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The Wisconsin Post-reunification Support (P.S.) Program: Interim Evaluation Report

May 2016

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Executive Summary

From March 2011 to April 2012, 20.1% of children who were reunified from out-of-home care in Wisconsin re-entered out-of-home care within 12 months of their reunification, a percentage that represented the 5th highest re-entry rate among all states and over twice the national average. The re-entry rate in Milwaukee County declined following implementation of a post-reunification program in January 2012 (known as Post-Permanency Support), which suggested to the DCF leadership that a similar program might help reduce the re-entry rate in the rest of the state. A DCF application for a demonstration project to provide post-reunification support services was approved by the Children’s Bureau in September 2012.

The Wisconsin Department of Children and Families (DCF) implemented the Post-Reunification Support (P.S.) Program in 35 counties throughout the state in April 2014. The P.S. Program seeks to promote family stability following a child’s reunification; empower parents to strengthen caregiving, problem-solving, and coping skills; improve the short- and long-term well-being of the child and his or her family members; and reduce the likelihood of child maltreatment recurrence and re-entry into out of home care. To accomplish these goals, P.S. Program caseworkers engage family members during frequent face-to-face meetings in order to assess their needs, develop an individualized case plan and goals, and provide formal services and enhance informal supports. County agencies receive a monthly case rate (\$1100 per enrolled child) to cover costs associated with the continued child welfare case management and services.

The evaluation of the P.S. Program consists of three components: a process evaluation, an outcome evaluation, and a cost analysis. Using a matched comparison group design,¹ the outcome evaluation examines whether receipt of P.S. Program services is associated with reduced rates of maltreatment recurrence and re-entry into out-of-home care, while the process evaluation provides a better understanding of how the intervention worked and for whom. A cost analysis will compare the costs associated with the P.S. Program and those in the comparison group (i.e., “treatment as usual”) during the initial 12-month post-reunification period.

This interim evaluation report describes the results of the data collection and analysis to date, including:

- Site visits conducted in several counties that implemented the P.S. Program. During each site visit, existing program documents were reviewed and focus groups were conducted with caseworkers, supervisors, and child welfare managers. In addition,

¹ The impact of the Post Permanency Support program that was implemented in the Bureau of Milwaukee Child Welfare (BMCW) in 2012 is being evaluated separately, through the use of an interrupted time series (ITS) analysis that examines maltreatment recurrence and re-entry into out of home care before and after program implementation.

interviews were conducted with DCF administrators and key program stakeholders who were involved in the development and implementation of the P.S. Program.

- Detailed data about the monthly services provided to the families in the P.S. Program were gathered from caseworkers via an online report known as the Monthly Family Service Report. For each family enrolled in the program, caseworkers report the services the family received or needed but did not receive, the amount of each service received, the service recipient(s), and the service provider. For each service that was needed but not received, information was collected about the reasons.
- Parent surveys were distributed about a month prior to reunification and about 12 months after reunification. Both surveys contain measures of parent engagement with the caseworker, parent stress, family resources, social support, and family functioning. The follow-up survey also contains a measure of service provision during the 12-month post-reunification period. Unfortunately, very low response rates for the follow-up survey prevented us from analyzing the parent survey data for this report.
- Administrative data from Wisconsin's child welfare administrative database, known as eWiSACWIS, were collected to determine which families experienced maltreatment recurrence or re-entry into out-of-home care during the 12-month post-reunification period.

Data collection and analysis for the other components of the evaluation, including the cost analysis and the interrupted time series analysis of outcome data in BMCW, will occur in late 2016 and 2017, and the results of these evaluation activities will be included in the final evaluation report.

Findings from the Process Evaluation

The P.S. Program was implemented in 35 Wisconsin counties between January and April 2014. A tremendous amount of effort by a large variety of stakeholders was put into the development and implementation of the P.S. Program, and the county caseworkers, supervisors, and managers that were interviewed during the site visits all expressed a firm commitment to the program's philosophy and practice. However, the implementation of a new program is never without challenges, and the initial implementation stage is often the most fragile period of implementation, as front-line practitioners attempt to incorporate new rules, procedures, and practices into their day-to-day work in the context of their organizational environment. Findings from the implementation evaluation identified two areas in which small changes to the implementation supports may have a large impact on the fidelity of front-line worker practice. The first area that many P.S. Program stakeholders felt needed to be bolstered was caseworker and supervisor training. During the program installation stage, members of the P.S. Program Steering Committee decided not to provide additional training modules for P.S. Program case managers and supervisors beyond what was already being provided to all caseworkers. Instead, county supervisors were invited to attend several information webinars that provided information on the new P.S. Program case management and documentation requirements.

Many of the case managers and supervisors expressed a strong desire for additional training related specifically to case management skills needed in the pre-reunification and post-reunification phase, including safety management once the children return home, helping parents manage their emotions and behaviors, and dealing with unexpected stressors that can upset the delicate family balance after the child returns home. Some workers mentioned the usefulness of the trauma-informed practice curricula, but this is currently not a required training for all ongoing case management staff. In addition, several county staff described ongoing areas of confusion related to completing the CANS assessment, which highlights the need for additional training. Finally, although this varied by county, workers still expressed uncertainty about some of the basic elements of the P.S. Program requirements, such as the types of services that could and could not be purchased with P.S. Program funds.

The second area in need of enhancement was communication strategies. One of the most consistent themes that emerged from each of the site visits was the desire for increased levels of communication from DCF to the counties regarding the P.S. Program. Many case managers and supervisors felt as if they were not provided with enough guidance about the details of the P.S. program during the initial implementation, and were left to figure things out for themselves. Although staff were able to get answers to specific questions by reaching out to the P.S. Program Coordinator and praised his responsiveness, not all county staff took the initiative to reach out to get answers. This sometimes led to situations in which staff were working under incorrect assumptions and implementing certain program requirements incorrectly.

Since the site visits in November 2014, DCF has provided several trainings and peer-to-peer learning opportunities relevant to the P.S. Program. These include a P.S. Program Summit for professionals involved in the program, CANS case planning trainings, Motivational Interviewing (MI) trainings, training related to the Wisconsin Trauma project, and regional supervisor meetings. The amount of instructional material available on the P.S. Program website has also been expanded. Important implementation evaluation questions going forward concern the impact of these learning and communication opportunities on practice and the extent to which staff implementing the P.S. Program now feel prepared to implement the program.

In addition to data related to the implementation process, the process evaluation examined how caseworkers have implemented the core components of the P.S. Program, including assessment and case planning, case management, and service provision. The results suggest that around three-quarters of families in the program had a strengths and needs assessment prior to enrollment in the program and 80% had an initial case plan. Caseworkers spent a considerable amount of time working with families each month – six hours on average and 13 hours or more for a sizable portion of families (16%). Service provision is a critical part of the program, and findings of the evaluation reveal that families received a wide assortment of both traditional and non-traditional services during the post-reunification period. Families received an average of seven different services each month and 12 services over the course their enrollment in the P.S. Program. The most commonly received services were economic support (64.1%), home management (61.2%), individual therapy (58.5%), parent mentoring or classes

(55.0%), and transportation (46.5%). Social support was a vital component of the program (44.6%), and was most often provided to families by informal sources such as family, friends, and clergy. Not all services that families needed were readily available; families had an average of two services that were needed but not received. The two services that were most often needed but not received were individual therapy (8.5%) and family therapy (7.7%).

Findings from the Outcome Evaluation

The goal of the P.S. Program is to reduce maltreatment recurrence and re-entry into out of home care during the 12-month post-reunification period. Results of the outcome analyses indicated that to date, there were no significant differences between families enrolled in the P.S. Program and their matched counterparts who did not receive P.S. Program services in either the rate of maltreatment recurrence or re-entry into out of home care. There are several plausible explanations for the lack of difference in outcomes between the two groups. The data used in the outcome analyses were from families enrolled in the P.S. Program during the first year following implementation, when the program was less mature; program outcomes may improve over time. It is also possible that families in the comparison group received post-reunification services that were comparable to those received by families in the P.S. Program. Another possibility is that counties that chose to participate in the P.S. Program may have had higher rates of re-reports and re-entries prior to the program, making it difficult to demonstrate an advantage compared to non-participating counties. Another possible explanation is that a surveillance effect may have mitigated any positive effect of P.S. Program on re-reporting and re-entry rates. For example, families in the P.S. Program may have had more contact with professionals than comparison families, increasing the probability of detecting a problem that would lead to a re-report or re-entry. Finally, though families in the P.S. Program received substantial case management and a number of services and supports, their quality and effectiveness may not have been sufficient to address risk factors for re-reporting and re-entry. Additional data collection will allow us to test some of these alternative hypotheses in the final evaluation report.

Chapter 1: Introduction and Overview

On September 27, 2012, the State of Wisconsin received approval from the U.S. Department of Health and Human Services (DHHS) to waive certain provisions of the Social Security Act and Program Regulations in order to operate a demonstration project, now known as the Post-Reunification Support (P.S.) Program. As part of the Demonstration Project Terms and Conditions, the Wisconsin Department of Children and Families (DCF) agreed to engage a third party to conduct an evaluation of the demonstration project that consists of three components: a process evaluation, an outcome evaluation, and a cost analysis.²

Through a competitive RFP process, the Wisconsin DCF selected the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign to serve as the independent evaluator of its waiver demonstration project. The CFRC is responsible for the development of the final evaluation design and sampling strategy, execution of the data collection and analysis, and preparation of the interim and final evaluation reports.

As outlined in the Demonstration Project Terms and Conditions (p. 12), the Wisconsin DCF is required to submit an interim evaluation report to the DHHS no later than 60 days after the conclusion of the 10th quarter following the demonstration implementation date. This report should include available findings from the process, outcome, and cost components of the evaluation as well as discussion of any issues encountered or anticipated during the completion of the evaluation.³ The current report is submitted to the DHHS in fulfillment of this requirement. Some of the information included in this Interim Evaluation Report has been previously included in other reports submitted by Wisconsin DCF to the DHHS, including the *Wisconsin Waiver Demonstration Evaluation Plan* (October 2013),⁴ the *P.S. Program Year One Site Visit Report* (April 2015),⁵ and the semi-annual progress reports submitted on April 2014, October 2014, April 2015, October 2015, and April 2016.

This introductory chapter provides an overview and description of the Wisconsin waiver demonstration project (the P.S. Program) and the three evaluation components. Subsequent chapters report on the research questions, data collection and analysis methods, and findings to date from the Process Evaluation (Chapter 2) and Outcome Evaluation (Chapter 3), as well as a summary of Lessons Learned and Next Steps in the evaluation (Chapter 4).

² U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (September 27, 2012). *Wisconsin Demonstration Project Authority Terms and Conditions*.

³ Ibid, p. 12.

⁴ Children and Family Research Center. (2013). *Wisconsin's IV-E Waiver Demonstration Evaluation Plan*. Urbana, IL: author.

⁵ Fuller, T., Tittle, G., Cross, T.P., & Pacey, M. (2015). *The Wisconsin Post-reunification Support (P.S.) Program: Year One Site Visit Report*. Urbana, IL: Children and Family Research Center, University of Illinois.

1.1 Overview of the Wisconsin Waiver Demonstration Project

Wisconsin has a state-supervised, county-administered child welfare system, with the exception of the largest county, Milwaukee, where the state directly administers child welfare services through the Division of Milwaukee Child Protective Services (DMCPS). Eleven federally-recognized Indian Tribes located in Wisconsin receive funding from the DCF for some child welfare services, in addition to funding received directly from the federal government. As of December 31, 2014, 6,869 children were living in out-of-home care in Wisconsin, 33% of whom were living in Milwaukee County.⁶

1.1.1 Exploration and Adoption of the P.S. Program

Wisconsin's most recent Child and Family Service Review (CFSR) was conducted in April 2010 and a Program Improvement Plan (PIP) was developed and approved by the Children's Bureau on December 21, 2010.⁷ Although the CFSR rated the percentage of foster care re-entries as an area of strength because none of the 12 foster care cases reviewed during the statewide assessment experienced a re-entry, the statewide administrative data painted a much bleaker picture regarding foster care re-entry. For the period of March 2011 to April 2012, 20.1% of children who were reunified from out-of-home care in Wisconsin re-entered out-of-home care within 12 months of their reunification, a percentage that represented the 5th highest re-entry rate among all states and over twice the national average. Because re-entry was the weakest area of performance, DCF began to explore evidence-based programs that could improve performance in this area. Although the results of this exploration did not reveal any nationally-known programs that were categorized as evidence-based, the DMCPS had recently started a post-reunification program in January 2012 (known as Post-Permanency Support). The re-entry rate in Milwaukee County declined following implementation of this program, which suggested to the DCF leadership that a similar program might help reduce the re-entry rate in the rest of the state. The DMCPS Post-Permanency Support program therefore provided a starting point for developing the P.S. Program in the rest of the state.

Around this same time, the Children's Bureau announced that states could submit an application for a federal Title IV-E waiver demonstration project. DCF decided to move forward with an application for a demonstration project to provide post-reunification support services, which was submitted to the Children's Bureau on July 6, 2012.⁸ The Children's Bureau approved the Wisconsin Department of Children and Families' waiver request on September 27, 2012.⁹

⁶ Wisconsin Department of Children and Families. (2015). *Wisconsin Children in Out-of-Home Care : Annual Report for Calendar Year 2014*. Available at: <http://dcf.wisconsin.gov/cwreview/reports/OOHC/2014-OHC-Rpt.pdf>

⁷ Letter from the Children's Bureau approving the Wisconsin Program Improvement Plan (December 21, 2010)

⁸ *Wisconsin's Federal Title IV-E Demonstration Request: Promoting Child Permanency and Well-Being* (July 6, 2012). Retrieved from http://www.dcf.wisconsin.gov/children/TitleIV-E/demonstration/PDF/wi_IVE_waiver_proposal.pdf

⁹ Wisconsin Waiver Demonstration Project Authority Terms and Conditions (September 27, 2012)

1.1.2 P.S. Program Governance and Oversight

Once the waiver demonstration project request was approved in September 2012, internal implementation teams and external advisory groups were formed and began making decisions about P.S. Program policies and procedures. DCF established a governance structure to provide direction during the installation of the program.¹⁰ A Steering Committee composed of staff and managers from across DCF was formed to design the program. Three project teams, which report to the Steering Committee, were established to guide waiver implementation in specific operation areas:

- Program Implementation Team
- Fiscal and Project Reporting Team
- Program Evaluation Team

In addition to these internal implementation teams, DCF also established a Waiver Advisory Group (WAG) composed of external stakeholders with a strong interest and expertise in child welfare. The WAG was convened in January 2013 and met monthly to provide guidance and support to the project team leads. The WAG included representation from:

- Project team leads
- Wisconsin County Human Services Agency (WCHSA)
- Tribal child welfare agencies
- Children’s Court Improvement Program (CCIP)
- Wisconsin Council on Children and Families
- Wisconsin Association of Family and Children’s Agencies
- Wisconsin Child Welfare Professional Development System

When developing the P.S. Program practice model, members of the Program Implementation Team looked at the DCF’s existing case management standards, particularly those that had recently been developed for the Post-Permanency Support Program in Milwaukee County, and modified them to fit the needs of the new P.S. Program. The Program Implementation Team and WAG decided on specific areas of P.S. Program practice through the development and discussion of numerous options papers. Key decisions made through this process included:

- Minimum caseworker contact frequency
- Caseworker continuity requirements
- Case closure options
- Re-enrollment eligibility after re-entry into out of home care
- Scope of the target population
- Payment structure
- County reinvestment requirements
- County application requirements
- County readiness criteria

¹⁰ Wisconsin Title IV-E Child Welfare Waiver Demonstration Initial Design and Implementation Report

1.1.3 Selection of P.S. Program Counties

On July 31, 2013, DCF published the P.S. Program Application and invited all interested counties (other than Milwaukee County) to submit applications, which were due September 16, 2013.

The questions on the Year One application were related to:

- county readiness
- agency commitment and capacity to embrace new initiatives
- agency leadership and supervisory availability to support staff
- staffing plans
- agency ability to utilize data to understand and analyze performance and inform agency decision-making related to program improvement
- county service array
- plans for utilizing the enhanced funding available through the P.S. Program

Each county applicant was also asked to specify the maximum number of children that could be served in the P.S. Program during the first year, given current staff and supervisory capacity. Answers to these questions were scored by the three application reviewers. All 35 of the counties that applied in Year One were selected to implement the P.S. Program.

On September 4, 2014, counties were provided the opportunity to submit an application to implement the P.S. Program during Year Two (2015), and Year One counties were encouraged to renew their participation by completing a renewal application.¹¹ Thirty-one of the 35 Year One P.S. Program counties reapplied to continue with the program in Year Two, and two new counties applied. All new county and renewal county applications were approved on October 28, 2014. Table 1 lists the counties that implemented the P.S. Program during Years One and Two.

Table 1. P.S. Program counties

Adams	Barron	Brown	Buffalo*	Calumet*
Chippewa	Columbia	Dane	Door	Dunn
Eau Claire	Fond du Lac	Green	Green Lake	Jackson
Jefferson	Juneau	Kenosha	La Crosse	Marathon
Monroe**	Oneida	Pepin*	Polk*	Portage
Rock	Sauk	Taylor	Trempealeau	Vernon
Washburn	Washington	Waukesha**	Waupaca	Waushara
Winnebago	Wood			

*Year One only **Year Two only

¹¹ DSP Informational Memo Series 2014 – 13: Post-Reunification Support Program Year Two Application Instructions (September 4, 2014)

1.1.4 The Re-entry Prevention Models (RPM and RPM 2.0)

DCF anticipated that there would be more reunified children than available P.S. Program service slots. In order to allocate P.S. Program services to those families with children at highest risk of re-entering out of home care, DCF asked the CFRC to develop a statistical model to identify those children. Work on this predictive risk model, known as the Re-entry Prevention Model or RPM, began in October 2013. The statistical analysis for the model used historical (2012) data from eWiSACWIS and Wisconsin's Adoption and Foster Care Analysis and Reporting System (AFCARS) to determine which combination of factors were most predictive of re-entry into out of home care within 12 months of reunification. Factors tested included child and parent demographic characteristics, placement characteristics, and data from the Child and Adolescent Needs and Strengths (CANS), a standardized measure capturing a caseworker's assessment of a child and his or her family on multiple dimensions. Unfortunately, during the initial RPM development, the CANS had only recently been implemented and there was not enough available data to incorporate any information from the CANS into the predictive risk model.

In the initial RPM, four factors provided the best prediction of re-entry: 1) diagnosed child disability (including learning disabilities, physical disabilities, developmental disabilities, or significant emotional or behavioral problems (eWiSACWIS); 2) single caregiver/parent family structure (AFCARS); 3) length of time the child was in care prior to reunification, measured as the number of days between the date of removal and the date of discharge to reunification (eWiSACWIS); and 4) the number of service reports¹² on the child prior to the most recent entry into care (eWiSACWIS). Each reunified child received a single RPM score, which represented his or her probability of re-entry based on a weighted combination of these four factors. A cut-off score was determined that maximized the accurate predictions about re-entry (true positive and true negatives) and minimized the inaccurate predictions (false positives and false negatives). Initially a child qualified for the P.S. Program if his or her RPM score was greater than or equal to .24. A program was built into eWiSACWIS that allowed caseworkers to check a child's RPM score during the pre-reunification period to determine if he or she was eligible for the P.S. Program if reunification occurred within the next 60 days.

