Additionally, the evaluation may be useful for some states nationwide, but other states may have demographic compositions that are too dissimilar for the results to be readily transferable.

E. Anticipated Data Analysis Procedures

We anticipate several statistical methods will be used for data analysis. Regression analysis can be used to determine if families' inclusion in the treatment group causes decreased rates of re-referral to CPS, as well as increased reporting of family strength characteristics. Researchers can then estimate effect sizes, which are often helpful in communicating results to policymakers in a meaningful way. Additionally, researchers may conduct regression analysis to determine if there is a difference in program uptake and program outcomes between sites that have CPS workers implementing the program compared to sites that have community resource workers implementing the program. Contextual information about the type of agencies implementing CRP can be collected during the RFP process and used for this purpose.

Researchers may also perform statistical checks to ensure that characteristics between the treatment and control group families are effectively randomized.

Furthermore, we recommend calculating both Intent-to-Treat (ITT) and Treatment on the Treated (TOT) effect sizes, to be used as lower and upper bound effect size estimates respectively. CRP is a voluntary program. ITT measures the impact of the voluntary program for those who are *offered* services. TOT measures the impact of a voluntary program for those who *accept services*. ITT measures the impact of the program for the overall group that would be eligible for CRP and are offered the program, understanding that some families will choose to participate and some will choose not to. ITT analysis would estimate a lower bound estimate of the effect size, because the sample group includes treatment group families who accept services and treatment group families who do not accept services. This estimate is likely to be quite low in the case of CRP, due to the fact that only approximately one third of families accept the program. TOT measures the impact of the program for just treatment group families who accept services. TOT analysis would estimate an upper bound estimate of the effect size because the sample group only includes treatment group families who accept services. The TOT effect size estimate will likely be a biased estimate as it will include unobservable factors that are related to their participation in CRP and are included in the estimate. We recommend using ITT analysis to estimate a lower bound effect size and TOT analysis to estimate an upper bound effect size.

We also recommend conducting robustness checks to ensure that the treatment group population and control group population are similar. For outcome measures, this evaluation involves comparing responses from treatment group participants (families who agree to services) and control group survey respondents (those who agree to participate in the evaluation). This method might not yield an exact match in terms of treatment and control groups as the two

groups agree to participate in slightly different processes. We recommend using robustness analysis to ensure that observable characteristics are similar between the two populations.

Quality Control and Human Subjects Protection

A. Human Subjects Protection and Approval

Institutional Review Board approval is required in order to perform the CRP evaluation due to the use of the FaST survey. Informed consent should be obtained by caseworkers before involving the treatment and control groups. Draft consent forms are included in Appendix E.

B. Data Sharing Agreements and Security Measures

The Department of Children and Families maintains eWiSACWIS, an administrative database containing information about children referred to Child Protective Services. A data-sharing agreement will need to be formed between CTF and DCF in order to gather data about the rate of re-referral and screen-in among the treatment and control groups. A data-sharing agreement of this scope will cost approximately $8,000 each time data needs to be drawn, at least once per year.

In order to ensure the confidentiality of participants, the researchers will need to implement security measures for the storing of information and maintaining of confidentiality throughout the research process. These measures would ensure that personally identifiable information is never shared or becomes public and might include always using a password protected computer or transferring data through a secure process. Personally identifiable information should not be included in the dataset used for analysis purposes.

Evaluation Implementation

A. Evaluation Work Plan and Timeline of Activities

Appendix D outlines significant dates in the evaluation work plan and timeline of activities. The work plan follows a five-year grant cycle. On September 1, 2015, the Request for Proposals (RFP) will be released. At least eight weeks of response time will be necessary to allow counties the opportunity to respond. County RFPs will then be due to CTF by mid-November. The review process will then begin, with an anticipated completion date of early January. The Child Abuse and Neglect Prevention Board will need to meet and approve the plan in spring of 2016. Contract negotiations will begin and be completed in May and June of 2016. On July 1, 2016, grant funding will be released to participating counties. During the next three months, CTF will offer training for counties, sites will hire staff, CTF will get data sharing agreements signed, and researchers will set up randomization and data collection for the evaluation.

October 3, 2016 will be the go live date, when the first sets of families that participate in the evaluation will be contacted. Over the next 57 months, sites will continue to contact families as they are assigned to the treatment group. Survey data will be collected at the beginning, middle and end of treatment group families' experience in the program, as well as six months after the program ends. Survey data for control group families will be collected when they are first assigned to the control group, twice in the first 5 month period, and 11 months after assignment to the control group. The data pulls from data sharing agreements will be conducted approximately once per year during the five-year period. We recommend that researchers conduct a preliminary analysis of data at the end of years one, three, and five. Researchers will

then need six months after the completion of implementation and data collection to conduct a final analysis of the data and report findings.

