

Moving Forward with Wisconsin's Community Response Program

Prepared for Wisconsin Children's Trust Fund

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Foreword

This report is the result of collaboration between the Robert M. La Follette School of Public Affairs at the University of Wisconsin–Madison and the Wisconsin Children’s Trust Fund. The School’s objective is to provide graduate students at La Follette the opportunity to improve their policy analysis skills while contributing to the capacity of partner organizations.

The La Follette School offers a two-year graduate program leading to a master’s degree in public affairs. Students study policy analysis and public management, and they can choose to pursue a concentration in a policy focus area. They spend the first year and a half of the program taking courses in which they develop the expertise needed to analyze public policies.

The authors of this report are all in their final semester of their degree program and are enrolled in Public Affairs 869 Workshop in Public Affairs. Although acquiring a set of policy analysis skills is important, there is no substitute for doing policy analysis as a means of learning policy analysis. Public Affairs 869 gives graduate students that opportunity. I am grateful to Wisconsin Children’s Trust Fund for partnering with the La Follette School on this project.

Child maltreatment is a troubling issue for states and counties to manage. The system for protecting children while preserving parental control has evolved over time, with an emerging focus on preventing problems before children are in high risk situations. The Community Response Program (CRP) is an innovative approach designed to prevent future maltreatment and neglect by targeting specific risk factors. The Children’s Trust Fund has been a leader in the development of CRP models and worked closely with county programs to pilot the approach. This project provides a number of insights for the Children’s Trust Fund, including a review of state programs, a synthesis of the evidence supporting the expansion of CRP models and recommendation for future field research. While CRP is still an evolving approach and requires adaptation in each community, this report suggests a number of strategies that the Children’s Trust Fund can consider in the future. Hopefully this project will facilitate further innovations in Wisconsin that help to prevent more children from being victims of maltreatment.

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May 2014
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Executive Summary

Child maltreatment affects nine out of 1,000 children in the United States, with short-term and long-term consequences. Child maltreatment results in annual direct societal costs of \$38 billion and indirect societal costs of \$80 billion. Prevention and intervention programs reduce individual, family, and societal risk factors, and strengthen individual, family, and societal protective factors to reduce the risk of child maltreatment. Wisconsin's Community Response Program (CRP) has the potential to reduce the number of children re-referred to Child Protective Services (CPS), and therefore reduce direct and indirect costs for the state of Wisconsin.

The Wisconsin Children's Trust Fund (CTF) created CRP in 2006 as a preventative child maltreatment program for families screened out of CPS. CTF grounded CRP in the child welfare literature with the intention of reducing child maltreatment and saving taxpayer money. CRP targets families that are screened out of the CPS system due to a non-finding, yet these families are at high risk for a future re-referral to CPS. The program's core components include case management, home visits, collaborative goal setting, and access to financial supports. Sites can make adaptations within this framework to meet local needs. These adaptations result in programs that serve slightly different families, have different relationships with county CPS agencies, and provide different types of services, directly or through referral. Differences among sites pose challenges for evaluation efforts.

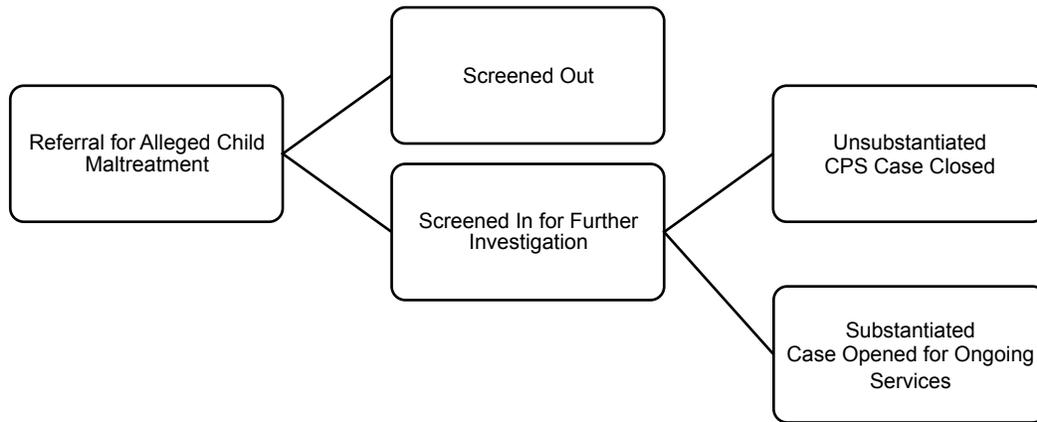
With the creation of CRP, Wisconsin leads the nation in the development of programs to meet the needs of families traditionally screened out of CPS. Other states have expanded efforts to meet the needs of screened-out families, with Colorado and North Carolina creating programs modeled after Wisconsin's CRP. About 30 other states have developed programs to provide services to families traditionally screened out of the formal CPS system and/or provide alternatives to the traditional investigatory response.

This report estimates \$100,000 in program savings, resulting from Project GAIN, which focuses on one CRP service area. Based on positive findings from this similar intervention, this report recommends that CTF conduct a cost-benefit analysis of CRP to demonstrate short-term and long-term societal benefits. This report reviews several evaluation alternatives and recommends that CTF conduct a randomized controlled trial. A robust evaluation of the CRP model, combined with a thorough cost-benefit analysis, will be an important step toward the replication and expansion of this program.

Introduction

The Child Abuse Prevention and Treatment Act of 1974 defines child maltreatment as “any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm” to an individual younger than age 18 (Paxson and Haskins 2009, 4). As seen in Figure 1, most states follow a process through which CPS workers, responding to an allegation of child maltreatment, begin by screening in or screening out referrals based on established criteria. Next, they conduct initial assessments of screened-in reports, which involve a determination of a need for services to assure the safety of children. Initial assessments can include home visits, interviews with all parties involved in the allegation, collection of physical evidence, and assessments of family stress and caregiver protective capacity. At the end of the assessment, caseworkers determine whether child maltreatment has occurred. A case is substantiated when a caseworker determines that maltreatment has occurred based on “a preponderance of evidence.” CPS uses a standard lower than what constitutes proof in criminal court procedures (Wisconsin Department of Children and Families 2013). When caseworkers determine that children are in danger of maltreatment, CPS workers must create a safety plan, regardless of whether a case is substantiated. However, variation exists among states in language and structure of services in the field of child maltreatment.

Figure 1: Child Protective Services Process



Source: Authors

Nearly 30 states have implemented alternatives to traditional investigative responses, from alternative or differential responses for screened-in reports to providing services to families that are screened out of the formal CPS system. The Wisconsin Children’s Trust Fund (CTF), which builds community partnerships and invests in prevention programs, leads the nation in these efforts. Its county-level Community Response Program (CRP), implemented in 2006, serves families whose CPS referrals are screened out or whose case was closed after initial assessment. This innovative program seeks to prevent child maltreatment by identifying potentially “at-risk” families and engaging them in community-based services.

This report reviews current policy to prevent child maltreatment among families screened out of formal CPS systems. It reviews the CRP model and its implementation, provides results from a

national survey, and analyzes evaluation models for CRP. This report recommends that CTF initiate a randomized controlled trial of CRP to fully evaluate the program's effectiveness at achieving the desired long-term outcomes. While reviewing several evaluation models, researchers consider a randomized controlled trial the "gold standard" of program evaluation because it allows causal inferences regarding program effects. Causal findings would go a long way to advancing CRP statewide and similar programs nationally. Additionally, a full cost-benefit analysis of CRP should be conducted, as this analysis would provide financial rationale for expansion of the program statewide.

Overview of Child Maltreatment

In 2012, CPS received an estimated 3.8 million referrals of child maltreatment in the U.S. (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families 2013). CPS staff receives referrals and uses criteria to decide if the referrals should be accepted for investigation; those accepted are often called screened-in reports. Referrals that do not meet the criteria may be screened out and referred to other services. From these screened-in reports, CPS identified 686,000 children as victims of maltreatment (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families 2013). Seventy-eight percent of these children suffer from neglect, whereas 18 percent experience physical abuse, and nine percent experience sexual abuse¹ (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families 2013).

In 2012, Wisconsin CPS received 70,266 referrals of alleged child maltreatment, with neglect being the most common (Wisconsin Department of Children and Families 2013). CPS screened in 37 percent of referrals for further assessment. From these referrals, CPS identified six percent of children as victims of maltreatment. This equates to 3.4 victims per 1,000 children, less than half the national rate of 9.1 per 1,000; (Wisconsin Department of Children and Families 2013; U.S. Department of Health and Human Services, Administration on Children, Youth, and Families 2013).

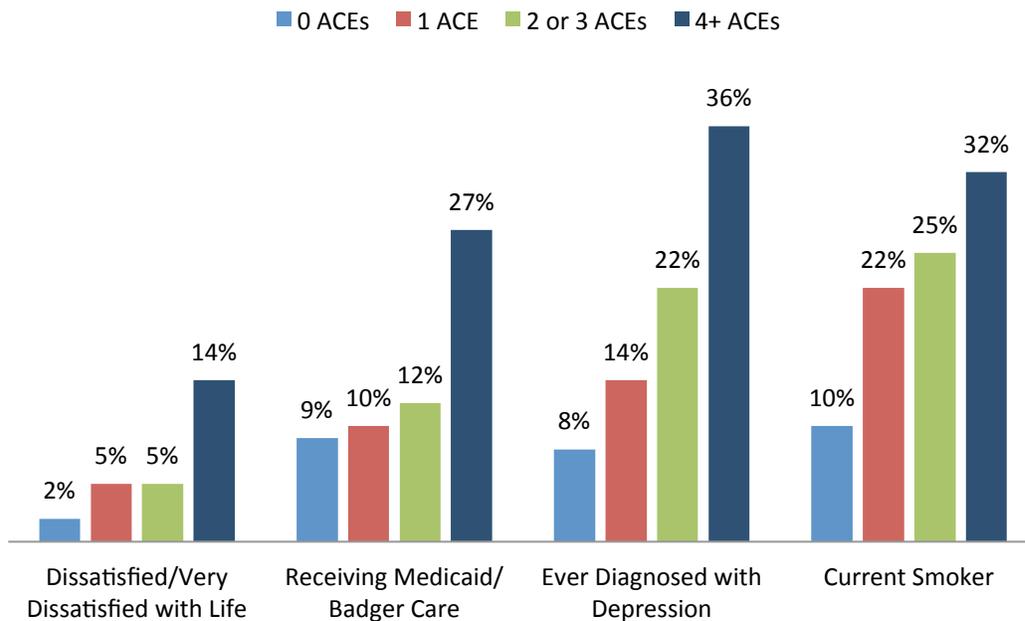
Societal Cost

Childhood experiences shape how individuals learn, form relationships, cope with life's stressors, and view themselves throughout their lives (O'Connor, Finkbiner and Watson 2012). Felitti et al. (1998) conducted the first large-scale study of the associations between negative childhood experiences, and health and well-being outcomes in adulthood, with more than 17,000 participants. In particular, they studied adverse childhood experiences (ACEs), a term used to describe all types of abuse, neglect, and other negative experiences that children encounter. This study revealed significant correlations between the number of ACEs and health and well being in adulthood. Wisconsin replicated this study as part of the 2010 Wisconsin Behavioral Risk Factor Survey in which researchers asked more than 4,000 randomly selected individuals about ACEs they may have faced and adult health outcomes (O'Connor, Finkbiner and Watson 2012). The Wisconsin study revealed significant positive correlations between ACEs and mental illness, increased rate of smoking, and poorer self-reported health status in adulthood. Significant negative correlations were found between ACEs and socioeconomic status, educational attainment, employment status, and health insurance coverage as adults (O'Connor, Finkbiner and Watson 2012). ACEs may not cause

¹ "A child may have suffered from multiple forms of maltreatment and was counted once for each maltreatment type" (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families 2013, xi)

negative outcomes later in adult life, but are highly correlated. Moreover, the prevalence of these negative adult outcomes appears to increase the number of ACEs reported increases, as shown in Figure 2.

Figure 2: Prevalence of Selected Outcomes among Wisconsin Residents by Number of Adverse Childhood Experiences (ACEs)



Source: (O'Connor, Finkbiner and Watson 2012)

Note: ACEs are a traumatic experience prior to age 18, including: recurrent physical abuse; emotional abuse; sexual abuse; neglect; an alcohol or drug abuser in the household; an incarcerated household member; a family member who was chronically depressed, mentally ill, or suicidal; violence between adults in the home; and parental separation and divorce (O'Connor, Finkbiner and Watson 2012; Centers for Disease Control and Prevention 2013).