Soon after the implementation of the RPM, several county administrators raised concerns that few or no children in their counties had RPM scores high enough to be eligible for the P.S. Program. Another concern was that county-level differences in the documentation and use of service reports was suppressing the number of eligible children in certain counties. Based on this feedback and additional analyses by the CFRC, the decision was made to lower the RPM eligibility score from .24 to .18 for all Year One P.S. Program counties.

In addition to these concerns about the inclusion of service reports in the initial RPM, DCF was eager to include information from the CANS assessment into the predictive risk model. Therefore, the process used to develop the original RPM was repeated in 2015 using newer

¹² A child protective service report is a type of Access Report used for documentation of referrals that allege some sort of abuse or neglect. Access reports have a named maltreater and a named victim.

data on a cohort of children reunified between April 2012 and March 2013. These new data were more complete, particularly on the CANS measure. Many variables were tested in the model, including child demographics, placement and episode characteristics, child and caretaker information from the most recent CANS assessment completed prior to reunification, indicators of need for concurrent planning, prior CPS reports, and prior initial assessment information. The revised RPM, known as RPM 2.0, contained five variables that best predicted re-entry into out of home care: 1) one or more prior out of home care (OHC) episodes; 2) parent incarceration was a reason for the child's removal; 3) child was removed from a single caregiver home; 4) the child was never placed in a treatment foster home during the most recent episode; and 5) the child had a higher level of items marked as a 2 or 3 on the most recent CANS life domain functioning scale.¹³ Similar to the initial RPM, each child receives a score on the RPM 2.0 that represents his or her probability of re-entry based on a weighted combination of these five variables. Children with an RPM 2.0 score of .18 or higher are eligible for the P.S. Program. RPM 2.0 was implemented in August 2014.

1.1.5 P.S. Program Eligibility and Enrollment

Children of all ages living in out of home care¹⁴ are eligible for enrollment in the P.S. Program if they:

- have an approved permanency goal of reunification;¹⁵
- have a Child Welfare or Child Welfare/Juvenile Justice case type (children in Juvenile Justice only or pre-adoptive cases are not eligible); and
- have a score at or above the cut-off threshold on the RPM/RPM 2.0.

If a caseworker identifies a child that is ready for reunification, he or she can check the child's eligibility for the P.S. Program by running a Pre-Enrollment Report, which calculates the child's score on the RPM. If the child has a score of 0.18 or higher, he or she is eligible for the P.S. Program and the caseworker can submit a P.S. Program Referral Request up to 60 days prior to the planned reunification date. If a referred child has siblings who are also in an out of home care placement and will reunify at the same time as the referred child, or within 60 days of him or her, those siblings are also eligible to participate in the P.S. Program. County agencies may determine whether they wish to refer some or all of the reunifying siblings to the P.S. Program.¹⁶ Referral requests to the P.S. Program are approved or denied by the P.S. Program Coordinator within one business day.

¹³ Items on the CANS life domain functioning pertain to: relationships with nuclear family members, relationships with extended family members, functioning in current living situation, developmental problems (cognitive, autism spectrum, communication, self-care), medical problems, physical limitations, dental health needs, self-care skills, positive social relationships with peers and adults, and legal difficulties.

¹⁴ Children placed voluntarily and under courts orders are both eligible.

¹⁵ Children with no permanency goal due to the short amount of time in substitute care are also eligible.

¹⁶ Post-Reunification Program Referral Guide (March 11, 2014)

If the referral is approved, there are additional requirements that must be met before a family is enrolled in the P.S. Program. Within 30 days prior to reunification, the caseworker must have a family team meeting that includes the parents, children 12 and older, and other key family supports or service providers. In addition, the caseworker must complete or update the CANS assessment in eWiSACWIS. During the family team meeting, the caseworker discusses the P.S. Program with the family and determines whether they wish to enroll in the program. Family members (adults and children 12 and older) and the caseworker must sign the P.S. Program Support Agreement for the family to be enrolled in the program.

A family can be served in the P.S. Program for up to 12 months following reunification, unless any of the following circumstances occur:

- the child re-enters out of home care for more than 30 days;
- the child or parent relocates out of state;
- the child or parent dies;
- the family cannot be located;
- the family explicitly requests to discontinue P.S. Program participation, if the family is being served voluntarily and there are no child safety concerns.¹⁷

1.1.6 P.S. Program Components

The P.S. Program seeks to promote family stability following a child's reunification; empower parents to strengthen caregiving, problem-solving, and coping skills; improve the short- and long-term well-being of the child and his or her family members; and reduce the likelihood of child maltreatment recurrence and re-entry into out of home care. To accomplish these goals, P.S. Program caseworkers engage family members during frequent face-to-face meetings in order to assess their needs, develop an individualized case plan and goals, and provide formal services and enhance informal supports. Each of these program components is described below.

Family Engagement. Caseworkers engage families creatively and meaningfully to develop a relationship that provides families support throughout the post-reunification period. Using a family teaming and solution-focused approach, families are empowered to identify their needs and concerns and contribute to the development and implementation of strategies to address those needs and concerns.¹⁸

Assessment and Case Planning. During the 12-month post-reunification period, caseworkers are responsible for continued safety reassessment and safety planning. They also are required to document any changes in child safety in eWiSACWIS. In addition to the CANS assessment that occurred within 30 days prior to reunification, the CANS assessment must be updated 6 months after reunification and within 30 days of case closure. The CANS assessments are used to develop individualized case plan goals and objectives, in collaboration with the family, which

¹⁷ P.S. Program Practice Requirements

¹⁸ Wisconsin's Post-Reunification Support Program Statement: Values, Principles, and Related Initiatives

are updated within 30 days after reunification, six months after reunification, and then as often as needed until the end of the 12-month post-reunification period.

Case Management. During the 12-month post-reunification period, the caseworker meets with the family on a regular basis to assess child safety and child, caregiver, and family functioning; make needed changes to the case plan; and facilitate connections to natural and community-based supports and services based on the ongoing assessment of each family’s unique needs. The frequency of the caseworker meetings with the family are determined by the family’s needs and case type, as described in Table 2.

Table 2. P.S. Program case types and minimum caseworker contact requirements

Case type (documented in eWiSACWIS)	Case type definition	Minimum contact requirements
In-home CPS case	Safety threat identified and safety plan in place	2 face-to-face contacts per month
In-home court-ordered child welfare case	No safety threat identified for any child, but court-ordered supervision is required	1 face-to-face contact per month
In-home voluntary child welfare case	No safety threats identified for any child and there is no in-home court-ordered supervision required	1 face-to-face contact per month during first 9 months, at least 1 phone contact per month thereafter

Within 30 days prior to case closure, the caseworker has a family team meeting to recognize family accomplishments, strengths, and successes; review family resources, including the transition to informal and natural supports; and plan for contingencies to address potential future concerns regarding child and caregiver needs and functioning.¹⁹

Services and Informal Supports. Each family receives services to address their needs as identified in the CANS and case planning process. The caseworker also works with the family to link them to informal supports in the community that can provide ongoing assistance after the 12-month post-reunification period. Caseworkers can draw on flexible funds provided through the P.S. Program. For each child enrolled in the P.S. Program, the local child welfare agency receives \$1100 per month for up to 12 months following reunification. These funds can be used flexibly by the child welfare agency across all actively enrolled children and their families throughout the 12-month service period. Funding is intended to be used to purchase services and supports that accomplish a reasonable purpose and meet a legitimate need for the child or family that is documented in their case plan.²⁰

¹⁹ Wisconsin’s Post-Reunification Support Program Statement: Values, Principles, and Related Initiatives

²⁰ Post-reunification support (P.S.) Program Technical Assistance Sessions FAQ (8-26-13)

1.1.7 P.S. Program Logic Model

The conceptual relationships between the P.S. Program components and expected short-term, intermediate, and distal outcomes are illustrated in the logic model presented in Figure 1. Represented in the *inputs* and *activities* columns are the various resources Wisconsin DCF has invested and the many actions involved in developing the P.S. Program, including funding (both in terms of re-investment of federal dollars and staff time devoted to developing the intervention); selection of agencies and staff to provide the services; provision of training to staff on specific components of the case management model; provision of adequate supervision and coaching to front-line caseworkers; supportive and cohesive agency leadership; development of a predictive risk model to guide the provision of services to the children most at risk of re-entry; development of a practice model for the intervention along with any changes to DCF policy and procedures; development or refinement of reliable and valid assessment instruments that will be used by caseworkers; and modifications to existing information technology (IT) and reports to identify children and their families to enroll in the P.S. Program and to monitor performance of P.S. Program practice requirements.

As a result of these inputs and activities, the necessary components of the intervention will be implemented (*outputs*): staff will be selected and adequately trained, supervised and coached so that they maintain a high level of fidelity to the post-reunification practice model. Through the use of the predictive risk model, children and families most at risk of experiencing re-entry will be identified. Caseworkers will engage the parents immediately upon their children's return home from out-of-home care and will meet with them on a regular basis. Using the CANS assessment, the family's needs and strengths will be identified and will be used to inform an individualized case plan that will address the family's needs and build on its strengths. As part of the case plan, the family will be referred to and will receive a variety of services that will be provided through local child welfare agencies and in their local community. The caseworker will also draw on and strengthen the family's informal and natural social support system whenever possible.

These outputs are expected to produce changes in the family's short-term, intermediate, and distal *outcomes*. Within the short term, families will be engaged with their caseworker and the services that are being offered to them; the services will decrease the amount of stress they experience as they re-integrate their children back into their family; the services will increase their ability to cope with the periodic and unexpected stresses that arise following reunification; and the family will be better able to access informal and formal social supports during times of stress. These short-term changes will lead to the intermediate outcomes of improved child and family functioning, decreased exposure to trauma, increased family self-sufficiency, and improved children's emotional, behavioral, and social functioning. These changes, in turn, will lead to improvements in distal outcomes, including reduced incidence of child maltreatment, reduced re-entry into out-of-home care, and improved child well-being.

Figure 1. Wisconsin P.S. Program logic model

Inputs	Activities	Outputs	Outcomes		
			Short-Term	Intermediate	Distal
Funding	County application and implementation planning	Staff are assigned	Increased family engagement with worker and services	Increased positive family functioning	Decreased maltreatment recurrence
Staff (caseworkers, supervisors)	Staff training	Staff are trained	Decreased parent stress	Increased family self-sufficiency	Decreased re-entry into out-of-home care
Supervision	Identification and enrollment of families using predictive risk model	Appropriate supervision occurs	Increased parent coping skills	Decreased child trauma exposure	Improved child educational outcomes
Coaching	Case management	Appropriate coaching occurs	Increased social supports	Improved child emotional and behavioral functioning	Improved child health outcomes
Leadership	Assessment (including CANS)	Agency leadership supports program		Improved child social functioning	
Risk Model	Development of individualized case plan, including identification of needed services and supports	Intervention is targeted to at-risk families			
Practice Model		Fidelity to practice model			
Assessment tools		Caseworker meets with family as required			
Policy and procedures		Assessments are completed			
Local Services and community-based family supports		Individualized case plan developed			
IT modification and report development		Families receive services that match needs			
Community support		Informal supports are engaged			
Data and technology					

1.2 Overview of the Waiver Demonstration Evaluation

The evaluation of Wisconsin's waiver demonstration program is designed to test the hypothesized linkages that are outlined in the P.S. Program logic model. The evaluation has three components: a process evaluation, an outcome evaluation, and a cost analysis.²¹ Using a matched comparison group approach in the balance of state and an interrupted time series approach in Milwaukee County (DMCPS), the outcome evaluation is designed to assess whether receipt of the P.S. Program is associated with reduced rates of maltreatment recurrence and re-entry into out-of-home care, while the process evaluation will help provide contextual detail to inform replications of successful strategies and a better understanding of how the intervention worked and for whom. The cost analysis assesses whether the intervention resulted in cost savings due to reduced rates of maltreatment recurrence and re-entry, and provides information that can be used in decision-making about resource allocation.

The evaluation will attempt to answer the following research questions:²²

1. What contextual factors influenced the implementation of the P.S. Program? How was each of the core implementation components described in the NIRN²³ framework addressed during the P.S. Program implementation process? [Process Evaluation]
2. To what degree are the core components of the P.S. Program (case management, individualized case planning, and linkage to community supports) implemented as delineated in the practice model? [Process Evaluation]
3. Are reunified children who receive the P.S. Program less likely to experience maltreatment recurrence than children who do not receive the P.S. Program? [Outcome Evaluation]
4. Are reunified children who receive the P.S. Program less likely to experience re-entry into out-of-home care than children who do not receive the P.S. Program? [Outcome Evaluation]
5. Do reunified children who receive the P.S. Program have more positive educational outcomes than children who do not receive the P.S. Program? [Outcome Evaluation]
6. Do reunified children who receive the P.S. Program have more positive health outcomes than children who do not receive the P.S. Program? [Outcome Evaluation]
7. Do reunified children who receive the P.S. Program demonstrate reductions in trauma exposure, social and emotional functioning, and behavioral functioning over time? [Outcome Evaluation]
8. Are expenditures for the P.S. Program offset by reductions in out-of-home care expenditures, resulting in overall child welfare spending that does not exceed the allowable computable dollar schedule listed in Wisconsin's Waiver Terms and Conditions? [Cost Analysis]

²¹ The majority of the information in this section comes from *Wisconsin's IV-E Waiver Demonstration Evaluation Plan* which was submitted to DHHS in 2013.

²² The evaluation of the post-reunification support program in the Bureau of Milwaukee Child Welfare will be limited to research questions 1-4.

²³ National Implementation Research Network

1.2.1 Research Methodology

To test the hypothesized links between the P.S. Program outputs and outcomes, the evaluation combines an interrupted time series (ITS) analysis of the DMCPs and a quasi-experimental design using Propensity Score Matching (PSM) for the balance of the state. Several factors made it difficult to find appropriate comparison families for the families receiving Post Permanency Support services in DMCPs, including the earlier start date (January 2012), the fact that all reunified families within the county are provided with services, and its unique nature within the state in terms of population, urbanity, and racial-ethnic composition. Because PSM is not feasible for the outcome evaluation in DMCPs, existing administrative data are being used to conduct an ITS analysis in which the rates of maltreatment recurrence and re-entry into out-of-home care before and after the implementation of Post Permanency Support services (January 2012) are compared. The effectiveness of the P.S. Program in the remainder of the state is being tested by using PSM to construct two statistically equivalent groups of families that did and did not receive the P.S. Program and comparing their outcomes.

1.2.2 Sampling Plan

Due to the different methodologies being used for the evaluations in DMCPs and the balance of the state, different sampling strategies are also being used. Since all reunified children in DMCPs receive post-reunification support services, all children returned home from substitute care in Milwaukee County between 2008 and 2016 are included in the ITS analysis. No comparison group is being used, for reasons described above.

For the balance of the state, the treatment sample consists of reunified children and their families enrolled in the P.S. Program. Because it is a family-level intervention and multiple children per family can be enrolled in the P.S. Program, the propensity score matching that forms the comparison group is being done at the family-level rather than the child-level. The comparison group families are selected from counties that have not yet implemented the P.S. Program.

1.2.3 Data Sources and Data Collection Plan

Several data collection activities have been initiated to gather information on the variables included in the P.S. Program logic model. Table 4 lists each of the outputs and outcomes included in the logic model and the data sources and measures that are being used to assess them. A description of each data collection activity is provided after the table. All data collection activities associated with the evaluation have been reviewed and approved by the Institutional Review Board (IRB) at the University of Illinois at Urbana-Champaign.

Table 3. Output and outcome measures and data sources

Output	Measure/Indicator	Data sources
Staff training	Qualitative descriptions of training	Site visit
Staff supervision and coaching	Qualitative descriptions of supervision and coaching	Site visit
Agency leadership support	Qualitative descriptions of program leadership	Site visit
Worker use of risk model to target services	Qualitative descriptions from caseworkers	Site visit
Caseworker contacts with families	# of in-person meetings or other types of contact with families and participants including extended family members in contacts	Administrative data MFSR
CANS completion	Percentage of families with CANS assessment completed: * 6 months after reunification * within 30 days prior to case closure	Administrative data
Case plan completion	Percent of families with a case plan completed at enrollment in program	Administrative data
Services and supports received	Number and type of services and supports received per family	MFSR Parent survey
Outcomes	Measure/Indicator	Data sources
Short-term outcomes		
Parent engagement	Alpert & Britner parent engagement measure	Parent survey
Parent stress	Perceived Stress Scale	Parent survey
Parent coping skills	Brief COPE	Parent survey
Social support	Protective Factors Survey	Parent survey
Intermediate outcomes		
Positive family functioning	Protective Factors Survey CANS*	Parent survey Administrative data
Family self-sufficiency	Family Resource Scale	Parent survey
Child trauma exposure	CANS*	Administrative data
Child behavioral functioning	Behavior Problem Index	Parent survey
Child social functioning	CANS*	Administrative data
Long-term outcomes		
Maltreatment recurrence	Percent of children who have a maltreatment recurrence within 12 months of reunification**	Administrative data
Re-entry	Percent of children who reenter out-of-home care within 12 months of reunification**	Administrative data
Educational outcomes	TBD	DPI
Child health outcomes	TBD	DHS

*Post-reunification CANS data is not available for families in the comparison group

**Data sources used in the outcome evaluation of the BMCW will be limited to maltreatment recurrence and re-entry into out of home care

Administrative data. Data from Wisconsin’s child welfare administrative database, known as eWiSACWIS, are obtained from DCF to capture numerous variables in the logic model, including family members’ demographic information, caseworker contacts with families, case plan completion dates, maltreatment recurrence, and re-entry into out-of-home care. Results of the Child and Adolescent Needs and Strengths (CANS) assessments are also available in the administrative data. For P.S. Program cases only, the CANS is updated within 30 days prior to reunification, 6 months after reunification, and within 30 days of case closure. Post-reunification CANS data does not exist for families who are not enrolled in the P.S. program. In addition to child welfare administrative data, data from other state agencies will be obtained to measure child educational and health outcomes.²⁴

Monthly Family Service Reports. There are several important components of the P.S. Program that are not captured in existing administrative data sources, including service provision and informal supports provided to families. The CFRC therefore created an online data collection tool, known as the Monthly Family Service Report (MFSR), in which P.S. Program caseworkers report the number and type of services that each family enrolled in the program received during the prior month. The first screen of the Monthly Family Service Report asks the caseworker to report the number of hours of case management provided to the family during the month. It also contains a list of specific services that families may have received during the month, including:

- case management
- basic home management
- parenting services
- family therapy
- daycare
- respite
- alcohol and other drug (AODA) assessment
- AODA services
- crisis services
- psychiatric assessment/services
- psychological assessment
- individual therapy
- group therapy
- economic support
- housing assistance
- transportation assistance
- occupational/physical therapy
- developmental assessment/service
- medical/dental services
- juvenile justice services/activities
- legal services

²⁴ Education data will be obtained from the Department of Public Instruction (DPI) and health data will be obtained from the Department of Health Services (DHS). This data has not yet been provided to CFRC for analysis.