B. Factors that may affect the Timeline

There are several factors that may affect the speed of the implementation timeline. Once the funds are distributed to counties, there will need to be time for sites to prepare and train. We estimate at least three months of preparation before beginning evaluation, but individual counties may need an additional month. Other counties may be prepared before the go-live date, but this difference in starting time should not significantly impact the evaluation. This three month period may also help to inform sites about the structure of the randomized controlled trial, why the evaluation may be helpful, and foster buy-in among stakeholders.

C. Budget Narrative

The CTF budget for the CRP program for the next grant cycle will be approximately $1.3 million per year for approximately eight sites. The costs of providing CRP services varies greatly by family, because each family's needs and identified areas of concerns are unique. We do not currently have access to an estimate of average program cost per family served. The costs of conducting the evaluation likely will come from this budget, although CTF and the researchers may apply for other sources of funding such as research grants. The main costs of implementing the evaluation of CRP includes the research team's salaries and benefits; transportation to evaluate sites; administrative costs such as the data pulls from eWiSACWIS and consumable office supplies; and control group incentives.

For the research team, CTF will put out an RFP. The research team will be in charge of overseeing the program evaluation implementation and data collection, facilitating the randomization, collecting data from the control group, and conducting the analysis and writing the resulting reports and papers. The cost of hiring a research team will likely include one or two primary researchers (with salaries and benefits totaling around $16,000 for one full-time month equivalent) and one or two project assistants (with salaries and benefits around $5000 for one full-time month equivalent) (Murray 2014).

Transportation costs will depend on the number and location of the sites in the evaluation. Those costs will likely be calculated as miles to be reimbursed. There will likely be significant variation in transportation costs for site visits based on sites' locations within Wisconsin, the number of offices each site has, and going with caseworkers on home visits. The number of overall trips anticipated will depend upon which counties are selected and whether there are sites that serve multiple counties. The administrative costs will include any items needed to complete the randomization (a software program, etc.), drawing data from eWiSACWIS, and consumable office supplies, including printing, envelopes, and stamps. The cost per eWiSACWIS draw is $8,000, which will be done annually. (Pulling from eWiSACWIS and other administrative systems costs $55,000, which the researchers may choose to do for further analysis). The costs of collecting data for the control group (and the final survey for the treatment group) will include mailing the surveys and the incentives. For the control group, there will be a total of four surveys mailed; the incentives will be a general gift card for $20 per survey. The number of control group families will depend on the counties included and the number of referrals. The total costs for mailing and incentives will depend on the response rate of the control group and if and when a control participant is lost due to attrition.

Anticipated Results

A. Anticipated Significance of the Study

We anticipate that this evaluation design will determine if CRP reduces the rate of re-referral to CPS among families who are contacted by CRP compared to those who are not. We also anticipate that the evaluation will determine whether CRP increases rates of reported family strengths as measured by the FaST Tool among families who are contacted by CRP compared to those who are not. Both of these measures are indicators of child treatment and household stability. We anticipate that researchers will be able to calculate what effect sizes the program has, which may be used in helping to determine whether CRP should be implemented statewide. Measures of effect sizes may also provide useful information for a cost-benefit analysis of intervention programs.

Using both ITT and TOT analysis, this evaluation design may determine the effects of CRP on families *contacted* by CRP compared to those *not contacted* (using ITT analysis), as well as the effects of CRP on families *provided services* by CRP compared to those *not provided services* by CRP (using TOT analysis). Together, the data analysis may estimate a lower bound effect size (using ITT analysis) and an upper bound effect size (using TOT analysis). This design will allow researchers to better estimate what the range of effects of the voluntary program may be if implemented statewide.

B. Remaining Questions

There are a few remaining questions that could be addressed by follow-up research upon completion of the five year cycle. Questions that decision-makers may ask in considering

whether to implement CRP statewide include:

1. What is the cost per (presumably) positive outcome?
2. Are there long-term cost savings to the state/county?

Answering these questions would help the evaluation be more influential in determining whether CRP is implemented statewide. If CRP significantly reduces incidences of child maltreatment, there would likely be a significant reduction in both social costs and fiscal costs that are correlated with cumulative child maltreatment. If CRP significantly reduces re-referral to CPS, there would also be a reduction in long-term costs on the CPS system. In addition, if an increase in parent-child attachment is measured by the FaST tool, it is likely to have benefits to the child.