These negative childhood experiences have significant health, social, and economic costs borne by victims, their families, and society. Direct and indirect costs include but are not limited to: adult criminality and subsequent incarceration, direct medical costs, foster care, protective services, psychological and welfare services, and special education (Wang and Holton 2007; Fang, et al. 2012). Wang and Holton (2007) estimated the annual societal cost of maltreatment at \$117.6 billion, adjusted for 2014 dollars.² They estimated direct costs of \$37.9 billion, including \$7.5 billion for hospitalizations, \$1.3 billion for mental health care systems, and \$29.1 billion for child welfare service system. Child maltreatment has a much higher indirect cost of \$80.1 billion, including \$31.7 billion for the criminal justice system and \$37.4 billion for loss of productivity (Wang and Holton 2007). Fang et. al (2012) estimated individual cost of child maltreatment. Their study found that the lifetime cost of non-fatal child maltreatment is \$226,120 per victim in 2014 dollars, including \$35,152 in childhood health care costs; \$11,338 in adult medical costs; \$155,432 in productivity losses; \$8,321 in child welfare costs; \$7,265 in criminal justice costs; and \$8,613 in special education

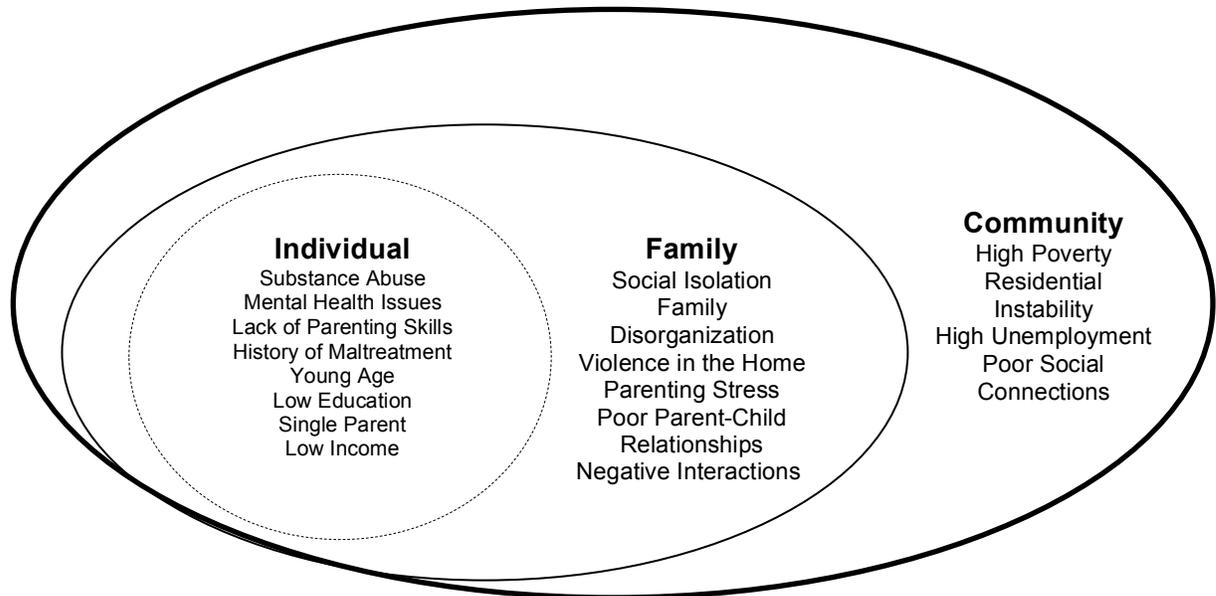
² Wang and Holton's 2007 figures were put into the CPI Inflation Calculator to get 2014 dollars (U.S. Department of Labor, Bureau of Labor Statistics n.d.).

costs.³ The substantial cost burden of child maltreatment found in these two studies necessitates prevention and intervention efforts.

Risk and Protective Factors

No one factor can explain why some individuals abuse or neglect children, or why maltreatment seems to be more prevalent in some communities and states than others (Butchart, et al. 2006). For this reason, maltreatment is best understood in a social-ecological model. This model, first conceptualized by Bronfenbrenner (1977), postulates that to understand human development, the entire ecological system in which human growth occurs needs to be taken into account, including the individual, family, community, and societal factors (Centers for Disease Control and Prevention 2013; Butchart, et al. 2006). Certain characteristics on all of these levels are associated with increased risk of child maltreatment but are not direct causes. Individual risk factors include having younger children; infants have the highest rates of victimization and more than a third of all victims are younger than three years (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families 2012). Children with special needs (physical disabilities, mental disabilities, mental health issues, and chronic physical illnesses) may increase caregiver burden and therefore have increased risk of maltreatment (Centers for Disease Control and Prevention 2014). As 80 percent of perpetrators are the child’s parents, their characteristics also contribute to risk level (U.S. Department of Health and Human Services, Administration on Children, Youth, and Families 2012). Figure 3 lists risk factors for the perpetration of child maltreatment at the individual, family, and community levels.

Figure 3: Risk Factors for Perpetration within the Social-ecological Model



Source: (Centers for Disease Control and Prevention 2014)

On the other hand, protective factors “are conditions or attributes of individuals families, communities, or the larger society that reduce or eliminate risk [of maltreatment] and promote healthy development and well-being of children and families” (U.S. Department of Health and

³ 2010 figures were adjusted for inflation as 2014 dollars using the CPI-UX (U.S. Department of Labor, Bureau of Labor Statistics n.d.).

Human Services, Administration on Children, Youth, and Families 2014, 4). Protective factors have not been as well researched as risk factors but have been developed with the emergence of strengths-based practices in prevention programming. Programs use several different protective factor frameworks based on differences in populations served. Generally though, protective factors exist at various levels within the socio-ecological model and include resilience, social connections, nurturing and attachment, knowledge of parenting and child development, access to support in times of need, and social-emotional competence (Child Welfare Information Gateway 2014, U.S. Department of Health and Human Services, Administration on Children, Youth, and Families 2014). Helping families build and strengthen these protective factors can help them cope more effectively with stressful situations and reduce the risk of child maltreatment.

Effective Prevention Efforts

Reducing risk factors and building protective factors has been proven effective in several prevention efforts. One such effort is the Nurse-Family Partnership. Targeting first-time, predominantly low-income, and unmarried mothers, during their pregnancy and children's infancy, this program has existed in various capacities for almost 40 years (Nurse-Family Partnership n.d.). The program seeks to diminish risk factors through promoting the use of welfare to reduce financial stressors in the home (Olds, et al. 2002). Additionally, by building protective factors through parenting guidance, education, and supervision, the Nurse-Family Partnership has shown a positive effect on improving mother-child relationships and interactions. It has assisted parents in providing "sensitive and responsive" care to their children. This type of nurturing environment serves as a protective factor against abuse and neglect and is associated with healthy emotional development in children (Olds, et al. 2002). The Nurse-Family Partnership has shown decreases in child abuse, neglect, and injuries among children of these at risk mothers (Olds, et al. 2002).

Researchers conducted three randomized controlled trials of Nurse-Family Partnership programs and found sustained effects on key child and maternal outcomes in all trials (Coalition for Evidence-Based Policy 2014). One study documented a 48 percent reduction in child maltreatment 15 years following families' participation in this program (Olds, et al. 2002). These studies limited threats to validity and equalized the two groups through randomization. Through interventions targeting high-risk populations and building protective factors, the Nurse-Family Partnership has proven that addressing risk and protective factors can reduce rates of child abuse and neglect. Evidence of the effectiveness of home visiting has led to the creation of the Maternal, Infant, and Early Childhood Home Visiting Program as part of the Affordable Care Act, which provides \$1.5 billion over a five-year period for this social service program (Coalition for Evidence-Based Policy 2014; U.S. Department of Health and Human Services, Administration on Children, Youth, and Families n.d.).

A second such proven prevention effort is CTF's Project GAIN in Milwaukee. Key features of Project GAIN focus on increasing access to economic resources and decreasing financial stressors for participant families. Despite research showing that families of low socioeconomic standing interact more with CPS (Paxson and Waldfogel 1999; Slack 1999; Slack, Lee and Berger 2007), Project GAIN will be the first to experimentally test the potential role that economic factors may play in child maltreatment prevention, using a randomized controlled trial (Slack and Berger n.d.). Initial findings of this ongoing study show that "participant families with a history of CPS involvement are 39 percent less likely (15.8 percent versus 25.8 percent) than non-participants to have subsequent investigated CPS reports over a one-year period following Project GAIN participation" (Slack and Berger n.d.; Murray 2014). These families are 45 percent less likely to have

a subsequent substantiated report and 12 percent less likely to have subsequent out-of-home placement of one or more children during a one-year period following Project GAIN participation (Slack and Berger n.d.). The preliminary findings from Project GAIN indicate that addressing financial stress, one risk factor correlated with child maltreatment, can help reduce the incidence of child maltreatment.

Project GAIN in Milwaukee Cost-Savings Estimate

The demonstration of cost savings with CRP based on a set of reasonable, evidence-based assumptions will help promote program expansion and replication. Standard cost-savings estimates based on Project GAIN, a similar program providing an economic intervention, shows significant cost savings for the public sector and society at large. The savings result from estimates of the reduction in number of children re-referred to CPS, reductions in subsequent substantiations of maltreatment, and fewer out-of-home placements.

Minnesota’s alternative response program evaluation provides a useful basis for estimating the savings for the Bureau of Milwaukee Child Welfare as a result of Project GAIN. The Minnesota and Wisconsin CPS systems have similar cost structures, similar screen-in and screen-out rates, and serve similar populations. The Minnesota evaluation estimated the cost of staff time and services for families re-reported to CPS. Because of limited Wisconsin data, the Minnesota estimates can serve as a useful proxy. The cost of re-referral for a family not originally served by CPS was \$1,538 (Loman and Siegel 2004). Based on this analysis, the estimated cost savings of Project GAIN range from \$1,300 to \$2,000 per case (see Appendix A for an explanation of distribution assumptions).

There were 6,661 cases screened out of the Bureau of Milwaukee Child Welfare in 2012 (Wisconsin Department of Children and Families 2012). Prior studies sponsored by CTF show that take-up rates for CRP-like services range from 39 to 54 percent (Slack, Berger and Jack 2012; Wisconsin Children’s Trust Fund 2014). Based on an estimate of the number of clients exposed to the program and the estimated costs savings per client, the total cost savings can then be estimated.

Total cost savings consists of two components added together, program and societal savings. Program savings occur as a result of the reduction in re-referrals for families who take part in the program. Societal costs derive from the predicted present value of economic costs over a victim’s projected lifetime based on the research of Feng et al. (2012). Societal costs include health care, child welfare, special education, and productivity losses. A summary of these cost-savings estimates can be found in Table 1. Overall, based on 2012 estimates, the Bureau of Milwaukee Child Welfare annually saved between \$62,000 to \$108,000 in program expenses and \$694,000 in societal cost for a total cost savings ranging between \$763,000 and \$802,000.

Table 1: Estimated Cost Savings for Milwaukee Project GAIN in 2012

Distribution Assumption	Estimated Program Savings	Societal (Non-program) Savings	Total Savings
Uniform	\$69-108	\$694	\$763-802
Normal	\$62-102	\$679	\$741-781

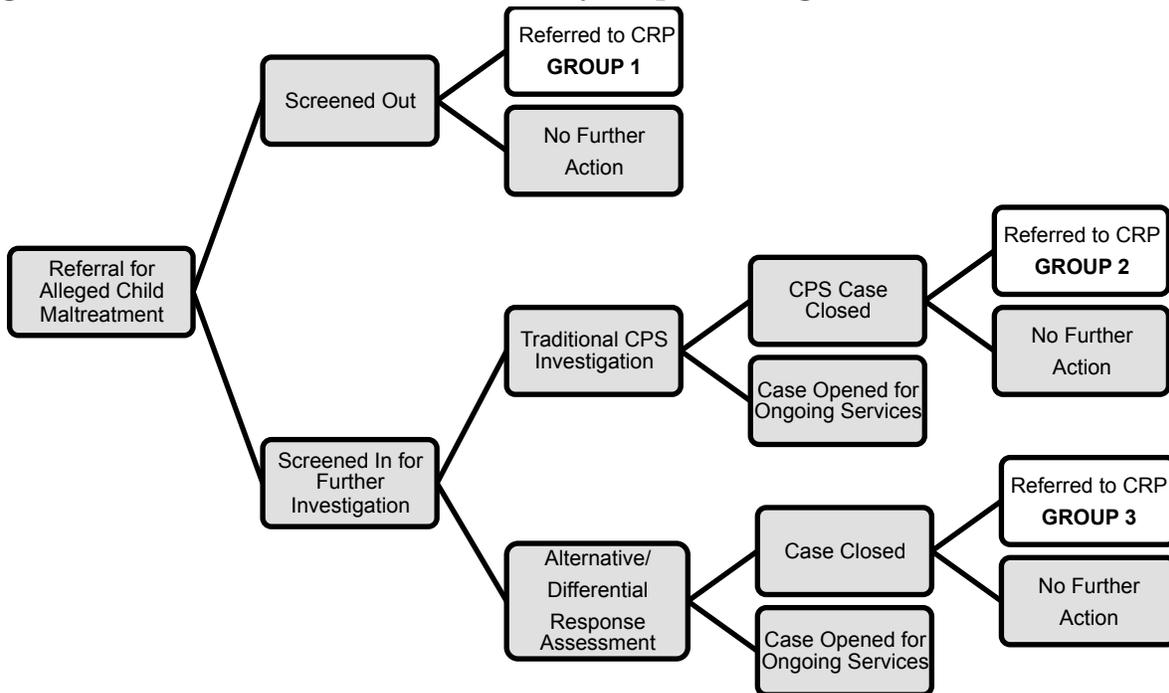
Note: All estimates in thousands

Source: Authors’ analysis based on Slack, Berger and Jack 2012, and 6,661 screened-out cases in Milwaukee (see Appendix A).