- educational assessment/services
- independent living
- work-related services
- domestic violence services
- mentoring
- recreational activities
- social supports
- spiritual/cultural supports

For each service, the caseworker reports whether the family: a) received the service as part of their case plan, b) received the service but it was not listed in the case plan, c) did not receive the service even though it was included in their case plan, or d) did not need or receive the service (one option must be selected for each service). Caseworkers may also report other additional services not listed that families received during the month under consideration. For each service that the family received (those checked a or b), the second screen asks caseworkers to report the amount of the service provided in hours (i.e., service dosage), the service recipient(s) (parent, child, other), and the service provider (caseworker, certified or licensed provider, paraprofessional, informal provider). For each service that was needed but not received (option c), a third screen asks caseworkers to specify the reason(s) that the service was not received (check all), including: 1) service unavailable; 2) provider at capacity; 3) missed appointment; 4) service discontinued by provider; 5) family/client refusing service; 6) family/client not able to participate.

To distribute the MFSR to P.S. Program caseworkers, the CFRC receives a list of all active P.S. Program cases and their caseworkers from DCF by the 5th of each month. The CFRC sends an email to these caseworkers with a link to the online MFSR. The deadline for completion of the form is the 20th of that month or the closest business day to this date. One week prior to this deadline, a reminder e-mail is sent by the CFRC to the workers who have not yet completed their reports. On the 20th, the CFRC then sends a report to DCF P.S. Program staff with Monthly Family Service Reports that have been completed and not completed. MFSR data collection began in July 2014, with caseworkers asked to report on services received by families during June 2014. Table 4 shows the MFSR completion rate for each month, as of April 2016. Caseworkers are allowed to complete the MFSR for prior months at any time, so completion rates for some months may increase over time.

Table 4. Monthly Family Service Report (MFSR) completion rates

Month	Number of Cases	# MFSR Received	Response Rate
2014			
June	39	27	69.2%
July	53	43	81.1%
August	69	43	62.3%
September	78	61	78.2%
October	81	66	81.5%
November	89	72	80.9%
December	97	87	89.7%
2015			
January	112	100	89.3%
February	121	104	86.0%
March	132	116	87.9%
April	135	121	90.0%
May	139	118	85.0%
June	148	123	83.1%
July	151	123	81.5%
August	148	118	79.7%
September	148	123	83.1%
October	149	112	75.2%
November	153	126	82.4%
December	158	124	78.5%

Site visits. Site visits were conducted in several counties that implemented the P.S. Program during Year One, as well as Milwaukee County, in order to collect data for the process evaluation. During each site visit, existing program documents were reviewed and focus groups were conducted with caseworkers, supervisors, and child welfare managers. In addition, interviews were conducted with several DCF administrators and key program stakeholders who were involved in the development and implementation of the P.S. Program. A semi-structured interview protocol was developed based on the National Implementation Research Network (NIRN) implementation science framework that addressed the core implementation components described in the model, along with additional topics of relevance to the evaluation:

- the presence and role of project champions
- the involvement and roles of organizational partners in project planning and service delivery
- the process used to select program staff
- pre-service and in-service training provided to selected staff
- staff supervision, coaching, and evaluation
- participant recruitment and retention
- use of EBPs and fidelity or adaptations to EBPs

- the role of project leadership and facilitative administration
- communication and information dissemination
- challenges to the project implementation and their resolution
- impact of organizational, community, and systems-level changes on the project
- plans for adaptations to the project
- plans for project sustainability

The next site visits are planned for the summer of 2016.

Parent surveys. The parent survey gathers information about families at two time points: at or around the reunification date (baseline survey) and 12 months after reunification (follow-up survey). Both surveys contain measures of parent engagement with the caseworker, parent stress, family resources, social support, and family functioning. The follow-up survey also contains a measure of service provision during the 12-month post-reunification period.

The baseline survey packet is distributed to families by the caseworker at the last family team meeting prior to reunification, which typically occurs within the month prior to reunification. In P.S. Program counties, baseline surveys are supposed to be distributed to all reunified families enrolled in the P.S. Program (treatment group). In non-participating counties, baseline surveys are supposed to be distributed to all reunifying families. Not all reunifying families in non-participating counties will be included in the matched comparison group. Because the matching procedures do not occur until several months after reunification, it is not known during the last family team meeting which families in non-participating counties will be included in the comparison group. Therefore, all reunifying families in non-participating counties are supposed to be given a baseline survey packet. Follow-up survey packets are mailed to both groups of families by CFRC staff around 12 months after their reunification date.

Each survey packet contains a recruitment letter describing the study, an informed consent form, the survey, an instructional checklist, and a postage-paid return envelope. Both English and Spanish versions of the survey are available. Parents can complete the survey in several ways:

- The paper version of the survey can be completed and mailed to the CFRC.
- An online version of the survey was created using Qualtrics.
- Parents may call a toll-free number for the CFRC and have someone read the survey questions to them.

Response rates for the baseline and follow-up surveys in the comparison group have been very low (see Table 5). Between February 2014 and December 2015, 285 families were enrolled in the P.S. Program and are included in the treatment group. However, only 241 of the 285 families were successfully matched with a similar family in a non-participating county. Of the 241 treatment group families in the matched sample, 122 baseline surveys have been received as of December 2015, which equates to a 50.6% response rate. Of the 241 comparison group families in the matched sample, 48 baseline surveys have been received as of this date, for a response rate of 19.9%.

As of December 2015, 112 treatment families and 112 comparison families have reached the 12-month post-reunification time point and have been mailed follow-up surveys. Of the 112 treatment families that were mailed a follow-up survey, 28 have completed the survey, for a 25% response rate. Of the 112 comparison families that were mailed a follow-up survey, 12 have completed the survey, for a 10.7% response rate.

Table 5. Baseline and follow-up parent survey response rates

Surveys Received					
Baseline Surveys Received			Follow-up Surveys Received		
	N	%		N	%
Treatment Group (n=241)	122	50.6%	Treatment Group (n=112)	28	25.0%
Comparison Group (n=241)	48	19.9%	Comparison Group (n=112)	12	10.7%

Because the response rates for the follow-up surveys among the treatment and control groups are so low (particularly among the comparison group), response bias is a big concern. Because of this concern, data from the parent surveys are not included in this report.

1.2.4 Evaluation Timeline

To complete the process, outcome, and cost evaluations, data are being collected from several sources and through multiple methods. Data collection began in April 2014 and will conclude around April 2018. Table 6 lists each of the data collection activities that will occur, their anticipated collection timeframes, and reporting schedules. The Interim Evaluation Report contains the results of data collection and analyses to date, including data from the round one site visits, MFSR data, and outcome data from eWiSACWIS. It was originally thought that data from the CANS assessments of families in the P.S. Program would also be included in the Interim Evaluation Report, but these data were not available in time for analysis. The Final Evaluation Report will be cumulative and will include data from all sources.

Table 6. Data collection and reporting schedule

Data collection	Timeline	Reporting	
		Interim Report	Final Report
Round 1 site visits	November 2014	✓	
Round 2 site visits	June – August 2016		✓
Round 3 site visits	April – June 2018		✓
eWiSACWIS data	Ongoing	✓	✓
CANS data	Ongoing		✓
Child health data (DHS)	December 2016 – May 2018*		✓
Child education data (DPI)	December 2016 – May 2018*		✓
MFSR	April 2014 – May 2018*	✓	✓
Parent survey	April 2014 – May 2018*		✓
BMCW admin data	June – August 2017*		✓
Cost data	September – December 2017*		✓

*estimated

Chapter 2: The Process Evaluation

The process evaluation of the P.S. Program consists of two components: 1) an implementation evaluation that documents and describes the processes utilized to develop, implement, and sustain the P.S. Program and 2) a fidelity assessment that identifies the degree to which the P.S. Program is being implemented with fidelity to its practice model. This chapter describes the research questions, data sources and data collection methods, data analyses, and findings to date from each component of the process evaluation.

2.1 Implementation Evaluation

The P.S. Program implementation evaluation utilizes the framework developed by the National Implementation Science Network (NIRN)²⁵ and adapted by the Permanency Innovations Initiative Training and Technical Assistance Project (PII-TTAP).²⁶ The Development, Implementation, and Assessment Approach (the Approach) described by the PII-TTAP assumes that implementation in child welfare settings is complex and requires a systematic approach. The Approach integrates implementation science and program evaluation. It emphasizes clearly operationalizing the new practice (the “innovation”) and the infrastructure needed to support practitioners’ implementation of the innovation with fidelity to ensure that there is a well-defined program to evaluate.

The Approach²⁷ describes four implementation stages: exploration, installation, initial implementation and full implementation. The exploration stage involves identifying the problem, assessing the potential match between community needs and the proposed intervention, making a decision whether to proceed with implementation, and planning for organizational change that creates an environment that is open to implementing a new innovation. During the installation stage, existing teaming structures are reviewed and refined, program manuals are developed in order to operationalize the new practice, and the infrastructure is built to support the program. During the initial implementation stage, children and families begin to receive program services and implementation supports are functional. The purpose of the initial implementation stage is to test critical elements and modify components to improve processes. Full implementation is reached when practitioners are skilled in delivering services and the implementation supports are institutionalized. During this stage, critical elements are tested and data is used to strengthen and improve practice and implementation supports.

²⁵ Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.

²⁶ Permanency Innovations Initiative Training and Technical Assistance Project. (2016). *The development, implementation, and assessment approach*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau.

²⁷ *ibid*

The goal of implementation is to have practitioners use the new program or innovation with fidelity to its intended practice model. The NIRN implementation framework and the PII-TTAP Approach suggest that high fidelity practitioner behavior is created and supported by six implementation supports that provide an infrastructure for the successful implementation of the new program: staff recruitment and selection, staff training, staff coaching, fidelity assessments, identification and use of data, and leadership and stakeholder supports.²⁸

The goal of the implementation evaluation is to describe the P.S. Program as it moves through each of the four stages of implementation and to understand how each of the six implementation supports influenced the development of high fidelity practice. It attempts to answer the following research questions:

1. What are the contextual factors that influenced the implementation of the P.S. Program?
2. How did each of the implementation supports described in the NIRN/PII-TTAP framework influence the P.S. Program implementation process?

2.1.1 Data Sources and Data Collection

The implementation evaluation is being conducted through a series of site visits: the first round occurred in November 2014, approximately 6-9 months after the P.S. Program began enrolling families; the second round of site visits will be conducted in the summer of 2016, and the third round of site visits will occur during the spring of 2018. This chapter describes the methods and results from the site visits that were conducted in November 2014, during the initial implementation of the P.S. Program.²⁹

During the site visits, information was collected through three primary methods: (1) document review and analysis, (2) focus groups with caseworkers, supervisors, and managers involved in the provision of P.S. Program services, and (3) individual interviews with DCF project staff and key informants who had unique knowledge of the program development and implementation.

Document review. Existing documents related to the P.S. Program development and implementation that were reviewed and analyzed included:

- Wisconsin's Federal Title IV-E Demonstration Request
- Wisconsin Waiver Demonstration Project Authority Terms and Conditions
- Wisconsin Title IV-E Child Welfare Waiver Demonstration: Initial Design and Implementation Report (January 7, 2013)

²⁸ The implementation supports described by the PII-TTAP are similar, but not identical, to the implementation drivers described in the NIRN implementation framework (staff selection, staff training, staff supervision and coaching, performance evaluation, decision support data systems, facilitative administration, and systems intervention. The year one site visit report that was completed for the P.S. Program used the original NIRN implementation framework; therefore, the terms used in this chapter will mirror those used by Fixsen et al. (2005).

²⁹ A report based on the findings from the first site visits is available from the CFRC. This report was included with the semi-annual progress report submitted April 2015.

- Wisconsin Title IV-E Child Welfare Waiver Demonstration Quarterly Progress Report (1/1/13 – 3/31/13)
- Wisconsin Title IV-E Child Welfare Waiver Demonstration Quarterly Progress Report (4/1/13 – 6/30/13)
- Post-Reunification Support (P.S.) Program Technical Assistance Sessions FAQ
- Wisconsin Department of Children and Families Division of Safety and Permanence (DSP) Informational Memo 2013-06 re: Post-reunification Support Program Introduction and Timelines
- Wisconsin Department of Children and Families Division of Safety and Permanence (DSP) Informational Memo 2013-07 re: Post-reunification Support (Title IV-E Waiver) Program Expansion
- Wisconsin Department of Children and Families Division of Safety and Permanence (DSP) Informational Memo 2013-08 re: Post-reunification Support Program Documents and Application
- Wisconsin’s Post-Reunification Support Program Statement: Values, Principles and Related Initiatives
- Post-Reunification Support (P.S.) Program Application
- Post-Reunification Support (P.S.) Program Evaluation Overview
- Post-Reunification Support (P.S.) Program Referral Request form
- Post-Reunification Support (P.S.) Program Support Agreement
- Post-Reunification Support (P.S.) Program Initial Implementation FAQ (February 5, 2014)
- Post-Reunification Support (P.S.) Program Reports
- Post-Reunification Program Referral Guide (March 11, 2014)
- Post-Reunification Support Program Enrollment Flow Chart
- County Checklist for P.S. Program
- P.S. Program Practice Requirements
- Wisconsin Department of Children and Families Division of Safety and Permanence (DSP) Informational Memo 2014-05 re: Re-entry Prevention Model and Post-Reunification Support Planning
- Wisconsin Department of Children and Families Division of Safety and Permanence (DSP) Informational Memo 2014-13 re: Post-reunification Support Program Year Two Application Instructions
- Wisconsin Child and Family Services Review Final Report (August 2010)
- Wisconsin Department of Children and Families Division of Safety and Permanence Program Improvement Plan (revised December 14, 2010)

Focus groups and interviews. Thirty-five of Wisconsin’s 72 counties implemented the P.S. Program in Year One (2014). However, early enrollment in the program was slower than expected and several counties had few or no families enrolled when the site visits were conducted in November 2014. Therefore, a decision was made to select counties for site visits that had 5 or more families enrolled in the P.S. Program as of November 2014, which narrowed the number of eligible counties to six. Of these, five counties were selected to participate in the site visits. The five counties selected for site visits were geographically diverse, so that regional differences in

implementation and practice could be better understood. In addition to the five P.S. Program counties, a site visit was conducted in Milwaukee County, where a post-reunification support program similar to the P.S. Program had been implemented in 2012. In-person site visits were conducted in 4 of the 5 P.S. Program counties and in Milwaukee County, and a telephone site visit was conducted in one P.S. Program county due to scheduling difficulties.

After obtaining approval from the CPS managers in each of the selected counties, invitations to participate in the site visit focus groups or interviews were sent to all ongoing case managers with families enrolled in the P.S. Program, their supervisors, and CPS managers. Table 7 shows the number of site visit participants in each county.³⁰

Table 7. Number of site visit participants per county

County	Caseworkers	Supervisors	Managers	Total
County A	6	4	2	12
County B	7	2	1	10
County C	4	1	1	6
County D	4	2	2	8
County E	2	1	1	4
County F	9	5	0	14
Total	32	15	7	54

In addition to the focus groups and interviews with county staff, individual interviews were conducted with six DCF staff and other key stakeholders who were involved with the implementation of the P.S. Program.

The focus groups and interviews were conducted by two researchers from the CFRC over a two week period in November 2014. Separate focus groups were conducted with P.S. Program caseworkers and supervisors in each county, and individual interviews were conducted with county managers and state DCF staff. The focus groups and interviews were conducted in state and county DCF offices and were audio recorded and transcribed for analysis. Signed informed consent was obtained from each participant prior to participation. The focus group and interview protocols were developed by the CFRC to assess a range of topics related to the NIRN implementation drivers and fidelity to the P.S. Program practice model.

³⁰ Throughout the report, county names have been replaced by letters in order to protect the identity of the site visit participants, as specified in the informed consent procedures.

2.1.2 Data Analysis

An independent transcription service transcribed verbatim the audio recording of the focus groups and interviews. The CFRC evaluation team developed a data coding framework based on the NIRN implementation stages, implementation drivers, and P.S. Program practice components. Four CFRC researchers independently reviewed and coded the transcripts using the coding scheme, adding additional codes as needed. This had the effect of sorting text excerpts across interviews into homogeneous categories. Two of the four evaluators who conducted the data analysis participated in the primary data collection; the other two did not and provided an independent perspective. After the initial coding of the transcripts was completed, members of the evaluation team independently analyzed selected topics for this report. This involved identifying common themes within categories across interviews, and also identifying variation between counties in their experience. Quotations were used as appropriate following the qualitative analysis to illustrate themes that emerged from multiple interviews or from interviews of key stakeholders with unique responsibilities (e.g., the P.S. Program coordinator), but quotations themselves were never used out of context to yield conclusions. The team met frequently to discuss findings and review each other's work. Discrepant findings were re-analyzed until interpretive consensus was reached.

Using the NIRN framework, text on the early implementation process was sorted into the following categories: 1) the pre-implementation stage, during which the Wisconsin Department of Children and Families identified the problem facing the child welfare system that needed to be addressed through new practice innovation; 2) the exploration and adoption stage, when DCF administrators and other child welfare stakeholders gathered information on potential intervention programs, current family and system needs, and the agency's readiness to adopt new practice; and 3) the installation stage, when the "nuts and bolts" of the P.S. Program were developed and put into place.

Data on the implementation drivers or supports were sorted using the same process into the categories based on the NIRN core implementation components: 1) staff selection, 2) pre-service and in-service training, 3) supervision and coaching, 4) staff evaluation, 5) decision support data systems, 6) facilitative administrative support, and 7) systems interventions. Finally, data on the the core components of P.S. Program practice were sorted into the following categories: 1) program eligibility and enrollment, 2) family assessment and case planning, 3) case management, and 4) service provision.

2.1.3 Results from the Implementation Evaluation

During the data collection, participants described the activities that occurred during the exploration and installation stages of the implementation of the P.S. Program. Much of this information is included in Chapter 1 of this report. This section highlights findings related to the implementation drivers described in the original NIRN implementation framework.

Staff selection. In implementing a new program with new requirements, consideration must be given to the type of practitioner best qualified to carry out the responsibilities and requirements of the program. Although academic qualifications and prior experience are both important considerations when selecting practitioners to implement a new program, other staff characteristics may also be important to consider based on the needs of the program, such as knowledge of the field, basic professional skills, empathy, social justice, judgment, etc.³¹

One of the early decisions made by the P.S. Program Steering Committee and Waiver Advisory Group was that the ongoing case managers who were working with families prior to reunification would enroll eligible families in the P.S. Program and continue to provide P.S. Program case management services to families during the 12-month post-reunification period. Because current case managers provided P.S. Program services to families during both the pre-and post-reunification periods, it was not necessary for most counties to select and hire new case managers for the P.S. Program. According to the county staff who were interviewed, the only guidance provided to year one P.S. Program counties regarding hiring and staff selection was that the county child welfare agency needed to provide case management services directly, rather than contracting with other community providers. While all counties continued to employ the current caseworker in providing post-reunification services, some counties created additional positions within their agency specifically to assist with the P.S. Program. The “secondary caseworkers” assist the primary P.S. Program caseworker in providing services and carrying out other program requirements.