We recommend conducting a cost-benefit analysis upon completion of the evaluation. Elements of this evaluation, including estimated effect sizes and all program costs across all sites, would be particularly useful measures to use in conducting a cost-benefit analysis. A cost-benefit analysis could compare each implementation site to find whether some sites have larger benefits or costs than others. If some sites are implementing the program more efficiently, implementation information can be used to find out why, so that efficient practices can be shared with other sites. In addition, it would be useful to include a demographic analysis of various groups, such as income groups or race, to determine whether the program has larger benefit for some groups over the others. A cost-benefit analysis would add weight to the results and make the evaluation more influential in the policy decision-making process.

C. Stakeholders and Dissemination of Results

The results of the CRP evaluation should be published in a report and be presented to the Child Abuse and Neglect Prevention Board. This board is populated by stakeholders from the legislature and relevant state agencies and members of the public. If the results of the evaluation

show that CRP has a positive impact, they could likely be used in combination with a cost-benefit analysis in order to make a convincing argument for expansion of the program. Results should also be disseminated to other states if possible, given the lack of current evaluation of this program type, and the prevalence of alternative and differential response implementation in other states. Overall, the evaluation will considerably add to the body of literature and could spur further CRP implementation in Wisconsin.

Conclusion

In conclusion, evaluation of CRP using a randomized controlled trial will add a rigorous evaluation to the body of literature and will allow CTF to causally link CRP and program outcomes such as stronger parent child attachment and reduced re-referral to CPS. The evaluation could add credibility to the efforts of CTF and the agencies implementing CRP, allowing them to present an evidence-based case to policymakers for expansion of the program throughout Wisconsin.

Appendix A: Logic Model

Program: Wisconsin Community Response Program
Theory of Change: Addressing household stress factors and cultivating positive family strengths will reduce incidences of child maltreatment.

Inputs	Outputs		Outcomes -- Impact		
	Activities	*Participation*	*Short*	*Medium*	*Long*
Referrals from Child Protective Services (CPS) of families with screened-out referrals of child maltreatment Referrals from CPS of families with cases closed after initial assessment Community Partnerships Staff Funding Transportation Office Space Evidence-based practices and tools Evaluation of program	Primary caregivers self-identify needs and collaboratively determine service goals with caseworkers Case management Direct service or referral to services • Domestic violence services • Employment/job assistance • Family medical needs • Financial support • Household or family needs • Housing • Mental health services • Parent education and child development • Substance abuse services Flexible funds for emergent family needs Home visits Individual sites adhere to the CTF model of service delivery These activity outputs will be measured by sites' reports of service provision to CTF	Voluntary participation Strengths-based approach Community partners outside of the CPS system	Participant families attain most or all of the goals the caregiver set with caseworker, measured by the mutual assessment by the caregiver and caseworker on an on-going basis	Increase in family strengths from pre-post measures from the FaST tool	Participant families have fewer re-referrals to CPS Participant families have fewer substantiated re-referrals Participant families have fewer out-of-home placements Participant families have increased long-term strength of parent-child relationships measured from the FaST tool in the final survey

*Adopted from Bakken et al. (2014) and Slack and Berger (2009).

Appendix B: Design Matrix

Evaluation audience: DCF-CTF

Researchable Questions	Information Required and Sources	Methodology	Limitations	What analysis will likely allow team to say
Do families who have previously been reported to CPS who participate in CRP have significantly lower rates of re-referrals to CPS compared to eligible families who do not participate in CRP?	Rate of re-referral to CPS and rate of future substantiated cases for both treatment and control group families. Source: eWiSACWIS Data (will need data-sharing agreement between CPS and DCF)	Rate of re-referral to CPS and rate of future substantiated cases of the treatment group compared to the control group. Randomization occurs at point of referral before families are contacted. Data analysis including ITT (lower bound) and TOT (upper bound) estimates of effect sizes.	Measures the total effects of a voluntary program, which includes values for families in the treatment group who choose not to accept services (ITT method, lower bound of estimate). Analysis of only those treated (TOT estimate, upper bound of estimate) may be biased by unobserved characteristics.	Whether CRP decreases the rate of re-referral to CPS and substantiated cases of child maltreatment compared to the control group.
Do families who participate in CRP improve significantly more on measures of family strength (measured by the Family Support Tool) compared to eligible families who do not participate in CRP?	Levels of family strength characteristics measured in both treatment and control group families: the first week of the program, 2-2.5 months after the start of the program, at the end of the program (3-5 months after the beginning of the program), and six months after the end of the program. Source: CRP Family Support Tool	Measures in treatment group compared to measures in control group. Randomization occurs before families are contacted. Data analysis including ITT (lower bound) and TOT (upper bound) estimates of effect sizes. Control group (but not treatment group except for the final mailed survey) will be offered small monetary incentives for completing mailed surveys.	Mailed surveys have lower response rates, but require significantly fewer agency resources.	Whether CRP increases families' strengths, including parent-child attachment compared to the control group
Would CRP have similar impacts in other counties in Wisconsin if implemented statewide?	Characteristics of participating counties: including demographics, population density, number of cases that the county CPS handles, differences in service provision	Carefully select participating counties, run statistical comparisons of treatment and control groups to verify a happy randomization	The selection of counties depends on which counties apply for the RFP. Criteria for evaluating RFPs cannot directly exclude counties.	Whether the evaluation would likely have external validity for other parts of Wisconsin or the U.S.