The Community Response Model

CTF grounded CRP in theories found in the child welfare literature. Since 2006, CTF has funded 14 CRP sites across Wisconsin; see Appendix B for more information. The program started as a short-term voluntary prevention program that works with families to ensure that children live in a safe and stable environment. CRP targets families whose referrals are screened out at the report stage, as seen in Group 1 in Figure 4, or whose reports are unsubstantiated after investigation, Group 2 and Group 3. The program’s core components include case management, home visits, collaborative goal setting, and financial support. Sites administer services within this core component framework, making adaptations to meet local needs.

Figure 4: Process for Referral to Community Response Program



Source: Authors

CRP staff contacts a family through phone calls, letters, and home visits and encourages them to voluntarily participate in the program. CRP aims to strengthen family functioning and prevent child maltreatment through the provision of services and to assist families in accessing formal and informal resources to meet their needs.

CRP uses a strengths-based and collaborative approach with participant families to identify needs and service goals, and to develop a plan to meet those goals (see Appendix C for a full list of these service goals and examples). The CRP manual provides forms that facilitate dialogue between the CRP caseworker and the family. This dialogue should help the family in “identifying the ‘stressors’ that affect their parenting, time available to spend with their child(ren) or interactions with their child(ren)” (Wisconsin Child Abuse and Neglect Prevention Board 2013, 23). CRP staff provides an array of direct and referral services to stabilize families. After choosing three to five goals to pursue, the family works with a CRP worker to prioritize these service goals based on the urgency of the need as assessed by the family, and the feasibility of addressing the need as gauged by the worker.

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.

In addition to providing services, sites provide families with financial support through one-time small non-repayable grants known as flexible (flex) funds, which are a core component of CRP. Flex fund uses include increasing education, maintaining or securing employment, maintaining quality childcare, and maintaining or securing housing. Staff use these funds as a last resort on an emergency basis to help provide stability and support to the family when all other formal and informal resources have been explored and proven inadequate. Flex funds go directly to the payee, not to the client, and the CRP site must have CTF approval for cash assistance more than \$500 (Wisconsin Child Abuse and Neglect Prevention Board 2013). The CRP caseworker provides assistance to the family during this time to move toward economic self-sufficiency.

Through this process, the family hopes to achieve its service goals, the short-term outcome of CRP. See Appendix D for the full program logic model. Achieving service goals should lead families to more positively rate their strengths, as measured by the pre and post "Primary Caregiver Self-Assessment of Strengths" tool (Wisconsin Child Abuse and Neglect Prevention Board 2013). The self-assessment tool asks questions about the primary caregiver's agreement with statements that typify strong and resilient families. By building strengths, families better deal with stress, thereby reducing the likelihood of child maltreatment. Through this process, CRP achieves the long-term goal of reducing maltreatment as measured by fewer re-referrals to CPS overall, fewer substantiated re-reports, and fewer out-of-home placements, as compared to families that do not participate in CRP.

Although CTF grounded CRP in theories found in the child welfare literature, the program has not been evaluated therefore an effect has not been proven. However, the theory and the success in similar prevention programs like the Nurse-Family Partnership, indicate the importance of building individual and family strengths. Prevention efforts, in turn, should decrease incidences of child maltreatment and diminish the associated cost burden.

Heterogeneity in Current Sites and Implications for Evaluation

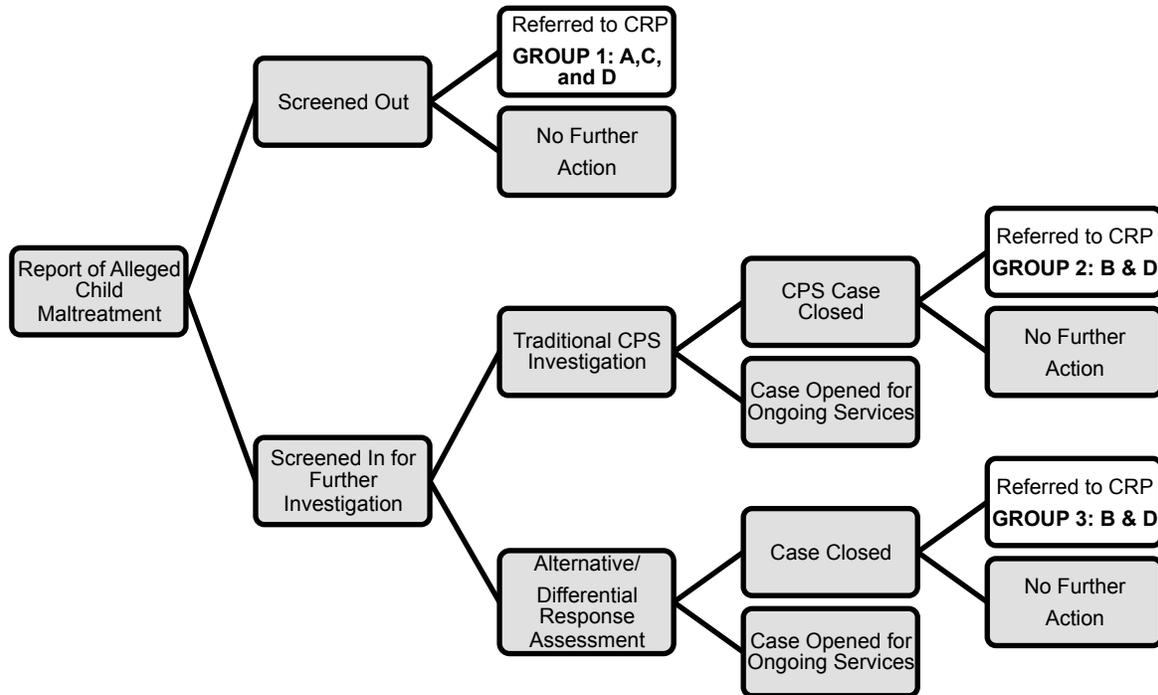
Four CRP sites in Wisconsin were examined for this report; to preserve anonymity, these will be referred to Site A, Site B, Site C, and Site D. Interviews with CRP workers and supervisors, summary reports, documents, and statistics serve as the basis for this analysis. These four sites are heterogeneous in structure, procedure, and in the contexts in which they operate. The points of variation have implications for CTF's ability to determine a program effect from a large-scale evaluation. Variation within the CRP model allows agencies to tailor services to the communities served, but poses a challenge for assessment of program impact through large-scale evaluation.

Point of Referral

CRP agencies differ in their point of referral. CPS refers families to CRP agencies through two processes. First, referral can occur when CPS receives a referral of child maltreatment, but screens it out because it deems the allegations in the referral do not rise to the level of maltreatment or threat of maltreatment as defined by Wisconsin statutes (Wisconsin Department of Children and Families 2013). Second, referral to CRP can occur when CPS screens in a family for initial assessment, but then finds it unsubstantiated. Sites A and C serve families whose referrals have been screened out

(Group 1 in Figure 5), whereas Site B takes referrals from CPS that are screened in but unsubstantiated (Group 2 and 3 in Figure 5). Site D takes CPS referrals from any of these groups, so provides CRP services to all of the aforementioned populations (Groups 1, 2, and 3 in Figure 5).

Figure 5: Process for Referral to Community Response Program



Source: Authors

Heterogeneity in the point of referral from CPS to CRP creates differences in the populations that each site serves. Sites A and C serve only families with screened-out referrals and therefore could conceivably be serving a lower risk population, as families' situations do not warrant assessment of child safety. Site B serves only families with screened-in referrals, which indicates that allegations involve a situation or threat of maltreatment meeting Wisconsin's statutory definition, giving this site a higher-risk population (Wisconsin Department of Children and Families 2013). Site D serves all of these groups and therefore likely has a combination of higher and lower risk cases. Varying severity in cases could correlate to different rates of re-referral, which would affect measured effectiveness of CRP in an evaluation. This difference could make drawing conclusions about average program effectiveness difficult.

Participation in Referral

In addition to variation in referral point from CPS, these four sites vary in their participation in the referral process. Sites A and C participate in choosing the families that are referred to CRP, while Sites B and D do not. Sites A and C indicated they were involved in the process to enable them to pick the families they thought would most benefit from participation in CRP.

Pre-selecting families who caseworkers feel will most benefit will affect the measured outcomes in an evaluation. Therefore, in a large-scale evaluation of CRP, staff members involved in the referral process may need to make procedural changes. Randomly referring families from CPS could be part

of CTF’s evaluation, as an objective, systematic, process would increase the ability to draw causal inferences about effectiveness. To achieve this change it may be easiest to have the researchers randomize families to avoid temptation of CPS or CRP workers to provide services to families despite their assignment. Given the current involvement of CRP staff in this selection process, getting buy-in from county staff may pose a challenge.

Service Type and Provision

Services provided by these sites vary significantly. The different service delivery models at these sites reflect their diverse organizational structures and funding sources. For the nine CRP service areas, Table 2 indicates whether sites provide direct services or referrals. All of the sites provide direct or referral services in each of the nine areas. Several sites simultaneously directly offer and refer out services within a given service area. For example, Site A assists individuals with completing income and benefit forms for programs addressing family medical needs (direct service) and helps them connect with the appropriate governmental agency (referral service). It also follows up with individuals to ensure follow through of application for governmental benefits. Methods of service delivery that include referrals to other agencies or service providers do not allow for as extensive follow-up on meeting participant goals; this variation contributes to the challenges of measuring effectiveness.

Table 2: Service Areas by Community Response Program Site

Service Area	Site A	Site B	Site C	Site D
Domestic violence services	R	R	R	R
Employment/job assistance	DO/R	R	DO/R	R
Family medical needs	DO/R	DO/R	DO/R	R
Financial support	DO	DO/R	DO/R	DO/R
Household or family needs	DO	DO/R	DO/R	R
Housing	DO	R	DO	DO
Mental health services	R	R	R	R
Parent education and child development	DO	DO	R	DO
Substance abuse services	R	R	R	R

Notes: DO: Directly offered; R: Referral to non-profit organization or other agency
Source: Authors

Consistency in Defining Success

Despite variations in implementation of the CRP model across the four sites, programs measure success in similar ways. All four sites regard reducing the probability of a family being re-referred to CPS as their primary long-term goal. In the short term, most CRP staff members view the completion of a family’s service goals as a success. Sites with a low participation rate also consider client acceptance of services a success. Consistency in defining success indicates that implementation of CRP aligns with the logic model, potentially simplifying the process of getting agency buy-in for evaluation. Overall, programs report success in meeting these short-, medium-, and long-term goals.

Despite perceived success, no formal evaluation has been conducted to show evidence of program effectiveness.

Heterogeneity of Child Protective Services Nationally

Great variation in CPS exists within Wisconsin and nationally. No two states have the same process for responding to referrals of child maltreatment, from the initial phone call to investigation and provision of services. Some states screen referrals of child maltreatment, while others respond to all referrals of child maltreatment. Most states use traditional investigative responses to determine whether maltreatment occurred, identify the perpetrator, and provide services to families. Some states also use an alternative or differential response in which the goal is not to substantiate maltreatment but rather to provide services and support to families in a collaborative and strengths-based manner. States also vary in the language they use to describe their systems and processes. States call screened-in referrals reports, accepted reports, appropriate or inappropriate reports, or assigned for assessment. Likewise, states have a variety of terms for CPS and for reports of maltreatment that are investigated and found to be true. This section summarizes findings regarding the variation in such systems, specifically as related to states' responses to referrals of child maltreatment that are screened out of the formal CPS system.

Reporting and Screening of Reports

Forty-eight states have laws requiring individuals in certain professions to report suspected child maltreatment. These individuals, known as “mandated reporters,” include teachers, social workers, physicians, nurses, counselors, therapists and other mental health professionals, child-care providers, and law enforcement officers. The law requires them to make a report to law enforcement or CPS when they “suspect or has reason to believe that a child has been abused or neglected” or have “knowledge of, or observes a child be subjected to, conditions that would reasonably result in harm to the child.” (Child Welfare Information Gateway 2012, 3) The remaining states, New Jersey and Wyoming, require all individuals to report suspected maltreatment, regardless of profession.

In most states, the agency that receives the maltreatment report screens it to determine if it meets the criteria for acceptance. In these states, a report “must concern actions that meet the statutory definition of child abuse or neglect in that state” to be screened in and accepted for investigation (Child Welfare Information Gateway 2013, 3). Referrals that do not meet these statutory criteria are screened out. In 15 other states, referrals are not initially screened; rather, all referrals are accepted.⁴ The statutory definition of maltreatment as well as the approaches used to screen referrals varies among states (Child Welfare Information Gateway 2013).