Staff training. When a new program is implemented, practitioners are typically required to use new skills or approaches to working with clients. To maximize fidelity and effectiveness, practitioners need to learn when, where, how, and with whom to use new approaches and new skills. Pre-service and in-service training are efficient ways to provide knowledge of background information, theory, philosophy, and values; introduce the components and rationales of key practices; and provide opportunities to practice new skills and receive feedback in a safe environment.³²

The Wisconsin Department of Children and Families contracts with the Wisconsin Child Welfare Professional Development System to provide training for all of its caseworkers and supervisors. This training includes required pre-service and foundation courses that are completed within the first two years of employment with DCF. The foundational training covers a variety of aspects of case management, including safety assessment, engaging families, and interviewing. In addition to these required trainings, there are trainings in special skills and topics that staff may choose or be required by their supervisor or manager to take to enhance their individual skills. Supervisors are also provided web-based trainings under the Wisconsin Initial Supervisory Training and Tools.³³

³¹ Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

³² Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

³³ Wisconsin Child Welfare Professional Development System. (2013). Caseworker training. Retrieved from <http://wcpds.wisc.edu/caseworker-training/>

Although the provision of post-reunification services and supports may involve new practitioner skills, members of the Steering Committee viewed the P.S. Program as a continuation of ongoing case management and therefore thought that additional or new training for caseworkers on providing post-reunification support and services was unnecessary. However, county staff reported that the current training available may not be fully adequate for managing cases after children return home.

County A supervisor: The other thing that we hear a lot about is that there are a number of dynamics that come into play for the family themselves upon reunification. We've got kids coming back into a parental home where they could be triggered by their anger about being removed in the first place. Where there's a huge transition from where they were living, to the routine and the structure of now where they're living back with their parents. It could be totally different in terms of socioeconomic. We don't have any kind of training or information even to know really what that's about to even talk to families about the fact that even those first 90 days, it can be a real struggle. We say to parents, don't be surprised if things are a little bit tough the first few weeks of reunification, because everybody's in this transition. There seems to be something specific to kids returning to their home, and what that is like for everybody, and the emotions around that, and how that plays out into behaviors and things. Then how do we as social workers then support that along the same lines as what [name] was saying, in terms of being able to maintain that safety for them, but recognizing when those struggles happen, and adequately supporting them? We just—it's out there. It's a known that it might be difficult, or that some of that stuff might happen. There's not really any good training that we get on what that really—how that really plays out for families.

Although skills-based trainings were not provided to county staff involved in the P.S. Program implementation, several regional meetings and webinars were held to provide information to county supervisors on the new P.S. program documentation and case management requirements. Case management staff were not invited to attend these regional meetings and webinars; supervisors attended and then provided the program information to their case managers through individual and staff team meetings.

Since the site visits in November 2014, DCF has provided several training opportunities that are relevant to the P.S. Program. DCF continues to offer CANS case planning trainings, first developed in May 2014. In 2016, this training will be incorporated within Ongoing Caseworker Training. In 2015, Motivational Interviewing (MI) training was offered to caseworkers and treatment providers serving P.S. Program families and a second cohort was trained in 2016. Motivational Interviewing is an empirically-based intervention in which workers learn to engage families in ways that promote their commitment and ability to make positive changes. Many counties participating in the P.S. Program are also participating in the Wisconsin Trauma Project, a DCF initiative to train workers in prevention and trauma-informed care. DCF organized or facilitated a number of relevant peer-to-peer learning opportunities, including a dedicated P.S. Program Summit for professionals involved in the program and has convened regional supervisor meetings.

Supervision and coaching. According to the NIRN implementation framework, most skills learned during training need to be transferred to daily work through the use of frequent supervision and coaching.³⁴ Recent studies have shown that support and training reinforcement from supervisors enhances the transfer of learning to skills following child welfare training.³⁵ The distinction between supervision and coaching can be explained as follows: formal supervision is more compliance-driven and determines practitioner fidelity to the practice model; coaching is more skills-based and helps to develop sound judgment grounded in best practices. Both are important for successful implementation of new practice skills.

In the P.S. Program, supervision of case managers varies by county and by supervisor, with formal supervision taking place on a spectrum from weekly to monthly or sometimes less often. Caseworkers and supervisors generally stated that they had planned supervision times but that these did not always take place as scheduled. Newer workers often meet weekly with their supervisors, while more experienced workers responded that they meet weekly, biweekly, or monthly. In these sessions, supervisors and workers discuss all of their cases and/or focus on ones that require particular attention. There was no mention of coaching in any documentation related to the P.S. Program. During site visits, coaching was not mentioned by any of those involved in the P.S. Program, either at the state office or at the counties.

Decision support data systems. When implementing a new program, organizational data can be used to measure and track key aspects of the agency's performance and provide information to support decision making to assure continuing implementation of the core intervention components over time. Frequent, user-friendly reports of process and outcome data provide guidance for decision making at the policy levels and practice levels of organizations and help keep whole organizations on the path toward continuous improvement.³⁶

Some counties track their performance outcomes through existing data systems such as eWiSACWIS, but the results of these internal monitoring processes are not always shared with front-line case managers. DCF was in the process of developing several new reports specifically related to P.S. Program monitoring, including an enrollment report, a case management report, and a service engagement report. In addition, each county participating in the P.S. Program will be able to view their "P.S. Profile" to find out information on the current:

- Number of current and total eligible and enrolled children
- Number of children who have re-entered out of home care
- Average length of time in the P.S. Program
- Child and Adolescent Needs and Strengths (CANS) assessment compliance
- Case plan compliance

³⁴ Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

³⁵ Antle, B.F., Barbee, A.P., Sullivan, D.J., & Christensen, D.N. (2009). The effects of training reinforcement on training transfer in child welfare. *Child Welfare, 88*, 5-26. Antle, B.F., Barbee, A.P., & van Zyl, M.A. (2008). A comprehensive model for child welfare training evaluation. *Child and Youth Services Review, 30*, 1063-1080.

³⁶ Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

- Caseworker contacts compliance
- Monthly family service report compliance

Some case managers worried that the performance feedback they are being provided by the state focuses too much on compliance with requirements rather than the quality of the case management being provided:

County A caseworker: There are lots of requirements that say whether or not we're meeting the expectations and the standards that are set by the state.

Moderator: Mm-hmm. Is that kind of data helpful?

County A caseworker: Yeah. I think it's good to know whether or not you're meeting the standards that are set by the state. The concern that I have is that you can't always tell—and I'm worried that people are just looking at the numbers, rather than the quality of work and the type of social work that's being done.

County A caseworker: Right, by, "Oh, did they see them every time in their out-of-home care?" when the kids were in out-of-home care. Well, you don't know what kind of a quality interaction was that.

County A caseworker: I mean, boom, it's checked in there, but they don't necessarily look at what's the content and the quality of that interaction.

County A caseworker: I worry that people are gonna be more focused on, "I need to get this done. I need to be able to check this box and get this form completed and this piece of work done so that it'll count on the report that's gonna be done." We're spending a lot of time on our computers in front of our screens, and not interacting with our families and trying to figure out how we can best serve them and help ensure the safety of their children.

Facilitative administration. Facilitative administration provides leadership and makes use of a range of data inputs to inform decision making, support the overall processes, and keep staff focused on the desired intervention outcomes.³⁷ It uses administrative supports to facilitate movement through the stages of implementation. Closely aligned with external systems interventions, it looks for ways to make the work of frontline practitioners easier and more effective. The elements most often described³⁸ as important to organizational change include:

³⁷ Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*, 531-540.

³⁸ Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

- Commitment of leadership to the implementation process, such as to
 - Initiate and shepherd the organization through the complex change process;
 - Set explicit goals, communicate them clearly throughout the organization, resolve conflicts with other goals, and reinforce persistence;
 - Help create the details of activities, processes, and tasks in order to operationalize implementation policies;
 - Inspire, guide and provide direction;
 - Recruit, select, train, locate, advance, promote, or dismiss employees to further the aims of implementation policies.
- Involvement of stakeholders in the planning and selection of programs to implement or encourage buy-in and ownership during implementation and continuing operations.
- Creation of an implementation task force made up of consumers, stakeholders, unions, and community leaders to oversee the implementation process.
- Suggestions to “unfreeze” current organizational practices, changing them and integrating them to be functional, and then reinforcing new levels of management within the organization.
- Resources for extra costs, effort, equipment, manuals, materials, recruiting, access to expertise, and retraining for new organizational roles.
- Alignment of organizational structures to integrate staff selection, training, performance evaluation, and ongoing training.
- Alignment of organizational structures to achieve horizontal and vertical integration (including training for managers and executive staff) and liaisons with resources and partners.
- Commitment of ongoing resources and support for providing time and scheduling for coaching, participatory planning, exercise of leadership, and evolution of teamwork, and for generating and using data locally.

Site visit participants reported that ongoing development and modifications to the program were the responsibility of the Steering Committee and Waiver Advisory Group. According to one administrator, several minor changes to the P.S. Program were made during the first year of implementation:

DCF administrator: A number of adjustments. During that first year, again, we changed the eligibility cutoff score for the RPM model. That was a big adjustment, because we understand that we weren't covering as many children and families as we expected. We made an adjustment around juvenile justice cases to clarify that if it's a joint case, the child could enter. We made an adjustment around trial reunification, because we realized that if a child was going into trial reunification, that was extending their length of time in stay. That was affecting their eligibility. We clarified that trial reunification doesn't count for purposes of the model of our RPM eligibility criteria, because we didn't want to create a disincentive for people to use trial reunification as a practice tool. Then, the biggest modification was we went through the retooling of the RPM, which was, again, I think a really healthy

process. Good result, in terms of we did it in a way where we solicited input from our advisory group and from the counties. Then, likewise, had a process where we were clear about what the changes were, so that there would be hopefully a good base of understanding of those changes. . . . Part of that, too, I think was having a better understanding of the data that were being fed into the model, which I think improved the validity of it.

Systems intervention: Systems interventions are strategies to work with external systems and stakeholders to ensure the availability of the financial, organizational, and human resources required to support the work of practitioners.³⁹ According to most of the participants who were interviewed for this report, external system stakeholders were involved in the early development and implementation of the P.S. Program primarily through membership in the Waiver Advisory Group (WAG). The WAG includes representation from:

- Wisconsin County Human Services Agency (WCHSA)
- Tribal child welfare agencies
- Children’s Court Improvement program (CCIP)
- Wisconsin Council on Children and Families
- Wisconsin Association of Family and Children’s Agencies
- Wisconsin Child welfare Professional Development System

According to several site visit participants, the external system that most heavily impacts the P.S. Program is the legal system, because most families enrolled in the P.S. Program are court-involved at least for a short period of time following reunification. In addition to communicating with the court system about the P.S. program through WAG members, additional outreach was done via written communication drafted by DCF and distributed to judges, attorneys, and others involved in the court system:

P.S. Program Coordinator: Part of the communications workgroup that I referenced was a county team that I facilitated back in November—we wrote external communication tools that counties use as templates. There was a court stakeholder letter than was very, very, very carefully drafted. It went through many of our contacts locally at the department and then the counties all reviewed it. That was a wordsmithing act of getting it just right because we don't want courts to order the program because it has to be voluntary.

Sometimes attorneys or courts want to mandate these services or say, "This family needs them, and we're going to order it now," or advocate, or do whatever they want to do. We wanted to really carefully nuance that the program is voluntary and it's based on eligibility determined by the department. We made a template that I

³⁹ Fixsen, D.L., Blase, K.A., Naoom, S.F., & Wallace, F. (2009). Core implementation components. *Research on Social Work Practice, 19*(5), 531-540. Fixsen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature* (FMHI#231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute. The National Implementation Research Network.

gave all the counties to put on their letterhead and add anything else they want to, but "make sure this core information is there and communicate it to your stakeholders in the court system." That's been important.

Despite this attempt to educate judges and attorneys about the P.S. Program, a few county case managers and supervisors reported that there is still a lack of understanding about the program in their county:

County B supervisor: I think that's where we could do a better job. When the program rolled out, I think—I don't think we did enough, at least from a management level down to staff, and even maybe external, about explaining the program. I think a lot the monetary amount got attached with it, and I think that's where we went wrong. I think that's what started us out on a wrong foot, especially with external stakeholders, like these attorneys and other people. If we had to do over, I think we would work more on informing staff about it, this is how it should be presented.

I know it comes up in court through our judges. Workers will bring stuff—will talk to the courts about, "This family's eligible. This is what we're doing." I haven't heard a lot of feedback. I don't know if you have, [Name], as far as judges' responses or anything like that. I know one of the things when we got the feedback from staff, that the attorneys in particular have really been causing a lot of havoc during these team meetings. [Name] and I talked about wanting to set up a meeting, to offer that they could come in and meet with us and try and educate them on this program and try and smooth that piece over so that, hopefully, it's not a barrier in any of these cases. I think we could do a better job in that way.

2.2 Fidelity Assessment

Chapter 1 provided a description of the core components of the P.S. Program, which include family assessment, case planning, case management, and service provision. The fidelity assessment uses data from several sources to examine each of these components and answer the research question: To what degree was each of the core components of the P.S. Program implemented as delineated in the practice model?

2.2.1 Data Sources, Data Collection, and Data Analysis

Data for the fidelity assessment were gathered from several sources:

1. Information on the presence and timeliness of required assessments and updates of the family case plan were gathered from the child welfare administrative database (eWiSACWIS).

2. The MFSR, which was described in more detail in Chapter 1, was used to collect detailed information on the services that were provided to families enrolled in the P.S. Program, including case management. When completing the MFSR, caseworkers reported the number of case management hours they provide a family per month, as well as detailed information about the services and community supports the family received. MFSR data collected from June 2014 through December 2015 were analyzed using Statistical Package for Social Sciences (SPSS) software.

Two MFSR data sets were created and analyzed:

- The “monthly data” includes all monthly entries for each family for each month they were enrolled in the P.S. Program (N = 1,874).
 - The “family data” aggregates the monthly data for each of the families that were enrolled in the P.S. Program through December 2015 (N = 296).
3. Qualitative data about casework practice were collected from P.S. Program caseworkers and supervisors during the site visits and are used to illustrate the findings from the administrative and MFSR data analyses.

2.2.2 Results – Assessment and Case Planning

According to the P.S. Program practice guidelines, a CANS assessment must be completed at three time points for cases enrolled in the P.S. Program: 1) within 30 days prior to reunification, 2) six months after reunification, and 3) within 30 days of case closure. The results of the CANS assessment are used by the caseworker and family to develop individualized post-reunification case plan goals and objectives, which are updated within 30 days after reunification, six months after reunification, and then as often as needed through the 12 month post-reunification period. Administrative data were analyzed to determine if each family enrolled in the P.S. Program had CANS assessments and case plans completed within the appropriate time frames. The analyses include 285 families enrolled in the P.S. Program from February 1, 2014 through December 31, 2015. In order to measure compliance with each of the required assessments and case plans, the first step was to determine the number of families that had reached each of the milestones; for example, how many families were enrolled in the P.S. Program for six months and therefore required a second CANS assessment. This number then became the denominator when calculating the compliance rate for the requirement. The second step involved calculating how many families that required an assessment or case plan update had one, either within the required time frame or at any time after it. Table 8 displays the percentage of cases that were compliant with the assessment and case plan requirements.

Table 8. CANS assessment and case plan update compliance rates

	Completed on Time	Completed Later	Not Completed
Initial CANS assessment (n=284)	74%	0%	26%
Second CANS assessment (n=165)	46%	30%	24%
Final CANS assessment (n=96)	29%	23%	48%
Initial case plan (n=264)	59%	22%	19%
Middle case plan (n=163)	52%	23%	26%

Baseline CANS assessments. A CANS assessment is required for all families enrolled in the P.S. Program within 30 days prior to reunification. Cases were included in the compliant category if they can a CANS assessment between 30 days prior to reunification and 10 days after reunification. Of the 285 families enrolled in the P.S. Program by December 31, 2015, 284 reached this milestone. Of these, 209 (74%) had a CANS assessment in the case file and 75 (26%) did not.

Six month CANS assessments. A second CANS assessment is required six months after reunification. Cases were included in the compliant category if they had a CANS assessment completed between the 152nd and 213th day of P.S. Program enrollment. Of the 285 cases enrolled in the P.S. Program by December 31, 2015, 165 reached this milestone. Of these, 76 (46%) had a CANS assessment completed during the appropriate time frame, 50 (30%) had a CANS assessment completed after the required time frame, and 39 (24%) did not have a CANS assessment completed for this milestone.

Final CANS assessments. A final CANS assessment is required within 30 days of P.S. Program case closure. Cases were included in the compliant category is they had a CANS assessment completed between the 335th and 375th day of P.S. Program enrollment. Of the 285 cases enrolled in the P.S. Program by December 31, 2015, 96 reached this milestone. Of these, 28 (29%) had a CANS assessment completed during the required timeframe, 22 (23%) had a CANS assessment completed after the required time frame, and 46 (48%) did not have a CANS assessment completed for this milestone.

Initial case plans. Individualized case plans should be developed for each family enrolled in the P.S. Program within 30 days after reunification. Cases were included in the compliant category if they had an updated and approved case plan within 45 days after P.S. Program enrollment. Of the 285 cases enrolled in the P.S. Program by December 31, 2015, 264 reached this milestone. Of these, 156 (59%) had a case plan completed during the required timeframe, 59 (22%) had a case plan completed after the required time frame, and 49 (19%) did not have a case plan completed.

Middle case plans. Case plans should be updated following the completion of the six month CANS assessment. Cases were included in the compliant category if they had an updated and approved case plan between the 45th and 213rd day after P.S. Program enrollment. Of the 285 cases enrolled in the P.S. Program by December 31, 2015, 163 reached this milestone. Of these, 84 (52%) had a

case plan completed during the required timeframe, 37 (23%) had a case plan completed after the required time frame, and 42 (26%) did not have a case plan completed.

During the site visits, focus group participants were asked about the use of the CANS assessment in the P.S. Program. According to several DCF administrators, the initial implementation and training related to the CANS assessment in Wisconsin emphasized its use as a foster care rate setting tool rather than as a child and family assessment tool used to plan for service provision. Consequently, front-line child welfare staff have been unenthusiastic about completing the CANS and using it during case planning:

DCF administrator: Some counties really appreciate the CANS for everything that it can offer and tell you about a family. And some counties view it simply as a rate setting tool. That's all they view it as. A lot of that has to do with how DCF rolled out the implementation of the CANS. . . . So they have this 195 questionnaire that the worker has to do with the family all to set a rate. Counties were not very excited to do it and many still aren't. If that's what you think it is, and that's all you see it being—I can understand the reticence.

Although DCF is now making a concerted effort to shift case managers' thinking about the CANS assessment and providing additional training and resources to staff to improve understanding and effective use of the tool, the case managers that participated in the focus groups described the CANS as cumbersome and difficult to use, and felt inadequately prepared to use it effectively:

County A caseworker: I don't think there's a clear understanding. I know, as a unit, we've had a lot of conversations about not even having a clear understanding of how to even fill out certain parts. We've all been to trainings and we've signed up to go to trainings, and excited about it, so we can finally understand what this is about, and the training has not been what we expected, at all.