Appendix C: Data Collection Methods

Output/Outcome	Measure/Indicator	Data Source	Measurement Interval	Person Responsible
Outputs				
Primary caregivers self-identify needs and collaboratively determine service goals with caseworkers	Self-identified by participants, surveyed	CRP Goal and Progress Forms	Surveyed shortly at first contact after case closure (contact within one week)	Caseworker
Case management	How many contacts does the caseworker make with the family	Caseworker's notes	Measured on an ongoing basis	Caseworker
Direct service or referral to services: Domestic violence services; Employment/job assistance; Family medical needs; Financial support; Household or family needs; Housing; Mental health services; Parent education and child development; Substance abuse services	Compared to rate of service take-up in control group (the rate at which control group accessed these services on their own or through other referral means)	Survey of control group to see if they accessed these services on their own or through other referral means	Surveyed shortly at first contact after case closure (contact within one week)	Caseworker
Flexible funds for emergent family needs		Case records		Caseworker
Home visits		CRP Family Contacts Log		Caseworker
Individual sites adhere to the CTF model of service delivery				CTF

Short-Term Outcomes				
Participant families attain service goals		CRP Goal and Progress Forms	Reported in treatment group on an ongoing basis	Caseworker
Increased use of other services (those being referred to)		CRP Goal and Progress Forms; survey of control group to see if they accessed these services on their own or through other referrals	Reported in treatment group on an ongoing basis	Caseworker
Intermediate Outcomes				
Increase in family strengths from pre/post measures	Increase in "rating" of family strengths as measured by 1-5 scale on FaST tool in treatment group compared to control group	FaST Tool	Surveyed 3-5 months after case closure	Caseworker will send survey to treatment group, researcher will send survey to control group
Decreased household stressors (examples: pertaining to finances, employment, housing, mental health needs, substance abuse)	Decrease in severity of household stressors as measured by 1-5 scale on FaST tool in treatment group compared to control group	FaST Tool	Surveyed 3-5 months after case closure	Caseworker will send survey to treatment group, researcher will send survey to control group

Long-Term Outcomes				
Increase in family strengths from pre/post measures	Increase in "rating" of family strengths as measured by 1-5 scale on FaST tool in treatment group compared to control group	FaST Tool	Surveyed 6 months after case closure	Caseworker will send survey to treatment group, researcher will send survey to control group
Participant families have fewer re-referrals to CPS	Decrease in rate of re-referral to CPS in treatment group compared to control group. Data sharing at the end of the five year evaluation timeline.	eWiSACWIS Data (will need data-sharing agreement with DCF)	Values for participant group and control group, collected at the end of evaluation	DCF staff member
Participant families have fewer substantiated re-referrals	Decrease in rate of substantiated re-referrals in treatment group compared to control group. Data sharing at the end of the five year evaluation timeline.	eWiSACWIS Data (will need data-sharing agreement with DCF)	Values for participant group and control group, collected at the end of evaluation	DCF staff member
Participant families have fewer out-of home placements	Decrease in rate of out-of-home placements among families screened in among treatment group compared to control group. Data sharing at the end of the five year evaluation timeline.	eWiSACWIS Data (will need data-sharing agreement with DCF)	Values for participant group and control group, collected at the end of evaluation	DCF staff member

Appendix D: Timeline of Activities

Sept 1, 2015:	RFP Released
Nov 16, 2015:	RFP Return-By Date
Spring 2015:	Child Abuse and Neglect Prevention Board Meeting and Approval
May-Jun 2015:	Contract Negotiations
Jul 1, 2015:	Release Funding to Counties
Oct 3, 2015:	Go Live Date
Fall-Winter 2016:	First Preliminary Data Analysis
Fall-Winter 2018:	Second Preliminary Data Analysis
Jul 1, 2020:	End of Cycle
Fall-Winter 2020:	Final Data Analysis and Report of Findings

Appendix E: Draft Consent Forms

UNIVERSITY OF WISCONSIN-MADISON

Treatment Group Research Participant Information and Consent Form
Title of the Study: Community Response Program Evaluation

Principal Investigator: Children's Trust Fund (phone: (XXX) XXX-XXXX) (email: XXXXXXXXXX)

DESCRIPTION OF THE RESEARCH
You are invited to participate in a research study evaluating the Community Response Program. The Community Response Program is a preventative child maltreatment program for families screened out of Child Protective Services. You have been asked to participate because you were screened out of Child Protective Services.