Investigating Referrals or Reports

Nineteen states⁵ and the District of Columbia have alternative or differential response programs that handle less serious cases and use family assessment approaches. More serious reports are assigned for the traditional investigative track (Child Welfare Information Gateway 2013). Traditional

⁴ Alabama, Alaska, California, Delaware, District of Columbia, Idaho, Iowa, Kansas, Maryland, New York, North Carolina, North Dakota, Ohio, South Dakota, and Wyoming.

⁵ Arizona, Colorado, Connecticut, Delaware, Kentucky, Louisiana, Maryland, Minnesota, Nevada, New York, North Carolina, Ohio, Oklahoma, Texas, Vermont, Virginia, Washington, Wisconsin, and Wyoming

investigation approaches generally focus on determining if an incident of maltreatment occurred, the person responsible, and what necessary steps CPS should take to ensure the child's safety. When the investigation results in a substantiated case of maltreatment, CPS enters perpetrators' names into a central registry and provides services to ensure the safety of the child or children. If CPS involves the court system, families can be ordered to participate in services (Child Welfare Information Gateway 2008). In comparison, assessments initiated in alternative or differential response programs tend to be less adversarial, assess the family's strengths and weaknesses, and then tailor services to fit the family's strengths, needs, and resources. Generally CPS does not find a perpetrator in these alternative and differential responses, and therefore it does not enter alleged perpetrators' names into the state's central registry. If families choose not to participate, CPS closes the case or switches it to another type of response (Child Welfare Information Gateway 2008). Again, due to a wide variation in state systems, alternative response varies from one state to the next. Wisconsin's alternative response program is slightly different than the theoretical description provided above.⁶

State Variation in Acceptance and Investigation

Six states and the District of Columbia accept all referrals and have a differential or alternative response track and traditional investigative track, as indicated in Table 3. The remaining 13 states that have a differential or alternative response track as well as a traditional track do not require acceptance of all referrals, but instead screen referrals based on criteria established by state statute and CPS protocol. The greatest number of states screen reports of maltreatment and have a traditional investigative response. Eight states, as indicated in Table 3, accept and investigate all reports using a traditional investigative response. Indiana, New Hampshire, and Tennessee do not have enough information in their state statutes to determine if the state screens referrals or accepts all referrals. These states do not have differential or alternative response programs.

National Survey

Increasingly states have been implementing differential or alternative responses (Merkel-Holguin, Kaplan and Kwak 2006). Studies have sought to determine the extent of usage of these multi-track systems and their contribution to the field of maltreatment prevention and intervention. These studies have revealed the development of formal responses to referrals of maltreatment that are screened out by CPS.

In April 2011, Morley and Kaplan conducted the first national survey to understand formal responses to screened-out reports of child maltreatment. They found that nine states⁷ had a uniform, statewide implementation of a formal response to screened-out reports of child maltreatment; another five states⁸ had implementation of a formal response in selected jurisdictions; and the remaining states had no program or did not respond to the survey (Morley and Kaplan 2011). To assess how programs may have changed since 2011, the authors of this report replicated Morley and Kaplan's survey.

⁶ For more information about Wisconsin's alternative response program, visit the Department of Children and Families website: http://dcf.wisconsin.gov/children/CPS/alternative_response/default.htm.

⁷ Connecticut, Florida, Illinois, Indiana, Iowa, Kentucky, Missouri, Oklahoma, and Tennessee

⁸ California, Georgia, Minnesota, New Jersey, and Wisconsin

Survey Methodology

This study used a survey developed by Caren Kaplan and Lauren Morley, with permission, and with minor changes suggested by Wisconsin Children's Trust Fund, University of Wisconsin - Madison Professor Kristi Slack, and Caren Kaplan. Questions were added to determine whether programs provided referral services, direct services, or no services around nine service areas. For the complete survey, see Appendix E. Using Kaplan and Morley's survey design 1) allowed comparison of data across time, 2) ensured reliability of responses, and 3) allowed prompt dissemination of the survey. Despite these benefits, limitations of the original survey remained, discussed in detail in Appendix F.

Survey respondents were identified from the National Resource Center for Community-Based Child Abuse Prevention website (FRIENDS n.d.), the list of respondents in the 2011 report (Morley and Kaplan 2011), and from web searches. The survey was sent by email to 102 potential respondents in 49 states and Washington D.C. in February 2014 with a description of the study and a link to the survey. Individuals who had not completed the survey were contacted via phone calls and follow-up emails, and reminded about the survey in early March. Thirty-nine states had started or completed the survey as of April 2.

Survey Results

In the 2014 survey, 26 states reported not having a formal response program for screened-out reports; six states reported having formal response programs in selected jurisdictions; and nine states reporting having statewide implementation of formal response programs. Maine and Florida, which reported not having a program in 2014, previously had formal response programs.⁹ Three states¹⁰ reported not having a formal response program but did report having an informal referral program for families screened out of CPS.

Of the 10 states that did not respond to the 2014 survey, one did not respond to the 2011 survey. Given that one state discontinued a formal response for screened-out referrals between 2011 and 2014, results presented within this report assume no change in response for states that responded in 2011 but not in 2014. Combining the responses from 2011 and 2014 shows that 32 states do not have any sort of formal response program, six have a formal response program in selected jurisdictions, and 12 have a formal response program implemented statewide.¹¹

As Table 3 indicates, the majority of states that report having some formal response for screened-out referrals of child maltreatment screen referrals of maltreatment based on predetermined criteria. Fifteen of the states (82 percent) that have a formal response program screen out referrals of maltreatment. Three states that accept all referrals reported having a formal response for screened-out referrals, two of which have traditional investigative response tracks. This disparity likely occurs due to the wording of the questions in the survey, which asked about the state response to screened-out referrals. This issue is discussed in further detail in the limitations section in Appendix F.

Nineteen states, or 37 percent, have traditional and alternative or differential response programs. A higher frequency of differential or alternative response exists among states that have a formal

⁹ Florida was reported as having a formal response program in Kaplan and Morley's report. Maine was not reported to have a formal response program in the 2011 report.

¹⁰ Nebraska, Oregon, and Oklahoma

¹¹ The number of states adds to 51 because it includes Washington, D.C. as a state for simplification of language.

response to screened-out referrals of maltreatment, with 45 percent of these states having differential or alternative response programs. In several situations, states integrated formal response to screened-out referrals into the alternative or differential response program.

Table 3: States' Responses for Screened-Out Referrals

	Differential and Traditional Response		Traditional Response	
	<i>All Referrals Accepted</i>	<i>Referrals Screened</i>	<i>All Referrals Accepted</i>	<i>Referrals Screened</i>
No Formal Response for Screened-Out Referrals	Delaware District of Columbia Maryland New York Ohio Wyoming Total: 6	Arizona Louisiana Oklahoma Vermont Virginia Washington Total: 6	Alabama Alaska Idaho Kansas North Dakota South Dakota Total: 6	Arkansas Florida Hawaii Maine Massachusetts Michigan Mississippi Montana Nebraska New Hampshire* New Mexico Oregon Rhode Island Utah West Virginia Total: 15
Formal Response for Screened-Out Referrals	North Carolina Total: 1	Colorado Connecticut Kentucky Minnesota Nevada Texas Wisconsin Total: 7	California Iowa Total: 2	Georgia Illinois Indiana* Missouri New Jersey Pennsylvania South Carolina Tennessee* Total: 8

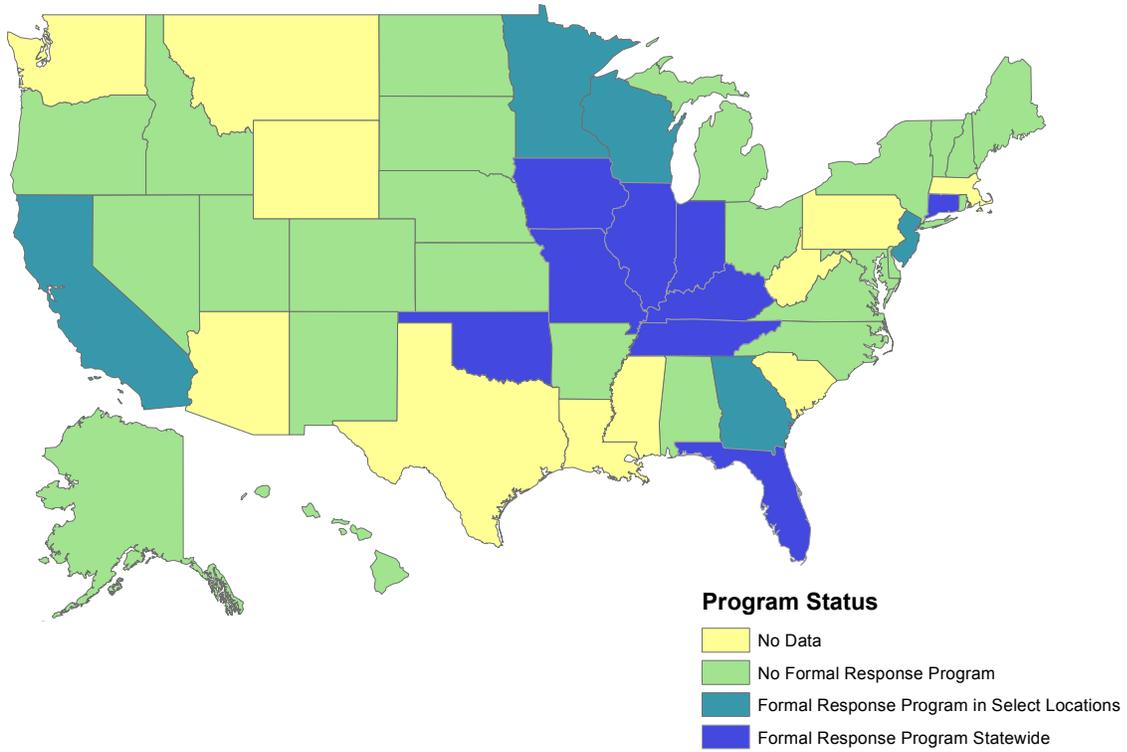
Source: Authors

* There was insufficient information in state statute to determine if Tennessee, Indiana, and New Hampshire screened out referrals based on criteria or accepted all referrals. They were included in the states that screen referrals because the majority of states with only traditional response programs screen referrals.

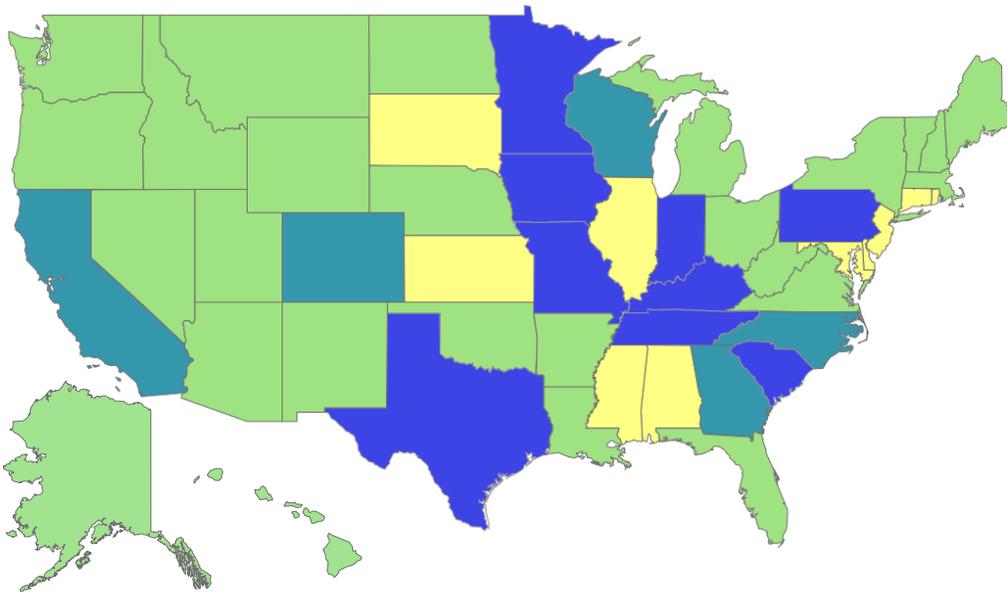
The maps in Figure 6 show states' responses to the survey in 2011 and 2014. These maps indicate several changes nationally. For information about selected states responses in 2011 and 2014 and brief program information, see Appendix G.

Figure 6: States' Program Status: 2011 and 2014

2011



2014



Source: (Morley and Kaplan 2011); Authors

The notable changes between 2011 and 2014 occurred in Colorado, North Carolina, and Minnesota. Through state legislation, Colorado developed a formal response program for screened-out reports based on Wisconsin's CRP. The program, known as Colorado Community Response, was implemented in selected counties in Colorado in 2013. Likewise, North Carolina developed its Community Response Program based on Wisconsin's CRP and implemented in four counties in 2014. Finally, Minnesota had a program in selected jurisdictions in 2011. A quasi-experimental design evaluation found this program effective at reducing re-referrals of child maltreatment among participating families. The positive findings of this pilot program resulted in statewide implementation of the Parent Support Outreach Program in July 2013.