County A supervisor: There's been this big push to use the CANS. Yet the training for CANS in this state has been almost non-existent. The training that we received was over 100 people in a room, where the nationally-known guy came. I was actually at the training where he showed up. I don't know how to use the CANS any better, because I went to his training. I did see then at the state level that they're bringing him in to do more huge trainings, which I don't think people find helpful.

I had one kid that had 65 actionable items and the expectation from the state is that you group them together and then use that information to write goals. It just does not make sense of what the state wants us to do with the CANS, with the very little bit of training. Every single one of my workers will say that they have a very difficult time assessing a child pretending they're not in services, or pretending they're not getting support. It's been extremely difficult to put a big emphasis on this CANS tool. No workers—I'll speak for myself as a supervisor, really don't know how to help out with that.

2.2.3 Results – Case Management

MFSR data were analyzed to determine the average number of case management hours provided to families in the P.S. Program (see Figure 2). The median⁴⁰ number of case management hours provided per month was 6, although many caseworkers reported a much larger number. Over 10% of caseworkers reported providing 17 hours or more per month.

Figure 2. Case management hours per month (N = 1874 families x months)

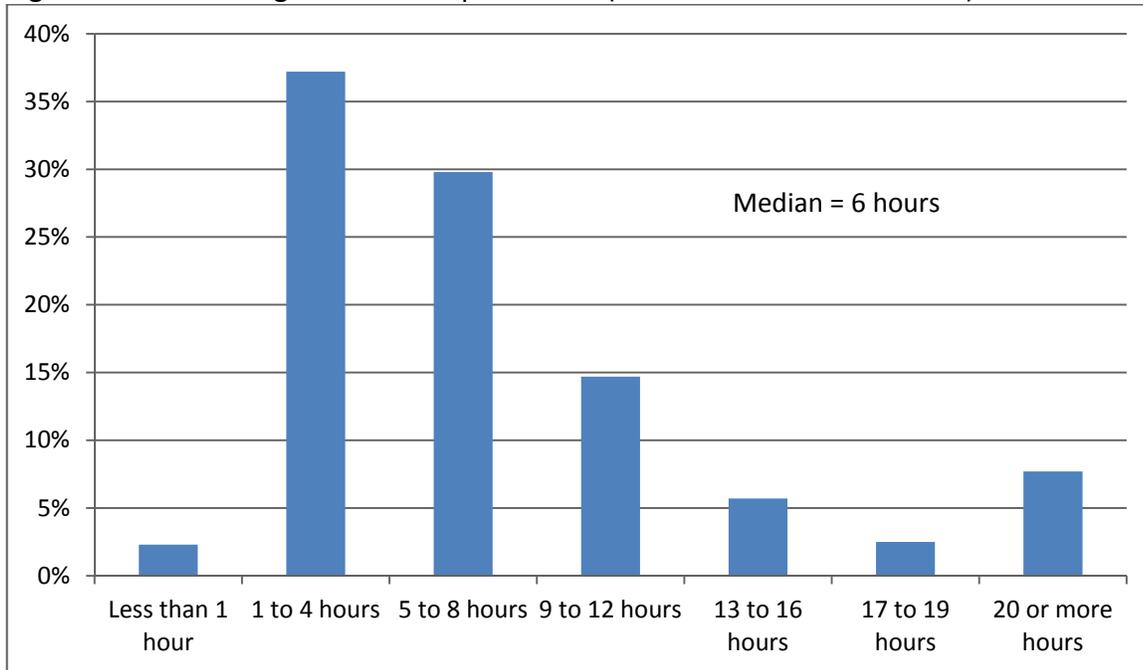


Figure 3 presents the minimum number of case management hours devoted to families per month. For most families, the minimum was one to four hours per month (only 9.5% received a minimum that was less than one hour). For a few families, the minimum case management hours were higher: over 10% received a minimum of 9 or more hours per month. One might think that those families that required a minimum of 20 hours per month had only been in the P.S. Program briefly, in a crisis state, but two families who had been in the program six months or more required at least 17 hours per month.

⁴⁰ The mean number of hours was not calculated because caseworkers entered the value of 20 to represent 20 or more hours, and therefore a true arithmetic mean could not be calculated.

Figure 3. Minimum monthly case management hours per family (N = 296 families)

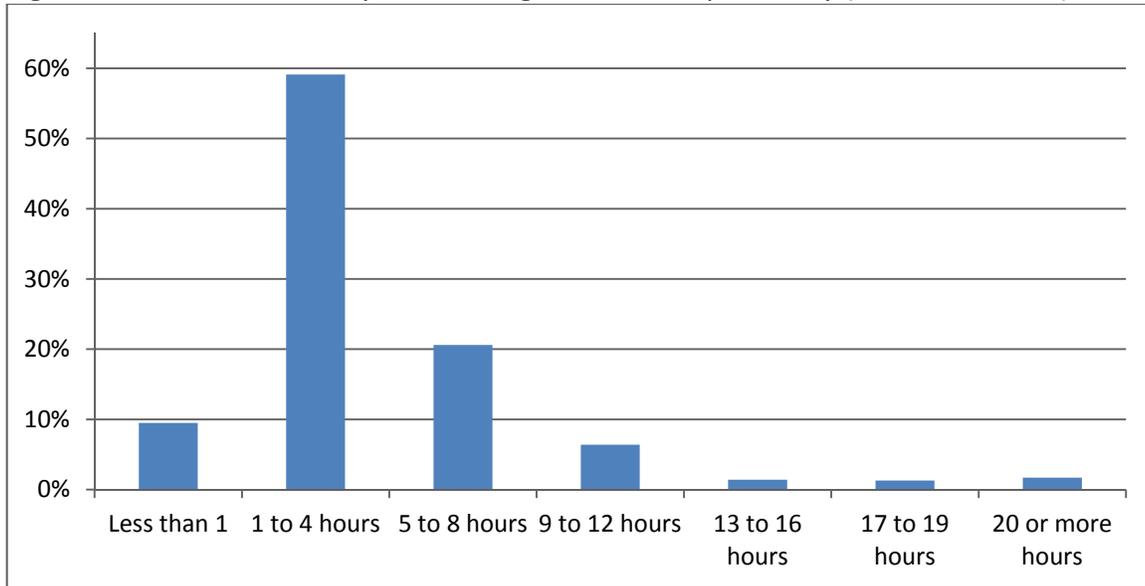
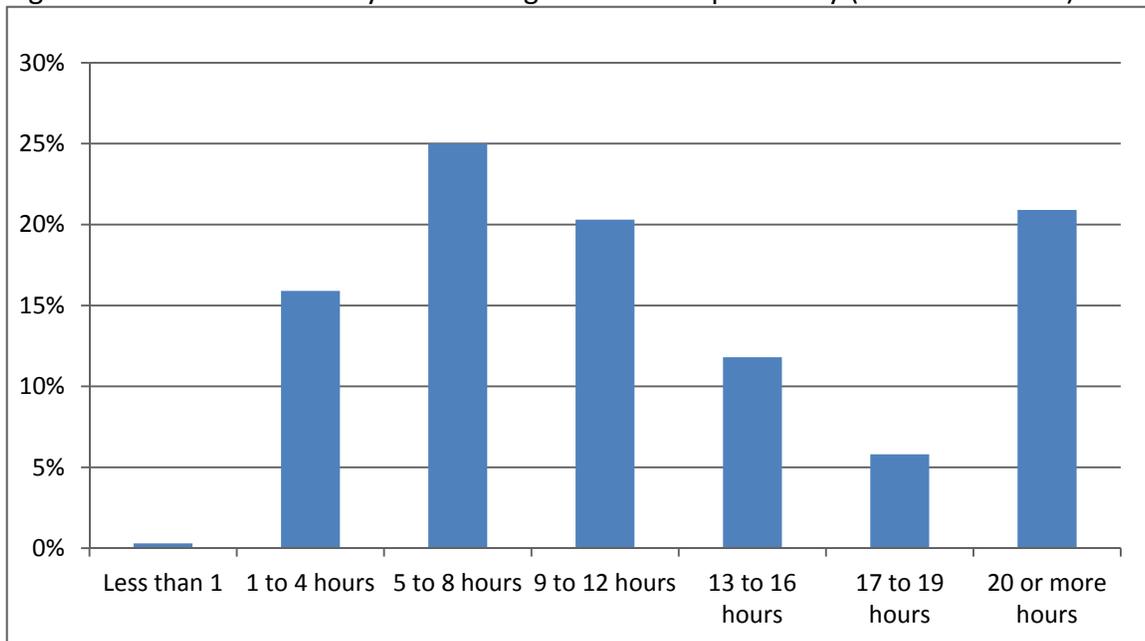


Figure 4 presents the maximum number of case management hours per month per family. Most families required a maximum of 12 hours or fewer, but almost a quarter received a maximum of 20 or more case management hours in a month.

Figure 4. Maximum monthly case management hours per family (N = 296 families)



2.2.4 Results – Service Provision

During the first round of site visits, caseworkers were asked to describe the types of services that they were providing to families enrolled in the P.S. Program and any challenges that they were experiencing with service provision. Several caseworkers mentioned a high demand for parent mentoring services, whereby professionals provide instruction, guidance, and emotional support to parents so they can learn to do many of the specific actions, communications, and decisions characteristic of good parenting. Parent mentors would coach parents in myriad different specific behaviors, including, for example, developing routines around bedtime, homework, and hygiene; linking families with services; helping families deal with housing and credit issues; and helping with financial planning.

Several respondents noted that the availability of flexible funds through the P.S. Program created a noticeable change in workers' abilities to serve families. One supervisor said, "The pleasant surprise was the amount of flexibility of using the funding. It allows that kind of thinking-outside-of-the-box brainstorming approach to intervention that we don't always get, because while we have flexible funding, it's flexible with strings." The flexible funds were used in multiple ways to meet the needs of families, such as fees for recreational activities; assistance with rent; and classes or activities that allow family members to bond and spend time together:

County C caseworker: She (the client) won't drive it (the car) because he (her husband) needs it cuz he's the main breadwinner in the family. She doesn't work. Getting her volunteer drivers and things like that to help her to go get groceries, to go to this support group that she really enjoys cuz it's helped her to maintain her sobriety from alcohol. She wants to continue to do that, so that this program helps. . . . I've also used bus passes, like I said, the additional extracurriculars. We paid for not just tae kwon do, but the volunteer driver to the Y along with the tae kwon do uniforms. I am also looking at purchasing a set of four chairs for the house from the P.S. Program as well because mom has identified she would like to do—and I hope she follows through—sit-down dinner with the family. We all know the research based on that, that families who eat together stay together.

County D caseworker: We've done—we helped pay for the single dad to have an AOD assessment so he can get his driver's license. We've used funding to get kids involved in the rec department programming, whether it's the playground group, whatever, or boys and girls club. What else have we used the funding for? Daycare. . . Football. We helped for one of the guys to play football this year, because that's what he liked to do. We've done respite. We've set up respite for our family. Gas cards for parents to get their kids to scheduled appointments or themselves to scheduled appointments with service providers. It's pretty much been across the board of you name it, we've tried to help the family.

Caseworkers also stressed the importance of building parents' informal supports and how much of their work revolved around attempts to increase those supports.

County A manager: Internally we have workers that are called social service specialists. They are people who can provide more of that hands-on work with families, but as our out-of-home care population has grown, their time is pretty much completely taken up with providing face-to-face contacts between kids and parents. We have, really, no capacity to use those internal staff to be able to provide assistance for parents whose kids are in the home. We're really finding that a lot of our parents just need some basic assistance on how to sign your kids up for classes at the community center, how to make sure you're connected with benefits.

A lot of our families don't have good natural support systems. How do we teach them the skills of developing those relationships out in the community? We really don't have an agency, or a program that we contract with, that provides that kind of service. We've been out soliciting different organizations that seem to be providing something like that, and we're gonna see if it really does meet the needs that the workers are identifying.

County B caseworker: I am on several cases where it's about the support. It's the support that the P.S. grant has to offer makes a huge difference. That financial could come or go. It's really that extra support. Going into the home twice a month, having those meetings where you're pulling everybody together, connecting them with the resources that they're gonna have, once we're out.

Although the flexible funding associated with the P.S. Program allowed many caseworkers to provide both traditional and non-traditional services to families, some counties struggled to set up contracts with service providers because of the shortfall in expected enrollment in the program that occurred in Year One. The shortfall in the number of children meant that there were too few cases to justify the risk of service providers developing new services; it would not be a good business decision to invest in developing a new service if there were too few families to generate payment for these services.

County A manager: What we're hearing from them is, "We'd be happy to provide that service to you, but you'll appreciate that we need some guarantees as to—if you expect us to bring on staff to provide this service, we need a guarantee from you that you're gonna send us X number of clients and X number of dollars. Cuz we're not gonna bring on staff to provide a service, and pay them, and have them sit at their desk, twiddling their thumbs.

Another service gap was the lack of mental health care, which affected every county. There were simply too few mental health professionals to provide the services needed, and counties consistently faced waiting lists. Practitioners for specialized services, such as in-home mental health services or trauma-focused cognitive-behavioral therapy (TF-CBT), were especially limited. Respite care, crisis management, AODA treatment, dental care, and transportation were also mentioned as services that were unavailable or insufficiently available in at least one county.

County B caseworker: Well, therapy, in general. There's waiting lists at both of our large clinics, our large hospitals. I think even our smaller agencies that are around here . . . they're getting waiting lists. We only have so many, and they can only take so many.

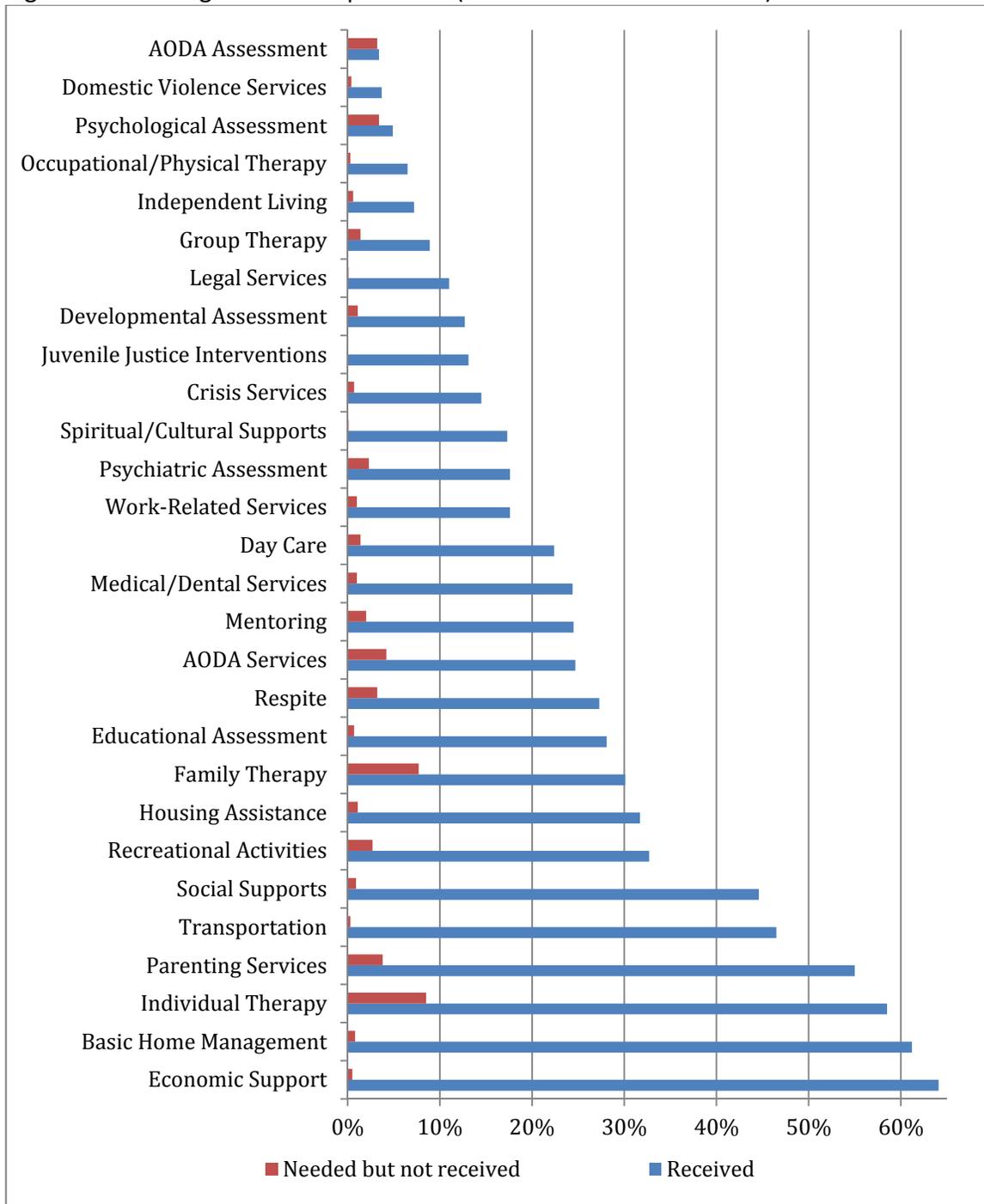
In addition to the qualitative data collected during the site visits, the Monthly Family Service Report (MFSR) provides a wealth of information about service provision for families enrolled in the P.S. Program. The MFSR contains a list of 28 services and informal supports, and each month, the caseworker reports whether the family: a) received a service as part of their case plan, b) received a service that was not listed in the case plan, c) did not receive a service even though it was included in their case plan, or d) did not need or receive a service (one option must be selected for each service). Table 9 and Figure 5 present information on service provision using the MFSR monthly data set. The first column in Table 9 and the blue bars in Figure 5 show the percentages of families that received each of the services, in order of frequency, regardless of whether or not it was included in their case plan. Families received a wide array of services—clearly the extensive list of services in the MFSR is needed to capture everything families are receiving. The most frequent services focus on maintaining the functioning of households (Basic Home Management, Economic Support, Transportation, Housing Assistance), supporting parents (Parenting Services, Social Support), and providing mental health care (Individual Therapy, Family Therapy). Recreational Services were also important. Other services were uncommon, primarily because they applied to only a subset of families (e.g., Juvenile Justice Services/Activities, Occupational/Physical Therapy) or because they typically are short-term services (e.g., Crisis Services, Developmental Assessment) that would not be needed frequently.

The next column in Table 9 and the red bars in Figure 5 show the percentage of families that needed the service but did not receive it. The two services that were most often needed but not received were individual therapy (8.5%) and family therapy (7.7%). The final column in Table 9 shows the rate at which specific services were received when they were needed. It represents the number of times a given service was received divided by the total number of times that service was needed. A service was counted as needed by adding two groups: services received (it was assumed that if a service was received it was needed) and serviced needed but not received. When examined in this manner, almost all services were received in 85% or more of the instances in which they were needed. Two services were infrequently needed, but were only received about half of the time they were needed: AODA assessments were received 51.5% of the time they were needed and psychological assessments were received 59.0% of the time they were needed. A more commonly needed service that showed a gap in service receipt was family therapy, which was received 79.6% of the time it was needed.