The purpose of the research is to determine the effectiveness of the Community Response Program. This study will include participation in the Community Response program and four surveys. Research will take place in the location of the meeting with caseworkers, often in your home. In addition, you will be asked to complete surveys mailed to your home.

WHAT WILL MY PARTICIPATION INVOLVE?
Participation in the Community Response Program will involve visits by a caseworker and referral to community services. Four surveys assessing demographics, parenting, economic status, and household stressors will be sent to your home over a one year period. Length of participation will depend on your service goals and self- and caseworker-determined progress.

ARE THERE ANY RISKS TO ME?
We don't anticipate any risks to you from participation in this study.

ARE THERE ANY BENEFITS TO ME?
Participants in the Community Response Program will participate in a potentially beneficial program that has been initially shown to have a positive impact on families. Respondents to surveys will be given a $20 gift card per survey to use at a local store.

WILL I BE COMPENSATED FOR MY PARTICIPATION?
You will receive approximately $80 for participating in this study. If you do withdraw prior to the end of the study, compensation is based on survey completion.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?
While there will probably be publications as a result of this study, your name will not be used. Only group characteristics will be published.

WHOM SHOULD I CONTACT IF I HAVE QUESTIONS?

You may ask any questions about the research at any time. If you have questions about the research after you leave today you should contact the Principal Investigator Children's Trust Fund at (XXX) XXX-XXXX.

If you are not satisfied with response of research team, have more questions, or want to talk with someone about your rights as a research participant, you should contact the Education and Social/Behavioral Science IRB Office at 608-263-2320.

Your participation is completely voluntary. If you decide not to participate or to withdraw from the study it will have no effect on any services or treatment you are currently receiving.

Your signature indicates that you have read this consent form, had an opportunity to ask any questions about your participation in this research and voluntarily consent to participate. You will receive a copy of this form for your records.

Name of Participant (please print):

_____

_____ _____

Signature Date

UNIVERSITY OF WISCONSIN-MADISON

Control Group Research Participant Information and Consent Form
Title of the Study: Community Response Program Evaluation

Principal Investigator: Children's Trust Fund (phone: (XXX) XXX-XXXX) (email: XXXXXXXXXX)

DESCRIPTION OF THE RESEARCH
You are invited to participate in a research study evaluating the Community Response Program. The Community Response Program is a preventative child maltreatment program for families screened out of Child Protective Services. You have been asked to participate because you were screened out of Child Protective Services.

The purpose of the research is to determine the effectiveness of the Community Response Program. This study will include participation in the Community Response program and four surveys. Research will take place in the location of the meeting with caseworkers, often in your home. In addition, you will be asked to complete surveys mailed to your home.

WHAT WILL MY PARTICIPATION INVOLVE?
Four surveys assessing demographics, parenting, economic status, and household stressors will be sent to your home over a one year period.

ARE THERE ANY RISKS TO ME?
We don't anticipate any risks to you from participation in this study.

ARE THERE ANY BENEFITS TO ME?
Respondents to surveys will be given a $20 gift card per survey to use at a local store.

WILL I BE COMPENSATED FOR MY PARTICIPATION?
You will receive approximately $80 for participating in this study. If you do withdraw prior to the end of the study, compensation is based on survey completion.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?
While there will probably be publications as a result of this study, your name will not be used. Only group characteristics will be published.

WHOM SHOULD I CONTACT IF I HAVE QUESTIONS?
You may ask any questions about the research at any time. If you have questions about the research after you leave today you should contact the Principal Investigator Children's Trust Fund at (XXX) XXX-XXXX.

If you are not satisfied with response of research team, have more questions, or want to talk with someone about your rights as a research participant, you should contact the Education and Social/Behavioral Science IRB Office at 608-263-2320.

Your participation is completely voluntary. If you decide not to participate or to withdraw from the study it will have no effect on any services or treatment you are currently receiving.

Your signature indicates that you have read this consent form, had an opportunity to ask any questions about your participation in this research and voluntarily consent to participate. You will receive a copy of this form for your records.

Name of Participant (please print):

_____

_____ _____

Signature Date

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