Colorado and North Carolina base their programs on Wisconsin's CRP. All three states (including Wisconsin) allow variable implementation across different sites to meet the needs of specific populations and communities. Each state partners its CPS agencies with community-based non-profits and has implemented the program in selected counties.

Differences in methods of service provision distinguish programs in Wisconsin, Minnesota, Colorado, and North Carolina from programs in other states. Programs in these four states reported providing direct services and referral services to clients in all nine service areas. The other states that provided this information¹² generally offered referral services rather than direct services.

Limitations

Several limitations exist with this study. First, the short timeframe limited the ability to engage in dialogue with survey respondents to the extent necessary. Second, different terminology for similar systems and processes across states resulted in misunderstanding of the goals of the survey. Third, contacting state-level employees through easily identifiable web-based searches likely resulted in the survey not always reaching the most appropriate person or not identifying county-initiated programs. Fourth, this survey had a low completion rate, which is likely attributable to the survey design. Finally, in several instances the same person completed the survey more than once. For a full discussion of all limitations, see Appendix F.

Summary of Findings

Despite wide variation, national trends show development and expansion of systems to meet the needs of families with allegations meeting and not meeting the statutory definition of child maltreatment. With the development of CRP, Wisconsin has been a leader in the expansion of traditional prevention and intervention systems. The preliminary results of the program thus far in Wisconsin, and similar evaluation results in Minnesota, have spurred Colorado and North Carolina to develop similar programs. Evaluations of these programs with positive results will aid in expansion of such programming nationally.

Evaluation Alternatives

CTF has funded CRP in Wisconsin for almost 10 years and has made alterations during this time. However, the time has come for CTF to evaluate the program and determine whether it should recommend statewide implementation or discontinue the program. Minnesota's evaluation of its

¹² Iowa, Kentucky, Louisiana, Missouri, South Carolina, and Texas.

Parent Support Outreach Program in 2009 convinced state legislators to fund and implement the program statewide. Furthermore, although an evaluation of Project GAIN in Milwaukee has yet to be completed, preliminary results indicate that among families with repeated referrals to CPS, families that receive the CRP treatment are 40 percent less likely to experience a re-referral than a randomized control group (Slack and Berger n.d.). Although these preliminary findings come from only one site, they indicate effectiveness of this prevention model in Wisconsin. The findings in Minnesota, coupled with the preliminary data from Project GAIN, suggest that CRP prevents child maltreatment. This section will provide an analysis of different evaluation methods CTF could use to evaluate the effectiveness of CRP in reducing re-referrals to CPS, future substantiations of child maltreatment, and out-of-home placements. Appendix H summarizes the methods and criteria used in this analysis.

Observational Method

The first method that CTF could use to evaluate CRP is an observational study, which is essentially what CTF has done thus far in regards to evaluation. This method involves limited manipulation of intervention, but enables evaluators to study the relationship between participation in CRP and the three long-term outcomes of interest (re-referrals to CPS, substantiations, and out-of-home placements). Comparisons between participants and non-participants would allow CTF to estimate a correlation between CRP participation and the program's desired outcomes. An observational study would not allow any causal inferences, as discussed below.

This relatively simple model uses binary independent and dependent variables. A multivariate regression would allow evaluators to estimate correlations between participation and long-term outcomes, while using other variables as controls or to estimate program effects among particular population sub-groups. These other variables may include age, race, gender of parent(s)/caretaker(s), age of children, number of children in family, whether case was referred to CRP at screening or at initial assessment, and number of prior CPS referrals. This design would allow CTF to estimate the percentages of CRP participants with re-referrals, substantiations, and out-of-home placements following program completion and compare this figure to the percentages of non-participants experiencing these same outcomes. Once CTF has examined the effect of the program, evaluators could do extensive analysis of which program elements are most important for influencing participant outcomes, which could inform CTF's plans for statewide expansion.

While simple, this model imposes a number of threats to internal validity. First, omitted variable bias exists because the model does not include all variables that could be correlated with participation, with the long-term outcomes, and with the error term of the regression. These factors could contribute to the estimation but would not be observed or measured, making the estimate potentially biased. Second, selection bias exists based on the voluntary nature of CRP. As this model does not manipulate or randomize participation, systematic differences may remain between participants and non-participants, limiting reliable comparison between the outcomes of the two groups. Third, events that occur outside of participants' or non-participants' experiences with program services may cause changes in outcomes during the evaluation. This history bias makes it difficult to associate changes in outcomes to program participation or non-participation or simply to changes in society. Finally, maturation bias as a result of changes in individuals that occur naturally over time may correlate to CRP's desired outcomes regardless of participation. For example, parents may naturally become more attentive and responsive to the needs of their children, thus decreasing potential for abuse and neglect. In addition to the above threats to internal validity, this model faces

a threat to external validity. Because variations in treatment exist even within the CRP model, implementation of CRP in other jurisdictions may not provide the same effect on long-term outcomes.

This evaluation model costs the least of the four outlined in this report. It does not include any programming changes or manipulation of implementation process that would create additional evaluation costs. In addition to the low cost of this model, little change would be required at the agency level for this design, so getting buy-in from CRP agencies should be relatively easy.

Quasi-Experimental Methods

CTF could use two types of quasi-experiments, where random assignment does not occur but natural variation provides a control group, to evaluate the effects of participation in CRP on desired outcomes. The first, referred to as the “county model,” would compare outcomes of families participating in CRP in counties where it is offered to outcomes for families with screened-out referrals in counties where CRP is not offered. Outcomes of interest include re-referral, substantiation, and out-of-home placement rates. The second type of quasi-experiment, referred to as the “dosage model,” would evaluate participants in CRP. It would compare the same outcomes as the county model among families with different levels of need and levels of services received. Specifically, comparisons would be made among outcomes of families with similar self-reported levels of need, but who participated in CRP to differing degrees. Evaluators used a similar method to assess Minnesota’s Parent Support Outreach Program (Loman, et al. 2009).

The county model would require collecting data on non-participant families in non-CRP counties, participant families in CRP counties, and non-participant families in CRP counties. The dosage model would require collecting data on participant families’ self-reported needs, self-reported strengths or protective factors, services offered, the delivery method of services (referral or direct provision), and a measure of family engagement in the services provided. Both models would require the collection of basic demographic data for families such as the age, race, gender of the parent(s); the number of children in the family; the age of the child(ren); and whether the case was referred to CRP at screening or at initial assessment. A county model would likely require an outside evaluator, while CRP workers could collect data on the variables of interest for a dosage model.

The analytical methods differ between these two quasi-experimental designs. A county model would involve an intent-to-treat (ITT) analysis and a treatment-on-treated (TOT) analysis. The ITT analysis would compare the mean outcomes of interest for all screened-out families in the CRP county to the mean outcomes of all screened-out families in the non-CRP county. The number of families that choose not to participate dilutes the measured ITT effect, and measured treatment effect would likely be positively correlated to the uptake rate. Because of this dilution the ITT analysis will represent a lower-bound estimate of the true effect of CRP. The effect of the program for families that choose to participate will be measured through the TOT analysis, which will represent an upper-bound estimate of the true treatment effect. To determine variation in program effectiveness within particular subgroups, both analyses would need to use a regression analysis to control for family demographics and characteristics.

The dosage model would require a difference-in-differences analysis of the outcomes between various groups of families. For Minnesota’s Parent Support Outreach Program, evaluators compared families across two dimensions and two levels, creating four groups. Families were divided by level

of need (serious/chronic and some/moderate), and level of service participation (moderate/high and low/none). Given the focus on family strengths and protective factors in Wisconsin's CRP, groups could include a measure of self-assessed family strengths or protective factors. The benefit of this approach would be the ability to show the interaction of families' needs, strengths and service participation. The drawback for this approach is with eight groups evaluators may not be able to find statistically significant differences among subgroups even if using a low and high scale. Despite tradeoffs in including a measure of self-reported strengths in the final analysis, the evaluators should collect the data, as it may be of interest.

The county and the dosage model evaluations present internal validity issues, though fewer validity concerns exist with the county model. Both models are subject to omitted variable bias, as defined previously, as a result of voluntary participation. The county model would face additional omitted variable bias related to the economic, political, and social context of the counties that may be correlated to measured outcomes for CRP and non-CRP counties. The dosage model would have a higher likelihood of omitted variable bias because there is not a reliable or objective measure for CRP worker effectiveness or how well a family responds to its caseworker. Worker effectiveness and other program-level factors would affect the service participation level of families, thereby creating correlation between the error term and the dependent variables. Both models also present internal validity issues related to Hawthorne Effects, as people being studied tend to behave differently than they would normally. Because families would know that researchers are observing long-term rates of re-referral, substantiation, or out-of-home placement, rates may be artificially lower.

In addition, the dosage model would face internal validity threats arising from selection bias, history effects, and maturation bias, but the county model will not. The voluntary nature of the program creates selection bias; unobservable characteristics that differentiate participating and non-participating families could conceivably correlate to outcomes of interest. History effects may be a threat to validity because, with the passage of time, changes in the environment may affect the measured outcomes. For example, Wisconsin could decide to implement a statewide TV and radio campaign to reduce child maltreatment. This campaign may reduce maltreatment for all Wisconsin residents, but because the dosage model does not compare a control group that does not receive CRP, the effects of this marketing campaign would be attributed to CRP in the analysis. Similarly, with maturation bias, as time passes people get older and wiser. Maturation bias is especially relevant to child maltreatment where young children are at a greater risk. Again, because this model lacks a control group the program effects will be biased upward by any positive effects maturation may play.

Despite potential validity concerns, each of these methods has its strengths. The county model would provide a comparison group of non-participants, without randomization, that may still be statistically similar enough to participants to make some strong statements about the correlation between participation and the measured outcomes. Likewise, it would provide two different measures of effects, the IIT and the TOT, which could approximate the effects that would be achieved when CRP is implemented statewide. The dosage model would be able to show correlation between the needs of families, the services received, and their measured outcomes. It would allow CTF to make decisions about how to most effectively serve these families. For example, Minnesota found that families with some basic needs (rather than serious basic needs) that participated in a high level of poverty-related services actually had more re-referrals at follow-up than families with similar levels of needs that participated in fewer services (Loman, et al. 2009). While counter-intuitive to the "more is better" axiom, this finding will help Minnesota focus its services in the right quantities to the families in need.

Both the dosage and county quasi-experimental approaches would allow CTF to make statements about CRP participation and its correlation to the intended outcomes for participant families. Each has a comparison group, which is valuable for making statements about the worth of the program. Quasi-experimental designs do not allow for the assumption of causation because of the lack of randomization. The county model, comparing outcomes for similar groups across counties with and without CRP, gets closer to causal inferences than the dosage model.

Randomized Controlled Trial

Randomization would provide a strong basis on which CTF could present the effectiveness of CRP. Random assignment creates two groups that are assumed to be statistically similar to one another, thus differences in outcomes could be attributed to CRP participation (Shadish, Cook, and Campbell, 2002). For CRP, randomization would occur prior to family acceptance of CRP services to avoid the need to offer CRP to families that would then be randomized out of the treatment group. This process, known as Zelen's Design, would also eliminate some of the ethical concerns that are often associated with randomized controlled trials for social service programs (Zelen 1979). A randomized design allows for observation of differences in treatment and control groups across CRP sites, which vary in service delivery methods. From this evaluation, CTF could make causal inferences regarding the effect of CRP participation on reducing referrals to CPS, case substantiations, and out-of-home placements. By randomly distributing unobservable characteristics across groups, a randomized controlled trial would allow CTF to more confidently state the program effect.

Two analytical methods should be used for a randomized controlled trial: ITT and TOT. ITT analysis would compare all screened-out families that randomized into the treatment group to screened-out families randomized into the control group. This model is possible because randomization occurs prior to the offer and acceptance of CRP services. Analysis for ITT would include a multivariate regression to determine if CRP is more effective for some subgroups than others. A TOT analysis would compare outcomes for families in the treatment group who accept CRP compared to control group families. Evaluators could use matching to control for observable differences between the treatment and control groups to provide a more robust TOT effect estimate. In addition to variables used in other evaluation methods, these analyses would also include a measure of whether CRP was offered to a family.

A number of potential threats to internal validity must be considered when using randomization to draw conclusions about relationships between CRP participation and desired outcomes. Using the ITT analysis leaves potential for attrition to affect validity, as CRP participation is voluntary and participants could end program participation at any time. Attrition would limit the sample size for the trial, leaving incomplete data on original participants. On the other hand, using the TOT analysis leaves potential for selection bias, as systematic differences may exist between those who accept services and those who do not, affecting the ability to draw causal inferences on program effect. Omitted variable bias remains in this model because of the presence of variables potentially correlated with participation, with the long-term outcomes, and with the error term of the regression. As programming is diverse across CRP agency settings, evaluators should expect that associations among program elements and outcomes at one site may not have the exact same relationship at a different site. Using control variables would help evaluators to estimate an average program effect.