Table 9. P.S. Program service provision (N = 1874 families x months)

	Received	Needed but Not Received	Rate of Receiving Needed Service
Economic Support	64.1%	0.5%	99.2%
Basic Home Management	61.2%	0.8%	98.7%
Individual Therapy	58.5%	8.5%	87.3%
Parenting	55.0%	3.8%	93.5%
Transportation	46.5%	0.3%	99.4%
Social Support	44.6%	0.9%	98.0%
Housing Assistance	31.7%	1.1%	96.6%
Recreational Activities	32.7%	2.7%	92.4%
Family Therapy	30.1%	7.7%	79.6%
Educational Assessment	28.1%	0.7%	97.6%
Respite	27.3%	3.2%	89.5%
AODA Services	24.7%	4.2%	85.5%
Medical/Dental Services	24.4%	1.0%	96.1%
Mentoring	24.5%	2.0%	92.5%
Day Care	22.4%	1.4%	94.1%
Spiritual/Cultural Supports	17.2%	0.1%	99.4%
Work-Related Services	17.6%	0.1%	99.4%
Psychiatric Assessment	17.6%	2.3%	88.4%
Crisis Services	14.5%	0.7%	95.4%
Developmental Assessment	12.7%	1.1%	92.0%
Legal Services	11.0%	0.1%	99.1%
Juvenile Justice Interventions	13.9%	0.0%	100.0%
Group Therapy	8.8%	1.4%	86.3%
Independent Living	7.2%	0.6%	92.3%
Occupational/Physical Therapy	6.5%	0.3%	95.6%
Psychological Assessment	4.9%	3.4%	59.0%
Domestic Violence Services	3.7%	0.4%	90.2%
AODA Assessment	3.4%	3.2%	51.5%

Figure 5. P.S. Program service provision (N = 1874 families x months)



Another way to examine service receipt is to look at how often each family received a service when they needed it (Table 10). Many services were almost always received during the months they were needed. Some families never received a service that they needed: about 28% who needed AODA assessment and 28% who needed psychological assessment never received these services. Also, more than 10% of families who had family therapy, group therapy, and domestic violence services on their case plan never received these services. One caveat for the analysis of

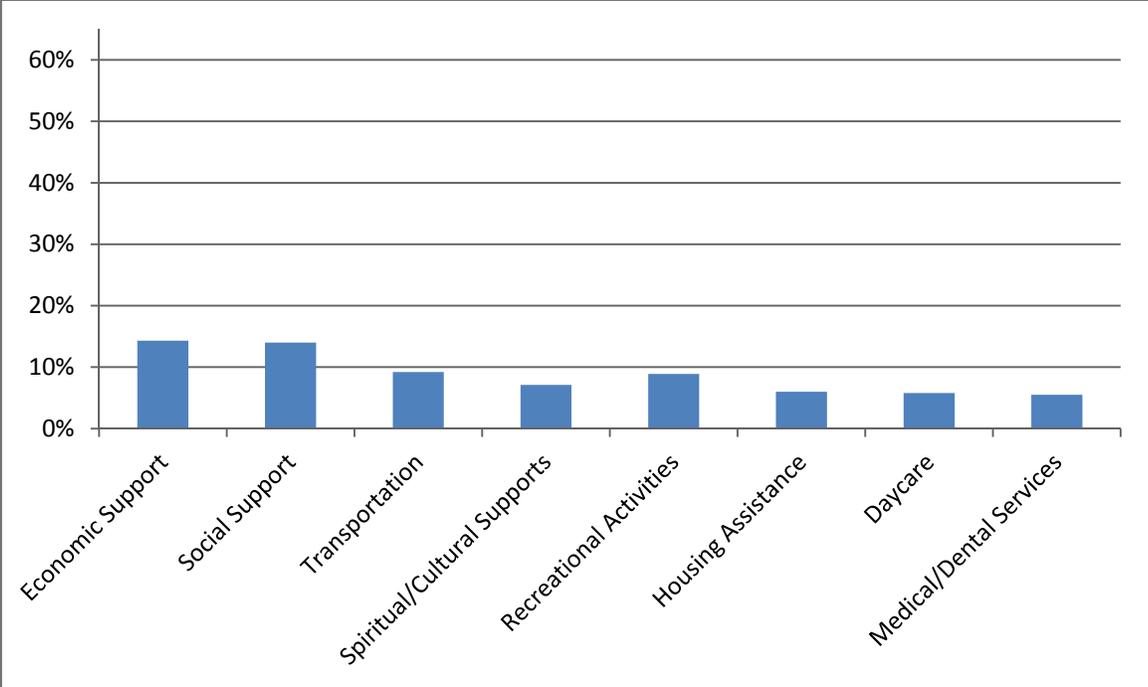
gaps in service receipt is that it does not take into account families' duration in the program; some gaps in service receipt could be a result of families being new to the program or only staying in the program a short while. Final analysis of MFSR data will need to take this into account.

Table 10. Frequency of service receipt (N = 296 families)

	% with service received at least once	How often was the service received when it was needed?			
		Never	Less than half of the time	Half the time or more	Always
Basic Home Management	81.4%	0.8%	0.0%	3.3%	95.9%
Economic Support	80.1%	0.4%	0.0%	2.9%	96.6%
Individual Therapy	75.0%	4.8%	4.3%	18.3%	72.6%
Parenting	72.5%	4.5%	2.2%	8.9%	84.4%
Transportation	68.6%	0.5%	0.0%	1.0%	98.5%
Social Support	63.4%	0.0%	0.5%	4.8%	94.7%
Educational Assessment	54.7%	1.2%	0.0%	3.7%	95.1%
Recreational Activities	53.0%	3.1%	2.5%	9.3%	85.2%
Housing Assistance	52.0%	1.3%	0.6%	7.7%	90.4%
Family Therapy	50.0%	10.4%	6.1%	19.5%	64.0%
Medical/Dental Services	45.9%	3.5%	0.7%	6.4%	89.4%
Mentoring	43.9%	3.0%	3.0%	5.3%	88.7%
Respite	40.3%	6.3%	4.8%	10.3%	78.6%
AODA Services	38.0%	6.7%	6.7%	15.1%	71.4%
Psychiatric Assessment	36.6%	8.5%	1.7%	8.5%	81.4%
Work-Related Services	35.1%	1.9%	0.0%	4.8%	93.3%
Day Care	33.8%	6.5%	1.9%	7.5%	84.1%
Crisis Services	32.5%	4.0%	1.0%	4.0%	91.0%
Legal Services	28.4%	0.0%	0.0%	2.4%	97.6%
Developmental Assessment	25.3%	5.1%	1.3%	5.1%	88.6%
Spiritual & Cultural Activities	25.0%	0.0%	0.0%	1.4%	98.6%
Juvenile Justice Interventions	23.0%	0.0%	0.0%	0.0%	100.0%
Group Therapy	22.1%	11.0%	1.4%	8.2%	79.5%
Independent Living	16.9%	7.4%	0.0%	5.6%	87.0%
Psychological Assessment	15.9%	27.7%	3.1%	2.3%	56.9%
AODA Assessment	12.2%	28.0%	8.0%	10.0%	54.0%
OT/PT	9.8%	3.3%	0.0%	10.0%	86.7%
Domestic Violence Services	8.4%	13.8%	3.4%	3.4%	79.3%

Sometimes families received services that were not on the case plan (see Figure 6). These may represent responses to needs that emerged that were unexpected or transient. This happened most frequently for economic support, social supports, and transportation.

Figure 6. Services provided that were not on the case plan (N = 1874 families x months)



If a service was needed but not received, caseworkers specified the reason from a list of pre-determined options. Although this happened infrequently, when the reasons why services were not received were analyzed, they usually centered on the family (family refused, family unable to participate, missed appointments) and less on capacity of or access to service providers (see Table 11). For example, AODA Services were not received in 2.1% of instances because the client refused the service, in 0.8% because the client was not able to participate, and in 0.8% because of a missed appointment. These small percentages are nevertheless much larger than the percentage of times that AODA Services were not received because the service was unavailable (0.2%), the provider was at capacity (0.3%), or the service was discontinued (0.1%).

Table 11. Reasons why services were not received (N = 1866 families x months)

	Service received	Service needed but not received						Service not needed
		Service unavailable	Service discon't	Provider at capacity	Client refused service	Client not able to participate	Missed appointment	
Economic Support	64.1%	0.1%	0.0%	0.1%	0.1%	0.2%	0.2%	35.4%
Basic Home Management	61.2%	0.3%	0.0%	0.0%	0.2%	0.3%	0.2%	38.0%
Individual Therapy	58.5%	0.8%	0.7%	0.3%	2.9%	2.8%	1.5%	33.0%
Parenting	55.0%	0.5%	0.4%	0.8%	1.0%	0.7%	0.6%	41.2%
Transportation	46.5%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	53.2%
Social Support	44.6%	0.3%	0.0%	0.0%	0.2%	0.3%	0.1%	54.6%
Recreational Activities	32.7%	0.6%	0.0%	0.0%	0.6%	1.4%	0.2%	64.6%
Housing Assistance	31.7%	0.4%	0.1%	0.1%	0.1%	0.4%	0.2%	67.2%
Family Therapy	30.1%	1.4%	0.5%	0.8%	2.1%	2.3%	0.7%	62.2%
Educational Assessment	28.1%	0.3%	0.0%	0.0%	0.1%	0.3%	0.0%	71.2%
Respite	27.3%	0.9%	0.1%	0.3%	1.4%	0.8%	0.0%	69.5%
AODA Services	24.7%	0.2%	0.1%	0.3%	2.1%	0.8%	0.8%	71.1%
Mentoring	24.5%	1.0%	0.1%	0.3%	0.4%	0.2%	2.0%	73.5%
Medical/Dental Services	24.4%	0.2%	0.0%	0.0%	0.2%	0.4%	0.3%	74.7%
Day Care	22.4%	0.3%	0.0%	0.0%	0.2%	0.9%	0.0%	76.2%
Work-Related Services	17.6%	0.0%	0.0%	0.0%	0.3%	0.7%	0.2%	81.4%
Psychiatric Assessment	17.6%	0.1%	0.1%	0.1%	1.0%	0.9%	0.3%	80.2%
Spiritual/Cultural Supports	17.3%	0.1%	0.1%	0.1%	0.0%	0.1%	0.0%	82.7%
Crisis Services	14.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	84.8%
Juvenile Justice Services	13.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	86.0%
Developmental Assessment	12.7%	0.3%	0.1%	0.0%	0.3%	0.4%	0.1%	86.2%
Legal Services	11.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	88.9%
Group Therapy	8.9%	0.4%	0.1%	0.1%	0.5%	0.2%	0.2%	89.8%
Independent Living	7.2%	0.3%	0.1%	0.0%	0.1%	0.2%	0.0%	92.2%
OT/PT	6.5%	0.1%	0.0%	0.0%	0.0%	0.2%	0.0%	93.2%
Psychological Assessment	4.9%	0.2%	0.4%	0.2%	1.3%	0.8%	0.5%	91.7%
Domestic Violence Services	3.7%	0.2%	0.0%	0.1%	0.1%	0.1%	0.0%	95.9%
AODA Assessment	3.4%	0.0%	0.6%	0.2%	1.5%	0.7%	0.4%	93.4%

The MFSR also provides information on which family member(s) received a given service in a given month. Table 12 shows the service recipients of a subset of services for which this information is relevant (for a number of services this comparison is not meaningful, e.g. housing assistance). A number of services and supports were provided about equally to the parent and referred child: individual therapy, transportation, social support, spiritual/cultural supports, psychiatric assessment, crisis services, psychological assessment, and legal services. AODA assessment and services were directed almost exclusively to parents. Four services were more likely to be received by the referred child: recreational activities, medical/dental services, mentoring, and occupational/physical therapy. Siblings of the referred child received services and supports less frequently.

Table 12. Recipients of P.S. Program services (N = 1874 families x months)

	Parent(s)	Referred Child	Sibling(s)
Individual Therapy	35.1%	36.3%	6.4%
Transportation	36.3%	30.3%	1.4%
Social Support	33.7%	37.7%	14.5%
Recreational Activities	12.7%	30.2%	9.9%
AODA Services	21.8%	2.4%	0.5%
Medical/Dental Services	8.1%	20.9%	6.2%
Mentoring	9.7%	17.0%	3.5%
Spiritual/Cultural Supports	13.8%	14.6%	6.8%
Psychiatric Assessment	9.7%	9.7%	0.9%
Crisis Services	11.1%	10.4%	2.7%
Legal Services	8.1%	5.4%	1.1%
Group Therapy	7.1%	3.0%	0.9%
Occupational/Physical Therapy	0.3%	5.5%	0.7%
Psychological Assessment	2.2%	3.1%	0.2%
AODA Assessment	3.0%	0.2%	0.1%

In addition, the MFSR collects data on who provided the service or support. As might be expected, most services (e.g., medical/dental services, legal services) are provided by licensed or certified professionals. A few services are provided primarily by caseworkers: home management (42.5%), economic support (34.1%), transportation (28.8%), and housing assistance (21.6%). Social support was most often provided by “informal providers” (e.g., family, friends, clergy).

Table 13 provides a summary of service delivery data. On average, families received over 7 services and supports in any given month and more than 11 over the course of their time in the program. The number of services they needed but did not receive averaged .52 in any given month and 1.63 over their tenure in the program. They received an average of 90% of services they needed.

Table 13. Service delivery summary

	Per Month (N = 1874 families x months)			Per Family (N = 296 families)		
	Number of services received	Number of services needed but not received	% of needed services received	Number of services received at least once	Number of services needed but not received	% of needed services received at least once
Mean	7.07	.52	93%	11.76	1.63	90%
Median	7	0	100%	11	0	100%
Minimum	0	0	0%	0	0	33%
Maximum	28	9	100%	28	13	100%

2.3 Process Evaluation Discussion and Limitations

When child welfare agencies implement a new program or practice, the goal is for caseworkers to use the new program with fidelity to its intended practice model. Both the NIRN implementation framework and the PII-TTAP Approach suggest that high fidelity practitioner behavior is created and supported by attending to six implementation supports that provide an infrastructure for the successful implementation of the new program: staff recruitment and selection, staff training, staff coaching, fidelity assessments, identification and use of data, and leadership and stakeholder supports. The P.S. Program process evaluation documented DCF's efforts during the initial implementation stage and examined the degree to which it is being implemented with fidelity to its practice guidelines.

Site visits were conducted in November 2014 in five counties that implemented the P.S. Program in Year One.⁴¹ The county case managers, supervisors, and managers that were interviewed during the site visits expressed a considerable amount of commitment to the P.S. Program – both the overall philosophy of supporting families during the post-reunification period and the specific practice elements of the P.S. Program that were implemented in Year One. Careful attention had been paid to each of the six implementation supports described in

⁴¹ Please see the full report for more detailed findings and recommendations: Fuller, T., Tittle, G., Cross, T.P., & Pacey, M.S. (2015). *The Wisconsin Post-reunification Support (P.S.) Program: Year One Site Visit Report*. Urbana, IL: Children and Family Research Center, University of Illinois at Urbana-Champaign.

the NIRN framework and the initial implementation of the P.S. Program was largely successful. However, two areas were identified as in need of some enhancement: 1) training and 2) communication and outreach.

Based on the findings, the site visit report recommended that DCF enhance the currently offered training by adding new training developed specifically for P.S. Program staff. Part of the training, the report recommended, should be skills-based, focusing on the case management skills that are unique to the pre- and post-reunification period. A further recommendation advocated for additional training sessions for P.S. Program staff on topics related to needs workers expressed or areas of confusion, such as CANS assessment, trauma-informed practice, and Motivational Interviewing. Finally, the site visit report recommended the development of a formal P.S. Program manual that combines all of the current program documentation that was located in several different documents and locations.

One of the most consistent themes that emerged from the site visits was the desire for increased levels of communication from DCF to the counties regarding the P.S. Program. Many case managers and supervisors felt as if they were not provided with enough guidance about the details of the P.S. Program during the initial implementation, and were left to figure things out for themselves. Since the P.S. Program Coordinator also expressed a desire to spend more time visiting the counties and meeting with staff, additional in-person regional meetings were recommended. In addition, staff expressed a strong desire to learn how other counties were implementing the P.S. Program and what approaches were most effective. Therefore, another recommendation was to offer peer-to-peer learning opportunities for counties that had implemented the P.S. Program. Finally, the findings from the site visits indicated that additional outreach from DCF to external stakeholders, especially judges, attorneys, and guardians ad litem, was necessary.

Since the site visits in November 2014, DCF has provided considerable training, outreach, and peer learning to staff involved in the P.S. Program, including a P.S. Program Summit in September 2015 that was designed in response to the recommendation in the site visit report. DCF also developed additional online instructional materials related to the P.S. Program that in total make up much of what a manual would provide, including a detailed instruction sheet on all P.S. Program requirements. Important process evaluation questions going forward concern the impact of these learning opportunities and communication efforts on staff implementing the P.S. Program.

The fidelity assessment examined how caseworkers were implementing the core components of the P.S. Program: assessment and case planning, case management, and provision of services and enhancement of informal supports. Analysis of administrative data revealed that nearly three-quarters of caseworkers completed the initial CANS assessment as required, although far fewer completed the final CANS assessment that was due during the final month of a family's participation in the P.S. Program (almost half of these families did not have a final CANS assessment). Required case plan updates were completed in approximately half of the cases.

An important component of the P.S. Program is service provision, and data from the MFSR suggest that families in the P.S. Program are receiving substantial assistance through a major investment of case management hours and extensive use of diverse services and supports. A majority of families receive at least 6 hours a month of caseworker time, and a meaningful proportion of families receive up to 20 hours a month of caseworker time. Families typically received a considerable number of services and supports, including some not represented on the case plan. Several services are usually provided by caseworkers, underlining their importance. Both parents and the referred child are a focus of service delivery, and receive many services at about the same rate.

To a great degree, families we have data on are receiving the services and supports that are planned, although there are some gaps, particularly for assessment services, attributed mostly to families' difficulties engaging in these services. Though the MFSR data cannot assess the appropriateness of service plans and the quality of services, the extensive investment of caseworker time and delivery of a wide array of services and supports provide important evidence that the P.S. Program is being implemented as planned.

However, a caveat to these conclusions is that the MFSR data are incomplete. Although a large majority of caseworkers complete the MFSR each month, over 15% of the families enrolled in the P.S. Program did not have corresponding MFSR data. It is possible (and likely) that these data are missing at random and attributable to simple human oversight and errors. On the other hand, some caution is warranted, because of the possibility that service provision among the cases with missing MFSR data differed systematically from those for which it was completed.