In addition to threats to internal validity, threats to external validity limit the ability for findings to be transferred to other settings. Because variations in treatment exist even within the CRP model, implementation of CRP in other jurisdictions may not provide the same effect on long-term outcomes found by the randomized controlled trial.

Compared with the other evaluation options, conducting a randomized controlled trial is more expensive. It involves the implementation of additional processes at the agency level, which is costly and requires extensive buy-in from frontline staff. Despite relatively high costs, this model would allow CTF to make causal inferences regarding program effectiveness. Other models allow for estimates on the correlation between program participation and other variables of interest, but randomization distributes differences randomly between the treatment and control groups so that differences in outcomes can be attributed to CRP participation. Additionally, the inclusion of ITT and TOT analyses allows for two different analyses that allow additional conclusions to be drawn.

Recommendations

For nearly 10 years, Wisconsin's CRP has been addressing the needs of families otherwise not served by the traditional CPS system. Evidence from evaluations of other prevention programs validates the theory of change and the program model underlying CRP. Likewise, preliminary evaluations have shown that CRP and similar programs, such as Minnesota's Parent Support Outreach Program and Milwaukee's Project GAIN, are effective at reducing the number of re-referrals, substantiations, and out-of-home placements for families served, as compared to non-participant families. Preliminary evidence thus far has spurred the development of similar programs in other states, such as Colorado and North Carolina. Wisconsin can continue to lead the nation in the development of effective programming to address the needs of families screened out of the formal CPS system, but first it must make a commitment to rigorously evaluate CRP. It is recommended that CTF conduct a randomized controlled trial of CRP to evaluate the short-, medium-, and long-term outcomes of the program. CTF should also pursue a cost-benefit analysis of CRP.

Recommendation One: Randomized Controlled Trial

Randomized controlled trials are the gold standard of program evaluation because these experiments allow for causal inferences about program effects. One of the primary barriers to conducting randomized controlled trials is the ethical nature of offering individuals or families a program, but randomizing them into a control group that does not receive services. To avoid this ethical concern, CTF could randomize clients into treatment and control groups prior to obtaining consent to take part in a study, as is sometimes done in clinical trials (Zelen 1979). Randomized controlled trials present fewer ethical concerns when programs do not have the capacity to serve all individuals or families, which is the case with several CRP sites. Random assignment does not change the number of families served by the program or excluded from services, but instead leaves that decision to chance rather than program administrators. Only a randomized trial will provide CTF with the evidence required to expand the program in Wisconsin and nationally.

Recommendation Two: Cost-Benefit Analysis

CTF should conduct an *in medias res* cost-benefit analysis (Boardman et al. 2011). This type of analysis provides a better estimate of program costs and benefits because actual cost and benefit data

is available. This cost-benefit analysis helps policymakers to decide whether a program should be continued or discontinued; for CTF, however, this analysis could influence decisions about potential program expansion.

Pursuit of an *in medias res* cost-benefit analysis requires more data than currently available. Examples of necessary data required include:

- CPS administration costs
- CPS and CRP staff salaries and benefits
- Re-referral rates among CRP participants and non-participants
- Substantiated re-referral rates among CRP participants and non-participants
- Out-of-home placements rates among CRP participants and non-participants
- Estimate of time spent by CPS workers on re-referred cases
- Estimate of time spent by CPS workers on re-referred cases that are substantiated
- Estimate of time spent by CPS workers on re-referred cases that result in out-of-home placement
- Out-of-home placement costs
- CRP costs

With this information, CTF could approach the La Follette School of Public Affairs to conduct an *in medias res* cost-benefit analysis.

Conclusion

Preventing child abuse and neglect is clearly an important policy priority. This report documents differences in prevention approaches across states, focusing on the strengths-based approach of Wisconsin's CRP model. Based on prior studies, this approach is well grounded in the evidence and well regarded as a national model. Nonetheless, CRP lacks rigorous evaluation evidence of effectiveness. An expansion of CRP requires further standardization in approach and stronger evaluations of reduced rates of children being re-referred to CPS. With a robust randomized controlled trial and a well-designed cost-benefit analysis, CTF can lead Wisconsin and the nation in improving the well-being of vulnerable children.

Appendix A: Project GAIN Cost-Savings Calculation Methods

Uncertainty exists in the results of any mathematical modeling because of potential error. To address this uncertainty, a sensitivity analysis is often performed. Sensitivity analysis allows selected variables to fluctuate, producing varying estimates. For example, best-case and worst-case models are common forms of sensitivity analyses. This report uses a type of sensitivity analysis known as a Monte Carlo analysis, which consists of generating a large sample of randomly generated numbers within a specified distribution, producing more robust results of cost estimation than a single point estimate. This analysis generates 1,000 estimates of each variable, allowing for a range of outcomes within the distribution.

Cost estimation for Project GAIN came from 2012, the only available data. Four models were developed: a low uniform distribution, a high uniform distribution, a low normal distribution, and a high normal distribution. Since the actual frequency distribution of costs across cases was not available, a uniform distribution and then normal distributions was assumed. While normal distributions are the most common (a “bell curve”), the uniform distribution (a continuous or “rectangle” distribution) adds variation to the estimates. For normal distribution models, the assumed mean was the mid-point between the high and low bounds of the range, with the upper and lower bounds representing three standard deviations.

The variables and their assumptions used in the cost-savings analysis consisted of the following:

(1) Savings to the Bureau of Milwaukee Child Welfare as a result of Project GAIN participants’ reduced re-referrals. These estimates were derived from the results of the cost-effectiveness portion of Minnesota’s alternative response program evaluation (Loman and Siegel 2004). This program provides different services to a slightly different population. However, this evaluation was chosen, because estimation of re-referral costs in the absence of treatment was needed for estimation (control group, period two). In Wisconsin, this group consists of families that did not receive CRP treatment and are re-referred to CPS. County bookkeepers totaled the costs in the Minnesota evaluation for all service and labor costs for CPS. In the Minnesota evaluation, the mean follow-up period was 15 months. The evaluation showed that the mean cost differential in 14 impact study counties was \$1,538. In this analysis, the cost savings used were \$1,496 to \$1,538 in the low estimation, and \$1,278 to \$2,012 for the high estimate.

Wisconsin and Minnesota are comparable in overall population and demographics (U.S. Census Bureau 2014), although some differences exist between their child welfare programs. Wisconsin handled 27 percent more CPS cases in 2012 (Minnesota Department of Human Services 2013, Wisconsin Department of Children and Families 2013), although Minnesota outspent Wisconsin by more than \$178 million on child welfare programs (Scarcella et al. 2006). Therefore, the mean estimate may overstate the savings for Wisconsin, with the low estimate more accurately reflecting savings from Project GAIN. Despite these differences, this estimate represents the most accurate cost estimate of re-referral in the absence of treatment found.

(2) The number of screened-out cases includes the total number of screened-out cases handled by the Bureau of Milwaukee Child Welfare in 2012. Only screened-out families were assumed to be eligible for Project GAIN based on the program manual (Bureau of Milwaukee Child Welfare 2012). The total number of cases used was 6,661, the total number of screened-out cases in Milwaukee for

2012 (Wisconsin Department of Children and Families 2013), and was not varied across estimates. Since not all screened-out families are eligible or willing to participate in Project GAIN, this estimate may overstate the true potential participant pool.

(3) The uptake rate represents the percentage of screened-out cases that voluntarily chose to participate in Project GAIN. The CRP uptake rate used was 39 to 54 percent (Slack, Berger and Jack, Community Response Program (CRP) Pilot Initiative 2012, Wisconsin Children's Trust Fund 2014), based on the 2012 Wisconsin CRP uptake rate, and the rate found in the previous evaluation of Wisconsin's CRP. This range reflected observed uptake rates in previous years. Therefore, this range is thought to accurately reflect the true uptake range.

(4) The case reduction rate is the difference in re-referral rates for participant families, as compared to non-participant families, over a follow-up period of one year. The reduction rates used were 5 percent to 15 percent, based on the 2012 preliminary results of Project GAIN (Slack and Berger n.d.). The mean reduction in re-referral was 10 percent; participants had a 16 percent re-referral rate, as compared to the 26 percent for non-participants (Slack and Berger n.d.). The reduction rate may be overestimated resulting from the voluntary nature of the program.

(5) Program costs are the total costs of Project GAIN. A year-by-year breakdown was unavailable, so estimates used were an annual approximation over the last three years of operation. This variable included staff salary and benefits, training, rent, administration, and all related costs of running the program. The estimate also included money spent on flex funds for participating families. The program costs used were \$380,000 to \$430,000 (Murray 2014). These estimates accurately reflect the true costs of Project GAIN, since estimates were based on actual cost data.

(6) Estimated lifetime societal cost savings, which are not directly related to any program costs or savings, are the aggregated societal cost savings of keeping families out of the CPS system. This estimate was based on the work of Fang, Brown, Florence, and Mercy in their article "The Economic Burden of Child Maltreatment in the United States and Implication for Prevention" (2012). These costs included health-care costs (short and long term), productivity losses, child welfare costs, criminal justice costs, and special educational costs. While many other estimates of these societal burdens exist in the literature, few break down their estimations on a case-by-case basis. The Fang et al. article provides a by-case estimate and differentiates case severity using the National Incidence Study classifications. Therefore, the estimate used for this analysis was based on the study's lower endangerment standard, which better reflects the type of case severity found in CRP families. The annualized rate used a life span of 70 years, as in Fang et al.'s article. The estimated present value of these costs was \$97,952 to \$210,012. The lower bound of the distribution was the annualized rate at a 3 percent annual discount rate, and the upper bound was the annualized rate at a 7 percent annual discount rate.

Table A-1 provides a summary of the variables used in this analysis as well as the calculation of savings.

Table A-1: Cost Savings Estimate Parameters

Variable	Lower Bound		Upper Bound	
Savings from reduced re-referrals (total dollars per case) ¹³	<i>Low Estimate</i>	\$1,496	<i>Low Estimate</i>	\$1,278
	<i>High Estimate</i>	\$1,538	<i>High Estimate</i>	\$2,012
Number of screened-out cases (total number) ¹⁴	6,661		6,661	
CRP take-up rate (percent participating) ^{15 16}	39%		54%	
Case reduction rate (percent reduction) ^{17 18}	5%		15%	
Program costs (total annual dollars) ¹⁹	\$380,000		\$430,000	
Estimated lifetime societal costs (health care, mental, productivity, criminal justice, etc.)- endangerment only (present value of costs at 3% discount rate) ²⁰	\$97,952		\$210,012	

Source: Authors' Analysis

¹³ (Loman and Siegel 2004)

¹⁴ (Wisconsin Department of Children and Families 2013)

¹⁵ (Slack, Berger and Jack 2012)

¹⁶ (Wisconsin Children's Trust Fund 2014)

¹⁷ (Murray 2014)

¹⁸ (Institute of Applied Research n.d.)

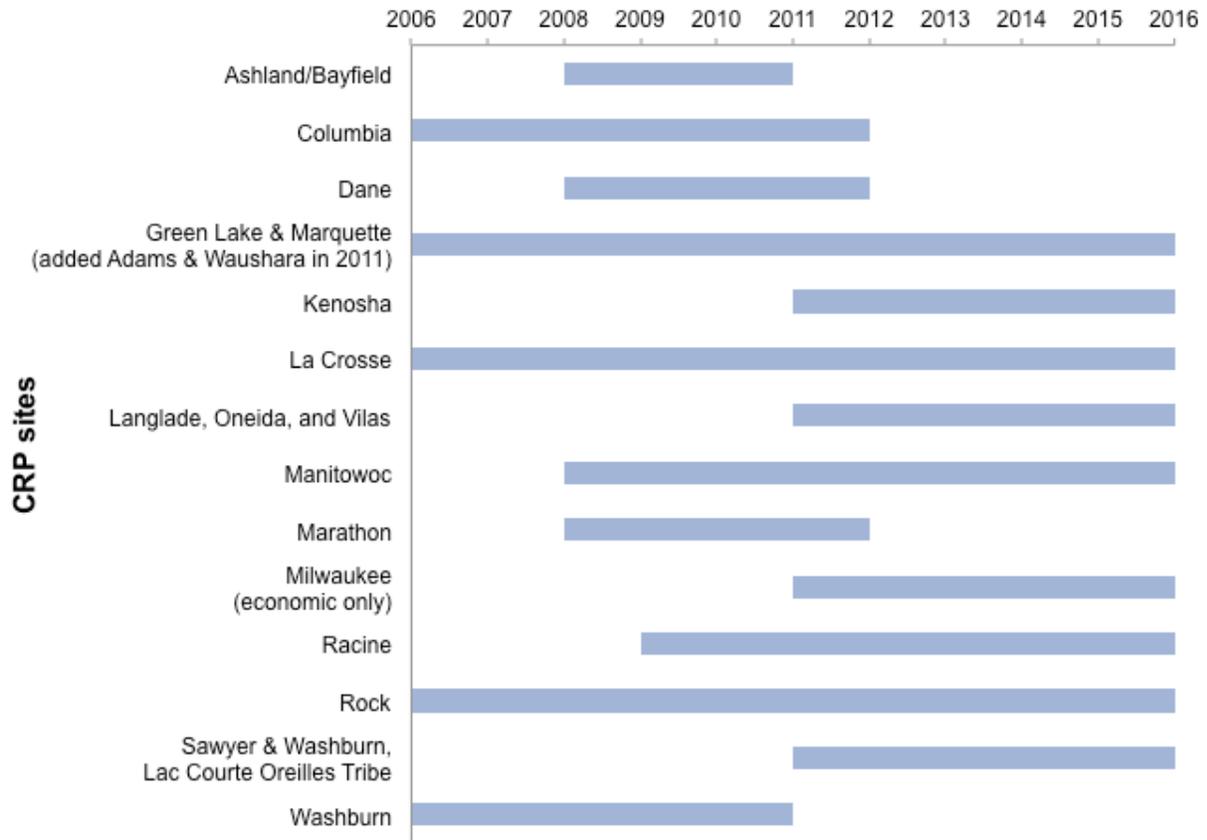
¹⁹ (Murray 2014)

²⁰ (Fang, et al. 2012)

Appendix B: Sites Funded for Community Response Program

Wisconsin Children’s Trust Fund (CTF) has funded sites for Community Response Programs across Wisconsin since 2006. Changes in funding have prevented continued provision of services in many sites, but nine sites will continue to be funded through July 2016, when the next funding cycle begins, as shown in Figure B-1.