Chapter 3: The Outcome Evaluation

The outcome evaluation of the P.S. Program compares the short-term, intermediate, and long-term outcomes of reunified children and families enrolled in the P.S. Program (the treatment group) to those of similar children and families in counties that have not implemented the P.S. Program (the comparison group). The outcome evaluation seeks to answer the following research questions:

1. Do parents who receive the P.S. Program have lower levels of parent stress than parents who do not receive the P.S. Program?
2. Do parents who receive the P.S. Program have higher levels of coping skills than parents who do not receive the P.S. Program?
3. Do parents who receive the P.S. Program have higher levels of social support than parents who do not receive the P.S. Program?
4. Do families that receive the P.S. Program have higher levels of positive family functioning than those who do not receive the P.S. Program?
5. Do reunified children who receive the P.S. Program demonstrate reductions in trauma exposure, social and emotional functioning, and behavioral functioning over time?
6. Are reunified children who receive the P.S. Program less likely to experience maltreatment recurrence than children who do not receive the P.S. Program?
7. Are reunified children who receive the P.S. Program less likely to experience re-entry into out-of-home care than children who do not receive the P.S. Program?
8. Do reunified children who receive the P.S. Program have more positive educational outcomes than children who do not receive the P.S. Program?
9. Do reunified children who receive the P.S. Program have more positive health outcomes than children who do not receive the P.S. Program?

Propensity score matching (PSM) is being used to create two statistically equivalent groups of families that did and did not receive the P.S. Program. Once these groups have been created, the short-term, intermediate, and long-term outcomes of the two groups can be compared, and any differences between the two groups can be attributed to the impact of the P.S. Program.

This chapter describes the results of the PSM, including the characteristics of the treatment and comparison groups before and after the match. Next, the results of the analyses that compare outcomes between the two groups are presented. Finally, alternative explanations and limitations of the findings will be discussed.

3.1 Sample Characteristics

3.1.1 Pre-match Sample Characteristics

Between February 2014 and December 2015, 285 families have been enrolled in the P.S. Program and are included in the treatment group. During the same period, 1,079 families were reunified in Wisconsin counties that did not yet implement the P.S. Program. Characteristics of the P.S. Program families and the reunified families in non-P.S. Program counties are shown in Table 14. Prior to the matching procedure, there were numerous significant differences between the two groups, which are noted in the table.

Table 14. Pre-match characteristics of P.S. Program and non-P.S. Program families

Variable	Categories	Pre-match comparison	
		Families enrolled in P.S. Program (N=285)	Reunified families in Non-P.S. counties (N=1079)
Child Gender	Female	44.2%	41.7%
	Male	55.8%	58.3%
Child Race/Ethnicity*	African American	27.0%	16.1%
	Other	9.8%	13.4%
	White	63.2%	70.5%
Child's age at reunification*	0 – 5 years	27.7%	24.3%
	6 – 10 years	25.3%	18.4%
	11 – 15 years	36.5%	36.3%
	16 years +	10.5%	21.0%
Child Disability*	Yes	54.7%	23.2%
Average # of days in care prior to reunification*		336.4	262.6
Number of placements prior to reunification*	1	32.3%	48.1%
	2 or more	67.7%	51.3%
Placement types experienced during most recent episode (categories not mutually exclusive)			
Foster Home*	Yes	60.0%	33.4%
Kinship	Yes	36.8%	36.2%
Shelter	Yes	12.3%	12.7%
Treatment Foster Home*	Yes	10.5%	6.1%
Group Home*	Yes	6.3%	10.9%

Residential Care Center, Hospital	Yes	13.3%	18.2%
Trial Reunification	Yes	13.7%	10.7%
Number of children* reunified	1	64.9%	73.7%
	2	19.0%	16.7%
	3 or more	16.1%	9.6%
Did family have an initial safety assessment at time of removal?*	Yes	80.0%	56.7%
Were there any safety threats identified at the time of removal?*	Yes	28.8%	17.2%
CPS investigation at time of entry into OHC?*	No CPS investigation at entry	6.7%	17.2%
	Substantiated CPS investigation	45.3%	37.5%
	Unsubstantiated CPS investigation	48.1%	45.3%
Prior CPS reports*	0	6.7%	17.2%
	1 – 2	42.1%	48.4%
	3 – 4	28.4%	19.3%
	5 or more	22.8%	15.2%
Prior screened-in service reports	0	44.2%	46.8%
	1	21.1%	18.2%
	2 or more	34.7%	35.0%
Was parent an alleged perpetrator in CPS report preceding entry?*	Yes	76.1%	64.6%
Family structure at removal*	Two parents/caregivers	29.1%	38.8%
	Single parent/caregiver	70.9%	61.2%
Reasons for removal (categories not mutually exclusive)*	Parent related issues	45.6%	36.2%
	Neglect*	55.8%	41.1%
	Abuse	16.1%	13.4%
	Child related issues*	21.8%	42.3%
	Parental alcohol problem	6.0%	5.1%
	Caregiver incarceration*	21.4%	12.1%

CANS Child/Youth life functioning*	Mean # of items marked 2 or 3	2.6	1.5
CANS Child/Youth trauma*	Mean # of items marked 2 or 3	1.3	0.6
CANS Identified permanent resource strengths & needs*	Mean # of items marked 2 or 3	3.4	1.9
CANS Child/Youth strengths*	Mean # of items marked 2 or 3	4.0	2.5
CANS Child/Youth behavioral emotional needs*	Mean # of items marked 2 or 3	1.4	0.8
CANS Child/Youth risk behaviors*	Mean # of items marked 2 or 3	0.7	0.4
CANS Child/Youth family & acculturation*	Mean # of items marked 2 or 3	0.4	0.2
CANS Child/Youth adjustment to trauma*	Mean # of items marked 2 or 3	0.7	0.3

* p < .05

3.1.2 PSM Procedures and Post-match Sample Characteristics

Since the P.S. Program is a family-level intervention, the PSM matching procedure was performed using the family as the unit of analysis. The first step of the matching process began by computing the RPM score for every reunifying child in families enrolled in the P.S. Program and in reunifying families in the balance of the state (excluding Milwaukee County). The child with the highest RPM score within each family was selected as the index child and his or her demographic and placement characteristics were used to compute the family's propensity score.

Next, the variables in Table 14 were entered as covariates into a logistic regression model to compute the probability of each family being in the P.S. Program (regardless of whether or not they actually were enrolled in the P.S. Program); this probability is the propensity score for the family. The matching procedure was run in STATA 13/PSMATCH2 using three different calipers: .05, .10, and .15. A caliper is the extent to which a matching propensity score (in this case, the non-P.S. family propensity score) is allowed to vary from the index case propensity score (in this case, the P.S. family propensity score). The caliper creates an interval defined as the index propensity score plus and minus the value of the caliper. For example, if a P.S. family has a propensity score of 0.43 and a caliper of .05 is used, a non-P.S. family would only be selected as a match for that family if their propensity score fell within the interval of 0.38-0.48. If more than one case fell within the caliper interval, the one closest to the index propensity score was

selected (i.e., the nearest neighbor). If there was more than one matching case with the same propensity score, one was randomly selected.

The matching procedure is done annually and has been done twice to date. The first matching procedure attempted to match the 104 families enrolled in the P.S. Program between February 2014 and November 2014 with one of the 473 reunified families in non-participating counties. The overall average propensity score for this group was .18 with a standard deviation of .196. The initial matching procedure was run with a caliper of .05, meaning that a matching propensity score could be plus or minus .05 of the index propensity score. Using that caliper, 93 out of the 104 families in the P.S. Program were successfully matched (89.4%). In order to maximize the number of cases with matches, the matching procedures were re-run using .10 and .15 calipers. The number of cases matched using these calipers were 96 and 100, respectively. The .15 caliper was used, meaning that successful matches were found for 100 of the 104 families enrolled in the P.S. Program between February and November 2014.

The matching procedure was performed a second time for the 181 families enrolled in the P.S. Program between December 1, 2014 and December 31, 2015, plus the 4 families enrolled during the prior period that could not be matched during the first matching procedure. The overall average propensity score for the second group was .22 with a standard deviation of .25. Using a .05 caliper, 129 of the 185 families in the P.S. Program were successfully matched (70.0%). To increase the number of families with matches, the procedure was re-run using .10 and .15 calipers, which increased the number of matched families to 134 and 141, respectively.

When the results of the two matching procedures are combined, 241 of the 285 families (85%) enrolled in the P.S. Program as of December 31, 2015 were successfully matched with reunified families in non-P.S. Program counties and 44 families (15%) were unable to be matched. Table 15 compares the demographic characteristics of the 241 families in the P.S. Program that were successfully matched, the 241 matched comparison families, and the 44 families in the P.S. Program that were unable to be successfully matched. After the matching procedure, there were no significant differences between the families in the P.S. Program and their matched comparisons, meaning that the PSM eliminated all of the differences between the groups that existed prior to the match (see Table 14). However, the 44 P.S. Program families that could not be matched were significantly different from the other families in the P.S. Program in several ways. The child with the highest RPM score in the unmatched families was more likely to be female, to have a disability, to have 2 or more placements prior to reunification, and had a higher number of actionable items on several CANS domains (child/youth life functioning, child/youth trauma, child/youth strengths, child/youth behavioral needs, child/youth risk behaviors, child/youth adjustment to trauma). The unmatched P.S. Program families likely represent a subset of the group at higher risk for re-entry into out of home care.

Table 15. Sample characteristics of matched and unmatched families in P.S. Program

		Matched		Unmatched
		Matched families enrolled in P.S. Program (n=241)	Matched families in Non-P.S. counties (n=241)	Unmatched families enrolled in P.S. Program (n=44)
Child Gender	Female	40.7%	44.0%	63.6%*
	Male	59.3%	56.0%	36.4%
Child Race	African American	25.7%	22.0%	34.1%
	Other	9.5%	10.8%	11.4%
	White	64.7%	67.2%	54.6%
Child's age at reunification	0 – 5 years	27.8%	26.1%	27.3%
	6 – 10 years	25.3%	23.7%	25.0%
	11 – 15 years	36.5%	39.0%	36.4%
	16 years +	10.4%	11.2%	11.4%
Child disability	Yes	51.0%	43.6%	75.0%*
Average # of days in care prior to reunification		320.8	307.6	422.0
Number of placements prior to reunification	1	35.7%	32.0%	13.6%*
	2 or more	64.3%	68.0%	86.4%*
Placement types experienced during most recent OHC episode (categories not mutually exclusive)				
Foster Home	Yes	58.9%	57.3%	65.9%
Kinship	Yes	34.9%	38.2%	47.7%
Shelter	Yes	12.9%	14.5%	9.1%
Treatment Foster Home	Yes	10.8%	9.5%	9.1%
Group Home	Yes	6.22%	11.2%	6.8%
RCC, Hospital	Yes	12.0%	12.9%	20.5%

Trial Reunification	Yes	13.7%	18.7%	13.6%
Number of children reunified	1	66.4%	67.2%	56.8%
	2	17.8%	17.4%	25.0%
	3 or more	15.4%	15.4%	18.2%
Initial safety assessment at time of removal?	Yes	78.4%	78.8%	88.6%
Any safety threats identified at the time of removal?	Yes	29.9%	27.8%	22.7%
CPS investigation at time of entry into OHC?	No CPS investigation at entry	7.5%	7.9%	2.3%
	Substantiated CPS investigation	43.2%	42.3%	56.8%
	Unsubstantiated CPS investigation	48.4%	49.8%	40.9%
Prior CPS reports	0	7.5%	7.9%	2.3%
	1 – 2	42.7%	44.8%	38.6%
	3 – 4	27.8%	26.1%	31.8%
	5 or more	22.0%	21.2%	27.3%
Prior screened-in service reports	0	44.8%	41.5%	40.9%
	1	22.0%	24.1%	15.9%
	2 or more	33.2%	34.4%	43.2%
Was parent an alleged perpetrator in CPS report preceding entry?	Yes	75.5%	75.1%	79.6%
Family structure at removal	Two parents	29.1%	31.5%	29.6%
	Single parent	71.0%	68.5%	70.4%

Reasons for removal (categories not mutually exclusive)	Parent related issues	45.2%	51.5%	47.7%
	Neglect	54.4%	54.8%	63.6%
	Abuse	14.9%	13.7%	22.7%
	Child related issues	22.4%	27.4%	18.2%
	Parental alcohol problem	5.4%	6.22%	9.1%
	Caregiver incarceration	20.8%	22.4%	25.0%
CANS Child/Youth life functioning	Mean # of items marked 2 or 3	2.4	2.1	3.8*
CANS Child/Youth trauma	Mean # of items marked 2 or 3	1.2	1.1	2.1*
CANS Identified permanent resource strengths & needs	Mean # of items marked 2 or 3	3.3	3.1	3.6
CANS Child/Youth strengths	Mean # of items marked 2 or 3	3.7	3.1	5.7*
CANS Child/Youth behavioral emotional needs	Mean # of items marked 2 or 3	1.3	1.1	2.1*
CANS Child/Youth risk behaviors	Mean # of items marked 2 or 3	.6	.6	1.2*
CANS Child/Youth family & acculturation	Mean # of items marked 2 or 3	0.4	0.4	0.5
CANS Child/Youth adjustment to trauma	Mean # of items marked 2 or 3	0.7	.6	1.1*

3.2 Data Sources and Data Collection

In order to measure the short-term, intermediate, and long-term outcomes included in the logic model, data are being collected from multiple sources.

1. The follow-up parent survey contains measures of parent engagement, parent stress, parent coping skills, social support, positive family functioning, family self-sufficiency, and child behavior problems.
2. The child welfare administrative database (eWiSACWIS) is being used to gather information on maltreatment recurrence and re-entry into out of home care during the 12-month post-reunification period.
3. Caseworkers complete the CANS assessment at three time points for families enrolled in the P.S. Program: within 30 days prior to reunification, 6 months after reunification, and within 30 days prior to case closure. Comparison of CANS assessment data over time will allow us to measure change in several child outcomes, including trauma exposure, social and emotional functioning, and behavioral functioning. Post-reunification CANS data is not available for families not enrolled in the P.S. Program.
4. Data on child educational outcomes will be obtained from the Department of Public Instruction (DPI) through a data-sharing agreement with DCF.
5. Data on child health outcomes will be obtained from the Department of Health Services (DHS) through a data-sharing agreement with DCF.

The only outcome data that were available for analysis in the Interim Evaluation Report were child welfare administrative data related to maltreatment recurrence and re-entry into out of home care. The data from DPI and DHS have not yet been shared with the evaluators, and post-reunification CANS data for families enrolled in the P.S. Program were not available for analysis. Data from the follow-up parent surveys were available; however, the very low response rate prohibited data analysis at this time (see Chapter 1 for additional discussion of the parent survey response rate).

3.3 Data Analysis and Results

Child welfare administrative data from eWiSACWIS were used to compute three outcome measures:

1. A *maltreatment re-report* was defined as a screened-in CPS report on any child in the family that occurred between the reunification date and 365 days after the reunification date, regardless of the finding of the report.
2. A *substantiated maltreatment re-report* was defined as a screened-in and substantiated CPS report on any child in the family that occurred between the reunification date and 365 days after the reunification date.
3. A *re-entry* into out of home care was defined as the entry of any child in the family into out of home care that occurred between the reunification date and 365 days after the reunification date.

In order to allow families to be observed for a 12-month post-reunification period, the sample used for these analyses included families reunified in the first year of the project (between February 1 and December 31, 2014). The percentages of families in the treatment and comparison groups that experienced maltreatment re-reports, substantiated re-reports, and re-entries into out of home care during the 12-month post-reunification period are shown in Table 16. The differences between the two groups were not significant on any of the three outcomes.⁴²

Table 16. Percentage of families with re-reports, substantiated re-reports, and re-entries

	P.S. Program (n=112)		Non-P.S. Program (n=112)	
	N	%	N	%
re-reported within 12 months	14	12.5%	15	13.4%
re-reported and substantiated within 12 months	2	1.8%	4	3.6%
re-entry within 12 months	22	19.6%	26	23.2%

3.4 Outcome Evaluation Discussion and Limitations

Unfortunately, the lack of parent survey data prevented us from testing the impact of the P.S. Program on the short-term and intermediate outcomes in the logic model: family engagement; parent stress and coping; social support; family functioning; family self-sufficiency; child trauma exposure; and child emotional, behavioral and social functioning. This means that at this point we cannot assess the direct effect of the P.S. Program on families. We were, however, able to test the impact of the P.S. Program on distal outcomes by comparing rates of maltreatment recurrence and re-entry into out of home care between families the received the P.S. Program (the treatment group) and a matched comparison group of families that did not receive services through the P.S. Program.

Although families in the P.S. Program sample had slightly smaller rates of re-reports, substantiated re-reports, and re-entries into out of home care compared to matched families who did not receive P.S. Program services, the size of the statistical effects is small and the differences are not statistically significant. These results do not provide adequate empirical support for concluding that the P.S. Program had a positive impact on these outcomes. It is not likely these null findings can be attributed to the sample size being too small. If there were

⁴² In a separate analysis, we compared the outcomes of three groups: 1) matched P.S. Program families (n=112), 2) matched non-P.S. Program families (n=112), and 3) unmatched P.S. Program families (n=13). There were no significant differences between the three groups on any of the outcomes.

truly a reasonably noticeable difference on these outcomes in all P.S. and comparison cases across Wisconsin, statisticians would call this a *medium effect size*. This has been described as “an effect likely to be visible to the naked eye of a careful observer.”⁴³ Research reviews have found that published results in various fields have a medium effect size on average.⁴⁴ We conducted a statistical power analysis for a medium effect size and the sample size of 224 for the two matched groups.⁴⁵ This analysis revealed that the probability of getting a statistically significant result exceeded 99% if the difference between groups truly had a medium effect size. Thus, if there truly had been a reasonably noticeable difference on outcomes between the treatment and comparison groups, we almost certainly would have detected it. The slight difference in outcomes between the two groups that was found might represent a true but small, hard to detect, difference between the groups statewide. However, for the comparison to be statistically significant with a small effect size, we would have needed a sample size around 785.⁴⁶

Below we examine a number of possible explanations for the lack of difference on outcomes between the treatment and comparison groups. Several could be operating at once; few are mutually exclusive.

Formative Stage of the P.S. Program. The outcome data analyzed in this chapter came from families enrolled in the P.S. Program in 2014, the first year of implementation. The first year of a program is a challenging time to apply a so-called *outcomes-based accountability* lens to a program.⁴⁷ A program is still fine-tuning its practice and working on implementation issues in its first year, and may be less ready for an outcome evaluation than later in its development. That is the reasoning behind the dictum “evaluate no program until it is proud” of the dean of evaluation research, Donald Campbell.⁴⁸ It also informed Jacobs’ influential “five-tiered approach to evaluation,” in which program evaluation methods with lesser to greater attention to outcomes are pegged to the developmental stage of the program. One particular difference between the first year and later years was the version of the RPM used. As discussed above, the original RPM had noticeable limitations, and many county professionals complained that it was not identifying children who in their judgment should have been eligible for the program. It is possible that the children enrolled in the P.S. Program in the first year were not as representative of the target population as intended, and this may have affected outcomes. Stakeholders should take to heart the fact that this is an interim evaluation report focused on early cases in the program, and outcomes may look different later in the program.

⁴³ Cohen, J. (1992). A power primer. *Psychological Bulletin*, 112, 155-159, p. 155

⁴⁴ Cohen, *ibid*

⁴⁵ We used Excel add-on software available from www.real-statistics.com

⁴⁶ Cohen, *ibid*

⁴⁷ Jacobs, F. (2003). Child and family program evaluation: Learning to enjoy complexity. *Applied Developmental Science*, 7, 62–75.