Figure B-1: Duration of Community Response Program Sites Funded by Wisconsin Children’s Trust Fund



Source: Authors

Notes: Children’s Trust Fund funding for the Ashland/Bayfield, Columbia, Dane, Marathon and Washburn CRP sites ended June 30, 2011. (Marathon Co. continues to provide CRP with county funding; Dane Co. provides Joining Forces for Families) Operations in Milwaukee began October 18, 2011

Appendix C: Wisconsin Community Response Program Service Areas

The nine service areas, described in Table C-1, encompass primary services provided directly or through referrals by Community Response Program (CRP) sites. All funded CRP agencies provide services from these areas in some capacity but vary in service provision based on their structure and the contexts in which they operate (Wisconsin Child Abuse and Neglect Prevention Board 2013).

Table C-1: 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)

Appendix D: Wisconsin Community Response Program Logic Model

The logic model illustrated in Table D-1 describes the sequence of inputs and activities that underlie the CRP theory of change. The theory of change postulates that by helping families attain service goals CRP will have a positive influence on family strengths, thereby reducing the incidence of child maltreatment in the future.

Table D-1: Wisconsin Community Response Program Logic Model

Inputs	Outputs		Outcomes -- Impact		
	Activities	Participation	Short	Medium	Long
<p>Referrals from Child Protective Services (CPS) of families with screened-out referrals of child maltreatment</p> <p>Referrals from CPS of families with cases closed after initial assessment</p> <p>Community partnerships</p> <p>Staff</p> <p>Funding</p>	<p>Primary caregivers self-identify needs and collaboratively determine service goals with caseworkers²¹</p> <p>Case management</p> <p>Direct service or referral to services</p> <ul style="list-style-type: none"> • 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 <p>Flexible funds for emergent family needs</p> <p>Home visits</p> <p>Individual sites adhere to the model of service delivery²²</p>	<p>Voluntary participation</p> <p>Strengths-based approach</p> <p>Community partners outside of the CPS system</p>	<p>Participant families attain service goals²³</p>	<p>Positive change in pre-post measures of family strengths^{24 25}</p>	<p>Participant families have fewer re-referrals to CPS²⁶</p> <p>Participant families have fewer substantiated re-referrals²⁷</p> <p>Participant families have fewer out-of-home placements</p>

²¹ (Slack and Berger 2009, 36)

²² Ibid.

²³ Ibid.

²⁴ (Slack and Berger 2009, 8)

²⁵ (Wisconsin Child Abuse and Neglect Prevention Board 2013, 7)

²⁶ Ibid.

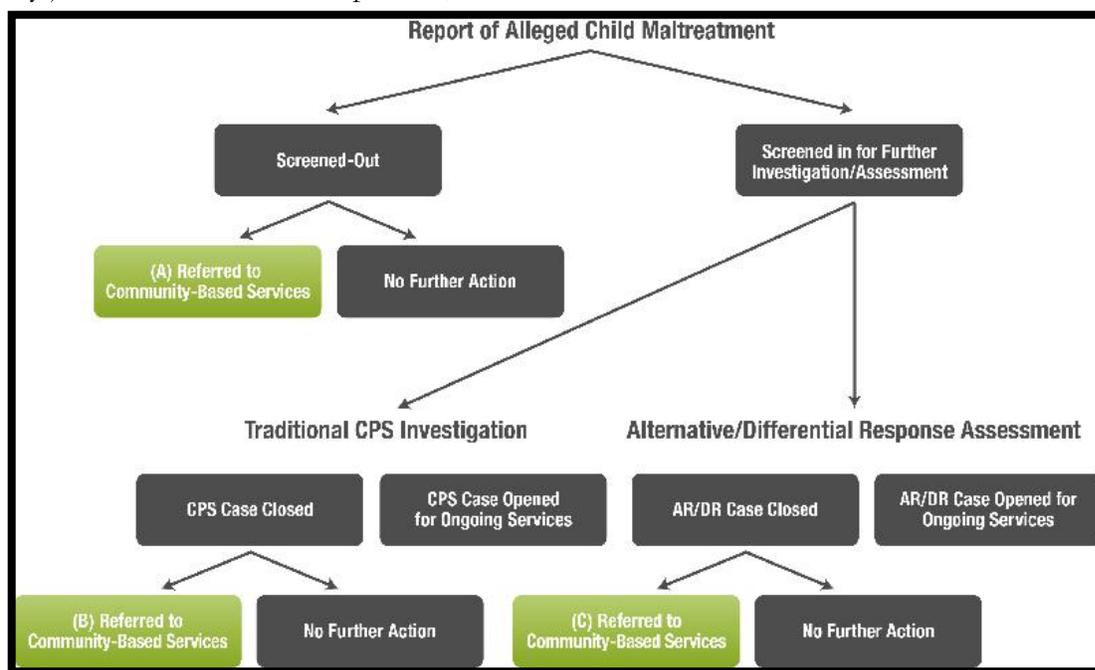
²⁷ Ibid.

Appendix E: State Responses to Screened-out Reports of Child Maltreatment 2014 Survey

The following survey, based on a 2011 survey conducted by Caren Kaplan and Lauren Morley, was disseminated by e-mail to 102 affiliates of child welfare agencies, whose contact information was retrieved from the National Resource Center for Community-Based Child Abuse Prevention. Contacts included individuals in 49 states and Washington D.C. The survey was not sent to contacts in Wisconsin.

Screened-out Reports of Child Maltreatment 2014 Survey

We are asking you to complete this survey to help us gather information on how your state handles referrals/reports of alleged child maltreatment that are screened out of Child Protective Services at any juncture within the CPS process, as illustrated below.



The number of states implementing differential or alternative response for CPS systems continues to grow. Many states have also developed and implemented formal responses to reports of alleged child maltreatment that are screened out of CPS, according to a 2011 survey conducted by Lauren Morley, MSW, LSW and Caren Kaplan, MSW for National Quality Improvement Center on Differential Response in Child Protective Services (QIC-DR)[1]. The Wisconsin Children’s Trust Fund, in partnership with the University of Wisconsin–Madison, is interested in learning what might have changed in states across the country since this 2011 report on responses to screened-out reports of alleged maltreatment. UW-Madison plans to aggregate all State responses to this updated survey and inform stakeholders about the national landscape of the intersection between the child protection agency and the prevention/early intervention community. We anticipate this survey will take you 10-20 minutes to complete. If you have any questions or concerns about this survey request and the data acquired during this process, please feel free to contact UW-Madison researcher Michele Dickinson, at 608-516-6992 or mmdickinson@wisc.edu. Thank you!

[1] Lauren Morley & Caren Kaplan. Issue Brief #3: Formal Public Child Welfare Responses to Screened-Out Reports of Alleged Maltreatment. (Denver, CO: National Quality Improvement Center on Differential Response in Child Protective Services, 2011).

- Q1: Respondent Information:
 - Name:
 - Agency:
 - State/Province/Jurisdiction:
 - Email Address:
 - Phone Number:
- Q2: Does your State, or do jurisdictions within your State, currently have a formal, established response to referrals/reports of alleged child maltreatment that are screened out of Child Protective Services (individuals represented in box A above)?
 - Yes
 - No
- Q3: DID your State, or jurisdictions within your State, have a formal, established response to screened out referrals/reports in the past but no longer has one currently?
 - Yes
 - No
- Q4: DID your State, or jurisdictions within your State, have an informal and/or periodic response to screened out referrals/reports?
 - Yes
 - No

NOTE: If respondents answered “no” to Q2, Q3, and Q4, the survey was completed at this point. The following questions were only presented to participants that answered “yes” to any of the three questions.

- Q5: What year was this formal response to referrals/reports of alleged child maltreatment that are screened out of Child Protective Services (CPS) established?
- Q6: Which option below best describes the geographic scope of implementation of this formal response to referrals/reports of child maltreatment that are screened out of CPS?
 - Statewide implementation
 - Selected Jurisdiction
 - *Next question, if “Selected Jurisdiction” selected:* Q7: Please provide names of geographic areas this formal response to referrals/reports of child maltreatment that are screened out of CPS have been implemented. (i.e. City of Madison, or Dane County)
 - Cities (list):
 - Counties (list):
 - Other:
- Q8: Are there plans in the State to expand the formal response to other areas?
 - Yes
 - *Next question, if “Yes” selected:* Q9: Please describe program expansion plans.
 - No
 - I don't know
- Q10: Which option below best describes the design and characteristics of implementation of this formal response to referrals/reports of child maltreatment that are screened out of CPS?

- Uniform Implementation: The design of the response is consistent in all geographical areas of the State where a formal response to screened-out referrals/reports is established.
 - Variable Implementation: The design of the response varies between and among geographic areas; local jurisdictions in your State have flexibility to design their formal response to screened-out referrals/reports different than other jurisdictions in the State.
- Q11: Is there a name used in referring to the formal response system for referrals/reports of alleged child maltreatment that are screened out of Child Protective Services?
 - Yes
 - *Next question, if "Yes" selected:* Q12: What is the name used to refer to the formal response system for referrals/reports of alleged child maltreatment that are screened out of Child Protective Services? (e.g., Parent Support Outreach Program, etc.):
 - No
- Q13: To the best of your knowledge, what was the primary motivation or reason for the establishment of this formal response to child maltreatment referrals/reports that are screened out of CPS? (please check all that apply)
 - New child welfare agency leadership/personnel
 - New state leadership/executive branch priority
 - State legislative priority
 - Child welfare crisis (high profile case or child fatalities)
 - Legal action such as a class action suit or consent decree
 - I don't know
 - Other (please specify): _____
- Q14: Which agency (or agencies) is (are) primarily responsible for carrying out and/or providing services related to the formal response to referrals/reports of child maltreatment that are screened out of Child Protective Services?
 - Child welfare agency
 - Community-based prevention agency
 - Other (please describe): _____
- Q15: What is the name and contact information (address, phone, and email) for the lead of the agency (or agencies) referred to in the question above? Agency #1
 - Contact Name:
 - Agency:
 - Address:
 - City/Town:
 - State:
 - Zip Code:
 - Email Address:
 - Phone Number:
- Q16: What is the name and contact information (address, phone, and email) for the lead of the agency (or agencies) referred to in the question above? Agency #2 (If applicable)
 - Contact Name:
 - Agency:
 - Address:
 - City/Town:

- State:
- Zip Code:
- Email Address:
- Phone Number:
- Q17: What is the name and contact information (address, phone, and email) for the lead of the agency (or agencies) referred to in the question above? Agency #3 (If applicable)
 - Contact Name:
 - Agency:
 - Address:
 - City/Town:
 - State:
 - Zip Code:
 - Email Address:
 - Phone Number:
- Q18: Is this formal response to referrals/reports of child maltreatment that are screened out of CPS established by: STATE STATUTE?
 - Yes
 - No
 - I don't know
- Q19: Is this formal response to referrals/reports of child maltreatment that are screened out of CPS established by: AGENCY POLICY?
 - Yes
 - No
 - I don't know
- Q20: Is this formal response to referrals/reports of child maltreatment that are screened out of CPS established by: AGENCY PRACTICE GUIDANCE AND/OR PROTOCOLS (that provides field-based implementation guidance)?
 - Yes
 - No
 - I don't know
- Q21: Is this formal response to referrals/reports of child maltreatment that are screened out of CPS established by: OTHER? Please explain:
- Q22: We would like to understand the specific process for your state in formally responding to referrals/reports of child maltreatment that are screened out of Child Protective Services (CPS).
 - Please choose the answer that best fits each step of the process & provide a written answer with a description of how that step of the process works in your state or local jurisdictions.
 - Who (position) from the child protection agency initiates the response or referral of families for this formal response?
 - What family information, other than identification, is relayed to the entity that provides the formal response to families?
 - How is the formal response initiated with the family? By whom? Or, do families initiate contact based on referral information provided by the child protection agency?
- Q23: Which Screened out referrals/reports are referred for a formal response?
 - All screened out reports

- Selected screened out reports that meet certain criteria
 - *Next question, if “screened out reports that meet certain criteria” selected:* Q24: Please share the specific criteria for referral for the formal response?
- Q25: Does the program accept other types of referrals?
 - Yes
 - *Next question, if “Yes” selected:* Q26: What other types of referrals are accepted?
 - Case investigated but closed after initial assessment (unsubstantiated - individuals represented in boxes B & C above)
 - Community partner referrals
 - Self-referrals
 - Other (please explain): _____
 - No
- Q27: What direct services and/or referrals does the formal, established response to screened-out referrals/reports program provide?

	Direct Service (1)	Referral (2)	No Services (3)
Domestic violence services Examples: Assistance with transportation to appointments, connection to benefits, advocating for services and a safety plan, etc. (1)			
Employment/Job assistance Examples: 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.) (2)			
Family medical needs Examples: Assistance with transportation to appointments, connection to benefits, advocating for services (immunizations, well-baby check-ups, dental care, etc.) (3)			
Financial support Examples: 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. (4)			
Household or family needs Examples: Connection to community resources, assistance with transportation to community resources, advocating for the family's needs, etc. (5)			
Housing Examples: Working with landlords; connecting to housing/rental assistance; assistance with relocating to a more economical location (rental cost or proximity to employment, etc.) (6)			
Mental health services Examples: Assessments, assistance with transportation to appointments, connection to benefits, advocating for services, etc. (7)			
Parent education and child development Examples: Assessments, assistance with transportation to appointments, connection to benefits and services, advocating for services, parent education classes, etc. (8)			
Substance abuse services Examples: Assessments, assistance with transportation to appointments, connection to benefits, advocating for services, etc. (9)			

- Q28: What is/are the funding source(s) for this formal response to referrals/reports of child maltreatment that are screened out of CPS? (please check all that apply)
 - Federal Funds (e.g., CAPTA/CBCAP, Title IV-B, Title IV-E waiver, etc.)
 - State Funds

- Local Funds (such as levies)
- Other (e.g., donations, foundations, corporations) _____
- I don't know
- Q29: Is there an evaluation being conducted of your formal response to screened-out cases?
 - Yes
 - *Next question, if "Yes" selected:* Q30: What is the name and contact information (address, phone and email) for the lead evaluator?
 - Name:
 - Company:
 - Address:
 - Address 2:
 - City/Town:
 - State:
 - Zip:
 - Email Address:
 - Phone Number:
 - No
- Q31: Is there a website or other source of information available to the public about your responses to screened-out cases?
 - Yes, please identify site: _____
 - No
- Q33: If we need to clarify information provided in this survey, who can we follow up with?
 - Survey respondent
 - Other
 - *Next question, if "Other" selected:* Q34: Please provide contact information for follow up:
 - Name:
 - Agency:
 - Address:
 - Address 2:
 - City/Town:
 - State:
 - Zip:
 - Email Address:
 - Phone Number:

Appendix F: 2014 Survey Limitations

Several limitations in this study exist due to the timeframe, language inconsistencies, the wide variety of state programming, availability of contacts, and survey mechanics. The short timeline limited the ability to conduct extensive dialogues with state respondents about their response programs.

Comprehensive conclusions cannot be drawn about the national policy landscape for serving this target population because full data was not received from all 49 states and Washington D.C. Trying to simultaneously disseminate a concise survey and gather useful information presented a challenge. Survey responses often required extensive follow-up with respondents.

Gathering data through a written survey left potential for misunderstandings of the research goals and questions due to language inconsistencies across the country. The survey referred to programs as “formal, established responses to screened-out reports of alleged child abuse and neglect.” Due to the variation in language used in CPS systems across the country, misunderstanding of the goals of the survey remains a concern despite efforts to mitigate its effect on data. The main points of misunderstanding occurred with the words “formal” and “screened out.”

As discussed, after the survey was sent, 15 states indicated they accepted all reports of maltreatment. Based on this finding, it follows that these states would answer “no” to questions about the existence of interventions for families that were screened out, even if they are serving these families. Any future versions of this survey should include questions about initial screening.

In states with county-administered child welfare services, it is possible that counties do provide the services about which the survey inquired, but the state-level contact was unaware of the innovation. In addition, state-level contacts often were not the best individuals to answer survey question. Recipients were asked to forward the email to those best able to answer the questions, though there is evidence that forwarding was not always effective or initiated.

Survey results data is limited by a low completion rate, which is likely attributable to the inability of respondents to answer the survey questions. Of the 54 recorded responses, 31 surveys, or 57 percent were completed. Over half of these incomplete surveys were for states that recorded having a formal response program. The survey did not allow for respondents to go back and change answers to the first three questions regarding the current or past existence of a formal response programs. If respondents answered yes to any of these three questions, including the question about the existence of an informal response, they were prompted to answer specific questions about when the program was implemented, the name of the program, etc. These questions all referred to the “formal response” program. Individuals who had responded they had an informal response program often quit the survey at this point, as they were unable to go back and change answers. One respondent emailed indicating she did not answer these questions because she did not want to provide incorrect data. In other cases the respondents were not able to answer the questions asked, such as date of implementation, and therefore discontinued the survey. Qualtrics considers a survey finalized after six days of inactivity, therefore responses for those who did not complete the survey were submitted automatically. In a few cases respondents communicated with us to let us know they were not the right person to complete the survey and they had forwarded it on to someone else. For incomplete surveys that indicated a formal response program, the authors attempted to follow up for more information; the authors did not make attempts to follow up for surveys that indicated no current formal response program.

Finally, in several instances, the same person completed the survey more than once. Because of the survey features previously discussed, respondents from several states looked at or started the survey and then went and found the right answers or right person before coming back to complete it. If a person attempted the survey from a different IP address, he or she would get a new survey, not the one that was originally started, resulting in two surveys being submitted from the same individual. In these cases, results include responses from the survey that was more complete.

Appendix G: 2014 Survey Selected Responses

This study’s replication of Marley and Caplan’s 2011 survey found variation in the statuses of state programs serving families with screened-out referrals of child maltreatment. Table F-1 includes summaries of findings and identifies limitations of data collection that influenced data completeness in the 2014 survey. It provides details from survey responses as well as from follow-up with survey respondents. Only states that reported having a formal program in the 2014 survey, or states that moved from having a formal response program to not having one, are in the table below.

Table G-1: Survey Summary of State Programs from 2014 Survey

State	Overview
Arkansas	Arkansas reported having a program in selected jurisdictions but did not complete the survey beyond the eighth question. A second respondent completed the survey after a request for clarification and indicated Arkansas did not have a formal program. The second response was consistent with the 2011 report.
California	California reported having a statewide formal response program. The respondent had recently started in her position and was unable to answer all questions in the survey. She volunteered to forward it to someone who would be able to answer it, but there was no further response.
Colorado	Colorado Community Response was established through state legislation, with implementation taking place in 2013 in selected jurisdictions. The program is modeled on Wisconsin’s Community Response Program (CRP).
Florida	Florida reported, “The state of Florida did an Alternative Response Pilot program for six months in Florida that was not continued beyond the implementation timeframe due to other legislative mandates and areas of concern in our overall child welfare program.” This survey respondent indicated this program occurred in 2008 in selected jurisdictions. According to Morley and Kaplan’s 2011 survey Florida created a statewide formal response in 2007 legislation.
Georgia	Georgia reported having a formal response program, but did not provide any additional responses to the survey.
Indiana	Indiana reported a formal program, but did not complete the survey.
Iowa	In Morley and Kaplan’s 2011 study, Iowa identified its formal response as a program established in 2007 called “Community Care,” “designed to strengthen families and prevent child abuse” and targets low-risk families (State of Iowa, Department of Human Services, Division of Child and Family Services 2009, 14). It is unclear if this program targeted families screened out of the formal child protective services system, or if this program served low-risk families for which the report of abuse or neglect was screened in. In 2014 Iowa identified its formal response program as established in 2014 and called “Family Assessment Response.” The website link provided by the survey respondent indicates that this is Iowa’s differential response program for accepted reports of abuse or neglect (State of Iowa, Department of Human Services, Division of Child and Family Services 2009). The survey respondent stated, in a clarifying email, “I was responding to the new system, which started this year. That system involves screening based on initial reports of suspected abuse. The other system involves screening after completion of an assessment. I am actually not that familiar with the previous reform (since we work on the prevention end), so I could not help with assessment of that effort – which is continuing, I believe” (Personal Correspondence with Survey Respondent 2014).
Kentucky	Completed survey and identified the same program in both surveys.

State	Overview
Louisiana	Reported having a statewide uniformly implemented formal response program. The survey respondent indicated that non-accepted reports were referred to law enforcement, and this response was established by state statute. For the purposes of this research, referral to law enforcement is not considered a formal prevention response.
Minnesota	Minnesota reported a formal response program implemented in selected jurisdictions in 2011. Its Parent Support Outreach Program was implemented statewide July 1, 2013, following positive evaluation results of the pilot program.
Missouri	Morley and Kaplan identified a statewide program, implemented in 1995, referred to non-child abuse/neglect referral. The 2014 survey respondent identified the same program, though indicated it was implemented in 1985.
Nevada	Nevada did not have a formal response program in 2011. Morley and Kaplan state "there are some formalized referrals that have been established in some areas of Nevada for screened-out cases, but they are localized" (Morley and Kaplan 2011). In 2014 Nevada reported having a formalized program in Washoe County. The respondent did not complete the survey. A second respondent reported that Nevada had previously had such a program, which was started in 2005. A name was not provided for the program, but the survey respondent indicated it was part of the differential response program and services were provided through family resource centers.
North Carolina	Since 2011 North Carolina created a response program, referred to as Community Response, which is implemented in four counties in North Carolina. This program is modeled after Wisconsin's CRP.
Oklahoma	Oklahoma reported the same type of program in the 2011 and 2014 surveys. However, after communicating with the respondent from Oklahoma, the program did not appear to fit the definition of prevention programs targeted to families screened out of the formal CPS system. Callers are provided referrals to other services, upon request, similar to a 211 service.
Pennsylvania	Pennsylvania reported a formal response program implemented statewide in 2014. The survey was not completed. There were no data from Pennsylvania in 2011.
South Carolina	South Carolina did not respond to the survey in 2011, but did report a formal response program in 2014 implemented uniformly statewide in 2011. The service is not formally named but referred to as community-based prevention services. The program provides direct and referral services for most services areas, other than domestic violence and substance abuse, for which only referral services are provided.
Tennessee	Neither respondent from Tennessee completed the survey, though the responses provided referenced the same program as the one identified by Morley and Kaplan in 2011.
Texas	There were no data for Texas in 2011. Texas responded to the 2014 survey though, indicating it has a statewide formal response program, implemented in 2011, referred to as Differential Response – Screener Program. The Texas Department of Family and Protective Services was listed as the primary agency contact, indicating the program is internal to the formal CPS system. In response to the question regarding whether all screened-out reports or selected screened-out reports were provided services, the respondent indicated that selected cases were provided services and stated, "I selected that response since some responses are screened out automatically at our statewide intake entry process. Any case closed by the screeners is eligible for the response. Cases going to the screeners are those that have victim children age 6 or above and are not our P! cases (requiring immediate response)."
Wisconsin	Wisconsin implemented CRP in selected counties in 2006.

Source: Authors

Appendix H: Summary of Alternative Evaluation Methods

Table H-1 summarizes information on four evaluation methods the Wisconsin Children’s Trust Fund (CTF) could use to assess the effect of CRP. Based on the provided information, the authors recommend that CTF conduct a randomized controlled trial.

Table H-1: Summary of Evaluation Alternatives

	Observational	Quasi-Experimental		Randomization
		Dosage	County	
Design Overview	Observation of differences in outcomes for CRP participants as compared to non-participants	The measurement of treatment received and the level of problems families had prior to service	The measurement of differences in outcomes in CRP and non-CRP counties	Random assignment before consent that creates two similar groups to measure differences between treatment and non-treatment
Internal Threats to Validity	<ul style="list-style-type: none"> • History bias • Maturation bias • Omitted variable bias • Selection bias 	<ul style="list-style-type: none"> • Hawthorne effects • History • Maturation bias • Omitted variable bias • Selection bias 	<ul style="list-style-type: none"> • Hawthorne effects • Omitted variable bias 	<ul style="list-style-type: none"> • Attrition • Omitted variable bias • Selection bias
Cost	\$	\$\$	\$\$	\$\$\$
Strengths	Limited change required at agency level and buy-in is typically easier to achieve	Demonstrates whether various levels of program participation result in different outcomes for families	Provides a non-participant comparison group and shows differences in effects	Allows for causal inferences regarding program effects because it provides a non-participant comparison group

Source: Authors

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