⁴⁸ Campbell, D. (1987). Problems for the experimenting society in the interface between evaluation and service providers. In S. Kagan, D. Powell, B. Weissbourd, & E. Zigler (Eds.), *America's Family Support Programs* (pp. 345-351). New Haven, CT: Yale University Press.

Comparable Services in the Comparison Group. Monthly Family Service Report (MFSR) data was only collected for families enrolled in the P.S. Program; we do not know what services and supports families in the comparison sample received. The lack of parent survey data limited us here too, because the parent survey included questions about services received. In our site visits to the P.S. Program counties, we learned that agencies sometimes provided families with post-reunification services even before the P.S. Program began. Also, sometimes courts ordered post-reunification services for families. It is possible that families in the comparison group received services and supports at comparable rates to those in the treatment group, which may have minimized any differences in outcomes between them. Supplementing data collection in the comparison counties in the remainder of the program evaluation will help us assess service delivery and its relationship to the distal outcomes.

Possible Pre-Existing County Differences. It is possible that counties that implemented the P.S. Program in Year One differed in systematic ways from those that did not implement the program, and that these differences may have affected outcomes. Counties that chose to participate in the P.S. Program may have been motivated by high re-reporting and/or re-entry rates, while counties that declined to participate may have had lower re-reporting and re-entry rates. *If such pre-existing differences existed*, they may have put P.S. Program counties at a disadvantage in the outcome analysis compared to non-P.S. Program counties, because pre-existing differences may have obscured gains made by the P.S. Program counties. In this scenario, reductions in re-reporting and re-entry in P.S. Program counties may have simply brought them to roughly the same level as the comparison counties. Analysis of re-reporting and re-entry rates in the participating and non-participating counties both before and after the start of the P.S. Program could help to assess whether county differences are a plausible explanation for the outcome results.

Surveillance Effect. Re-reporting and re-entry often result from professionals engaged with a family noticing a problem, reporting it, and taking action to address it. Families involved with the P.S. Program may have more contact with professionals because of the hours of case management and number of services they receive. While it is possible that comparison families have comparable contact (see above), they may also have significantly less. A family enrolled in the P.S. Program having a problem may be more likely to experience a report and/or re-entry because of this so-called *surveillance effect*. This will drive up re-reporting and re-entry rates even in effective programs. Chaffin and Bard's research suggests that surveillance can introduce a significant bias when a large proportion of families stay in the program and maintain contact over the entire follow-up period, both of which apply to the P.S. Program.⁴⁹

Social and Historical Changes. Change in social and historical factors or changes in policy or practice may influence the likelihood of different outcomes for families with reunified children, including re-reporting and re-entry. For example, Wisconsin, like many states has experienced a

⁴⁹Chaffin, M. & Bard, D. (2006). Impact of intervention surveillance bias on analyses of child welfare report outcomes. *Child Maltreatment*, 11, 301-312,

significant increase in opioid abuse in recent years.⁵⁰ Some studies have found that parental substance abuse is a significant risk factor for re-entry.⁵¹ Although we would expect that they would affect the treatment and comparison groups equally, social and historical changes may make it more difficult to achieve outcomes, which might mitigate the effect of the P.S. Program.

Quality and Effectiveness of Services. Effective services and supports are needed to address many of the risk factors for re-entry, such as parental substance abuse, deficits in parental skills, and lack of social support.⁵² These risk factors can be difficult to change and ideally are best addressed by well-trained professionals using empirically supported interventions. Analysis of the MFSR data shows that families enrolled in the P.S. Program typically receive multiple services and supports. But we lack data on how well the service plan matches families' needs, and whether the quality and effectiveness of the services and supports provided are sufficient to address risk factors for re-reporting and re-entry. One gap stems from the lack of the parent survey data, which would have assessed whether treatment and comparison families differed on measures of service receipt, support, functioning, and well-being.

⁵⁰ Wisconsin Department of Health Services, Division of Substance Abuse and Mental Health Services (2015). *Misuse and abuse of opioids in Wisconsin*. Retrieved from <https://www.dhs.wisconsin.gov/publications/p01127.pdf>

⁵¹ Kimberlin, S.E., Anthony, E.K., Austin, M.J. (2009) Re-entering foster care: Trends, evidence, and implications *Children and Youth Services Review*, 31, 471-481. Shaw, T.V. & Webster, D. (2011). A matter of time: The importance of tracking reentry into foster care beyond one year after reunification. *Journal of Public Child Welfare*, 5, 501-520. Terling, T. (1999). The efficacy of family reunification practices: Reentry rates and correlates of reentry for abused and neglected children reunited with their families. *Child Abuse & Neglect*, 2, 1359-1370.

⁵² Kimberlin et al., *ibid*, Terling, *ibid*, Festinger, T. (1994). *Returning to care: Discharge and reentry to foster care*. Washington, DC: Child Welfare League of America. Wells, M. & Correia, M. (2011). Reentry into out-of-home care: Implications of child welfare workers' assessments of risk and safety. *Social Work Research*, 36, 181-195

Chapter 4: Summary, Lessons Learned, and Next Steps

The Wisconsin Department of Children and Families (DCF) implemented the Post-Reunification Support (P.S.) Program in 35 counties throughout the state in April 2014. The P.S. Program seeks to promote family stability following a child’s reunification; empower parents to strengthen caregiving, problem-solving, and coping skills; improve the short- and long-term well-being of the child and his or her family members; and reduce the likelihood of child maltreatment recurrence and re-entry into out of home care. To accomplish these goals, P.S. Program caseworkers engage family members during frequent face-to-face meetings in order to assess their needs, develop an individualized case plan and goals, and provide formal services and enhance informal supports. County agencies receive a monthly case rate (\$1100 per enrolled child) to cover costs associated with the continued child welfare case management and services.

The evaluation of the P.S. Program consists of three components: a process evaluation, an outcome evaluation, and a cost analysis. Using a matched comparison group design,⁵³ the outcome evaluation examines whether receipt of P.S. Program services is associated with reduced rates of maltreatment recurrence and re-entry into out-of-home care, while the process evaluation provides a better understanding of how the intervention worked and for whom. A cost analysis will compare the costs associated with the P.S. Program and those in the comparison group (i.e., “treatment as usual”) during the initial 12-month post-reunification period. The evaluation will answer these research questions:

1. What contextual factors influenced the implementation of the P.S. Program? How was each of the core implementation components described in the NIRN framework addressed during the P.S. Program implementation process? [Process Evaluation]
2. To what degree are the core components of the P.S. Program (case management, individualized case planning, and linkage to community supports) implemented as delineated in the practice model? [Process Evaluation]
3. Are reunified children who receive the P.S. Program less likely to experience maltreatment recurrence than children who do not receive the P.S. Program? [Outcome Evaluation]
4. Are reunified children who receive the P.S. Program less likely to experience re-entry into out-of-home care than children who do not receive the P.S. Program? [Outcome Evaluation]
5. Do reunified children who receive the P.S. Program have more positive educational outcomes than children who do not receive the P.S. Program? [Outcome Evaluation]

⁵³ The impact of the Post Permanency Support program that was implemented in the Bureau of Milwaukee Child Welfare (BMCW) in 2012 is being evaluated separately, through the use of an interrupted time series (ITS) analysis that examines maltreatment recurrence and re-entry into out of home care before and after program implementation.

6. Do reunified children who receive the P.S. Program have more positive health outcomes than children who do not receive the P.S. Program? [Outcome Evaluation]
7. Do reunified children who receive the P.S. Program demonstrate reductions in trauma exposure, social and emotional functioning, and behavioral functioning over time? [Outcome Evaluation]
8. Are expenditures for the P.S. Program offset by reductions in out-of-home care expenditures, resulting in overall child welfare spending that does not exceed the allowable computable dollar schedule listed in Wisconsin's Waiver Terms and Conditions? [Cost Analysis]

This interim evaluation report describes the results of the data collection and analysis to date, including:

- Site visits conducted in several counties that implemented the P.S. Program. During each site visit, existing program documents were reviewed and focus groups were conducted with caseworkers, supervisors, and child welfare managers. In addition, interviews were conducted with DCF administrators and key program stakeholders who were involved in the development and implementation of the P.S. Program.
- Detailed data about the monthly services provided to the families in the P.S. Program were gathered from caseworkers via an online report known as the Monthly Family Service Report. For each family enrolled in the program, caseworkers report the services the family received or needed but did not receive, the amount of each service received, the service recipient(s), and the service provider. For each service that was needed but not received, information was collected about the reasons.
- Parent surveys were distributed about a month prior to reunification and about 12 months after reunification. Both surveys contain measures of parent engagement with the caseworker, parent stress, family resources, social support, and family functioning. The follow-up survey also contains a measure of service provision during the 12-month post-reunification period. Unfortunately, very low response rates for the follow-up survey prevented us from analyzing the parent survey data for this report.
- Administrative data from Wisconsin's child welfare administrative database, known as eWiSACWIS, were collected to determine which families experienced maltreatment recurrence or re-entry into out-of-home care during the 12-month post-reunification period.

Data collection and analysis for the other components of the evaluation, including the cost analysis and the interrupted time series analysis of outcome data in BMCW, will occur in late 2016 and 2017.

4.1 Summary of Interim Findings

The data collected and analyzed thus far provide preliminary answers to the first four research questions listed above. The findings of the evaluation suggest several areas for potential improvement in both practice and data collection, which are discussed in the following section.

4.1.1 P.S. Program Implementation

The P.S. Program was implemented in 35 Wisconsin counties between January and April 2014. A tremendous amount of effort by a large variety of stakeholders was put into the development and implementation of the P.S. Program, and the county caseworkers, supervisors, and managers that were interviewed during the site visits all expressed a firm commitment to the program's philosophy and practice. Because of the voluntary nature of the program and the opportunities to use the flexible funding to support families in new ways, many who were interviewed expressed that the program allowed them to truly partner with families to do "real social work" that "didn't have to be this narrow and prescribed list of services."

However, the implementation of a new program is never without challenges, and the initial implementation stage is often the most fragile period of implementation, as front-line practitioners attempt to incorporate new rules, procedures, and practices into their day-to-day work in the context of their organizational environment. One area that many P.S. Program stakeholders felt needed to be bolstered was caseworker and supervisor training. DCF currently requires all case managers and supervisors to complete pre-service and foundation courses within the first two years of employment. The foundation training covers a variety of aspects of case management, including safety assessment, family engagement, and interviewing. In addition to these required trainings, there are trainings in special skills that staff may choose to take to enhance their individual skills. During the program installation stage, members of the P.S. Program Steering Committee decided not to require additional training modules for case managers or supervisors prior to program implementation, thinking that current ongoing case manager training was sufficient. Instead, county supervisors were invited to attend several information webinars that provided information on the new P.S. Program case management and documentation requirements.

Many of the case managers and supervisors we spoke with expressed a strong desire for additional training related specifically to case management skills needed in the pre-reunification and post-reunification phase, including safety management once the children return home, helping parents manage their emotions and behaviors, and dealing with unexpected stressors that can upset the delicate family balance after the child returns home. Some workers mentioned the usefulness of the trauma-informed practice curricula, but this is currently not a required training for all ongoing case management staff. In addition, several county staff described ongoing areas of confusion related to completing the CANS assessment, which highlights the need for additional training. Finally, although this varied by county, workers still expressed uncertainty about some of the basic elements of the P.S. Program

requirements, such as the types of services that could and could not be purchased with P.S. Program funds.

Effective teaming structures and communication strategies are critical for implementation success.⁵⁴ One of the most consistent themes that emerged from each of the site visits was the desire for increased levels of communication from DCF to the counties regarding the P.S. Program. Many case managers and supervisors felt as if they were not provided with enough guidance about the details of the P.S. program during the initial implementation, and were left to figure things out for themselves. Although staff were able to get answers to specific questions by reaching out to the P.S. Program Coordinator and praised his responsiveness, not all county staff took the initiative to reach out to get answers. This sometimes led to situations in which staff were working under incorrect assumptions and implementing certain program requirements incorrectly. Additional communication and opportunities for networking among county staff (described in more detail below) are recommended.

4.1.2 P.S. Program Fidelity

When a child returns home after living in out of home care, the period of time following reunification is crucial as the child reintegrates into the family. The goal of the P.S. Program is to support parents and their children as they navigate this transition by assessing and understanding their needs, providing services to meet those needs, and helping them develop informal networks of support to draw on after formal services end. Using a combination of qualitative and quantitative data, the evaluation examined how caseworkers have implemented the core components of the P.S. Program, including assessment and case planning, case management, and service provision. The results suggest that around three-quarters of families in the program had a strengths and needs assessment prior to enrollment in the program and 80% had an initial case plan. Caseworkers spent a considerable amount of time working with families each month – six hours on average and 13 hours or more for a sizable portion of families (16%). Service provision is a critical part of the program, and findings of the evaluation reveal that families received a wide assortment of both traditional and non-traditional services during the post-reunification period. Families received an average of seven different services each month and 12 services over the course their enrollment in the P.S. Program. The most commonly received services were economic support (64.1%), home management (61.2%), individual therapy (58.5%), parent mentoring or classes (55.0%), and transportation (46.5%). Social support was a vital component of the program (44.6%), and was most often provided to families by informal sources such as family, friends, and clergy. Not all services that families needed were readily available; families had an average of two services that were needed but not received. The two services that were most often needed but not received were individual therapy (8.5%) and family therapy (7.7%).

⁵⁴ Permanency Innovations Initiative Training and Technical Assistance Project. (2016). *The development, implementation, and assessment approach*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

4.1.3 Maltreatment Recurrence and Re-entry into Out of Home Care

The goal of the P.S. Program is to reduce maltreatment recurrence and re-entry into out of home care during the 12-month post-reunification period. Results of the outcome analyses indicated that to date, there were no significant differences between families enrolled in the P.S. Program and their matched counterparts who did not receive P.S. Program services in either the rate of maltreatment recurrence or re-entry into out of home care. There are a number of plausible explanations for these findings, including the possibility that families in the comparison group are receiving post-reunification services and supports at rates similar to those in the treatment group. Additional data will be collected to rule out this alternative hypothesis.

4.2 Lessons Learned from the Interim Findings

4.2.1 Recommendations for Implementation

The information provided by the front-line case managers, supervisors, and managers in November 2014, as well as the empirical research on program implementation, suggested opportunities for improvement in the P.S. Program implementation process. One clear need that emerged in the site visits was additional training for workers and supervisors implementing the P.S. Program. Workers expressed the need to enhance skills and gain clarity about the P.S. Program. The site visit report therefore recommended the provision of training related to the case management skills that are unique to the pre- and post-reunification period. A second recommendation was the development of a P.S. Program manual. As discussed above, DCF has provided a number of training and peer-to-peer opportunities after we conducted our site visits in November 2014. While it has not produced a program manual *per se*, it has expanded the information available on the P.S. Program website. We recommend that DCF continue to provide training opportunities for P.S. Program staff. Periodic assessments should gauge current and emerging needs for training and whether current training opportunities are meeting workers' needs. DCF should also assess whether current informational material adequately address workers' needs for information on the program.

During the site visits, county staff expressed a strong desire to learn how other counties were implementing the P.S. Program and what approaches were most effective. In the site visit report, we recommended that peer-to-peer learning opportunities be offered to the Year One and Two P.S. Program staff, as well as new counties implementing the P.S. Program in Year Three. Since then, DCF has facilitated several peer-to-peer learning opportunities, including a dedicated P.S. Program Summit for professionals involved in the program and regional supervisor meetings. Finally, the site visit report highlighted the importance of additional ongoing outreach from DCF to external stakeholders, especially judges, attorneys, and guardians ad litem.

4.2.2 Recommendations for the Evaluation

The findings from the interim evaluation also highlight two areas where data collection procedures need to be modified or supplemented. The response rates for the parent survey have been lower than expected, particularly among families in the comparison group (see Table 17). Baseline surveys are distributed by the caseworker at the last family team meeting prior to reunification and the low response rate among the comparison group families leads us to believe that caseworkers in non-P.S. Program counties are not distributing surveys to families as required. The follow-up surveys are mailed to families around 12 months after reunification, and families in the comparison group, who have not received P.S. Program services, have very little motivation at that point to complete a mail survey, other than the incentive payment.

Table 17. Baseline and follow-up parent survey response rates

Surveys Received					
Baseline Surveys Received			Follow-up Surveys Received		
	N	%		N	%
Treatment Group (n=241)	122	50.6%	Treatment Group (n=112)	28	25.0%
Comparison Group (n=241)	48	19.9%	Comparison Group (n=112)	12	10.7%

The follow-up parent survey contains several measures of the short-term and intermediate outcomes of interest in the evaluation, including parent engagement, parent stress and coping, social support, positive family functioning, family self-sufficiency, and child behavior. It is therefore critical to the evaluation to collect follow-up survey data from families, especially those families that are included in the matched samples. In order to increase the response rate, we will be revising the data collection procedures for the follow-up survey from a mail survey to a telephone survey, and will increase the incentive for participation.

The second lesson learned from data collection thus far has been the need to collect information about post-reunification service provision in counties that have not implemented the P.S. Program. During the site visit data collection, focus group participants mentioned that some families receive post-reunification services for a few months, usually under a court-order, even if they are not enrolled in the P.S. Program. Child welfare services in Wisconsin are county-administered, so the extent of post-reunification service provision varies widely. Additional information is needed about post-reunification service provision in counties that have not yet implemented the P.S. Program in order to rule out the possibility that the treatment and comparison conditions are more similar than expected. A survey on post-reunification services in non-participating counties is being developed for distribution to county managers. County data will be explored to assess whether pre-existing differences between P.S. and non-P.S. Program counties may account for results on outcomes.

4.3 Next Steps

Data collection for the process and outcome evaluations and cost analysis will continue as outlined in the evaluation plan and timeline. Specifically, the following data collection and analysis activities will occur:

- A second round of site visits in counties that have implemented the P.S. Program will occur during the summer of 2016. In each site visit, qualitative data will be collected from county child welfare caseworkers, supervisors, and managers involved in the P.S. Program, as well as DCF administrators and other key individuals involved in the ongoing implementation of the program. Information will be collected about the implementation process and specific areas of P.S. Program practice.
- A third round of site visits in counties that have implemented the P.S. Program will occur in the spring of 2018.
- MFSR data will continue to be collected until May 2018
- Information from the child welfare administrative data base (eWiSACWIS) will be collected on a quarterly basis.
- Pre- and post-reunification CANS data on families enrolled in the P.S. Program will be obtained from DCF on a regular basis.
- Child health outcome data will be obtained from the Department of Health Services starting in December 2016 and will continue through May 2018
- Child education outcome data will be obtained from the Department of Public Instruction starting in December 2016 and will continue May 2018
- Parent survey data will continue to be collected. Pending IRB approval, the data collection method for the follow-up parent survey will switch from a mail survey to a telephone survey in an effort to increase response rates.
- A survey of post-reunification services in counties that have not implemented the P.S. Program will be developed and implemented in 2016.
- Administrative data from the DMCPS will be collected and analyzed to examine the impact of the Post-Permanency Support program on maltreatment recurrence and re-entry into out of home care.
- Cost data will be collected and analyzed in 2017.