Protect MiFamily Interim Report

MDHHS Michigan Department of Health & Human Services

Westat

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A IV-E Waiver Demonstration Project authorized by Section 1130 of the Social Security Act, as amended by Public Law (P.L.) 112-34.

This report was prepared for MDHHS by Westat.

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Executive Summary

The goal of Protect MiFamily, Michigan IV-E Waiver Demonstration Project is to test the hypothesis that an array of intensive and innovative home-based family preservation services tailored to the needs of individual families that have had contact with Children's Protective Services due to child abuse/neglect allegations will:

1. Prevent the incidence and recurrence of maltreatment.
2. Reduce the number of children who enter out-of-home placement.
3. Improve child safety and increase parental protective factors.
4. Improve family and child well-being.
5. Be cost effective and cost neutral.

The evaluation will determine whether families who receive the Protect MiFamily (PMF) services achieve better outcomes than those who do not receive these services, as well as answer the following questions: Which families benefited most from the Protect MiFamily service delivery model? Why? Which services or program components were most effective with regards to safety, permanency and well-being? How might the State of Michigan modify the Protect MiFamily service delivery model to achieve better outcomes?

The evaluation team will examine the following major research questions:

1. Is the duration and intensity of engagement and service intervention based on the family's identified needs? How does the Protect MiFamily intervention service regimen address family needs as compared to "services as usual" provided to control families?
2. Are the agencies providing and managing services to effectively engage the families, coordinating meaningful and effective services, and developing community relationships that ensure available and accessible services to meet the families' needs? How does the provision, accessibility and availability of waiver intervention services compare to the provision, accessibility and availability of services to control families?
3. Are families demonstrating increased capacity to safely care for their children, experiencing improved social and emotional well-being and less likely to experience subsequent maltreatment or out-of-home placement? How do measures of safety, permanency and well-being for children receiving waiver intervention services compare to measures of safety, permanency, and well-being for children in the control group?
4. Is spending for investigations and out-of-home care decreasing while spending for supportive evidence-based services to maintain children safely in their own home increasing?

5. Are the Protect MiFamily waiver intervention services cost-effective and commensurate with the outcomes achieved? Does the cost of waiver intervention services effectively demonstrate better outcomes of safety, permanency and well-being as compared to the outcomes demonstrated through "services as usual?"

Major Findings from the Evaluation

As for the analyses performed on program data received from August 1, 2013, through November 30, 2015, the evaluation reports the following major findings.

Process Evaluation Findings

Interviews and Focus Groups

- A significantly lower rate of referral to community services than expected. The low rate of referral to community services presents challenges to the success of Protect MiFamily because a core element of the Protect MiFamily model is to connect families with community services and supports that can sustain their progress and well-being after they leave Protect MiFamily. The low rate of referral may be due to Protect MiFamily staff providing most services (mainly psycho-educational) themselves in the home. Referrals are primarily used for clinical services (substance abuse treatment, mental health) that require specialized professional or certified providers. The low rate of referral to community services is also influenced by client reluctance to go, transportation or scheduling barriers, service availability, and the cost of outside services.
- Service availability remains a significant barrier, particularly mental health, temporary shelter, and affordable housing.
- Nearly one third of Protect MiFamily cases close before families complete the full 15 months. Protect MiFamily staff reported the major factors as: CPS removed the child(ren) from the home; change of custody; family moved to a different county, often due to housing crises; family declined further services; or, family became non-responsive to worker contact attempts for more than 30 days.
- Collaboration between CPS staff employed by MDHHS offices and Protect MiFamily staff employed by partner agencies faces significant challenges; however, successful CPS and Protect MiFamily staff teaming has occurred in several areas.
- Both MDHHS and the partner agencies have begun positive steps toward greater communication.
- Staff turnover is high in all three sites. Staff turnover in both Protect MiFamily and CPS causes breakdowns in collaboration.
- Hiring qualified candidates in a timely manner is a challenge stemming from competition from other programs as well as the entry level salary offered by Protect MiFamily.

Model Fidelity

- Though fidelity scores have fluctuated during the evaluation, item-level model fidelity data continues to document challenges with adherence to contact standards. These challenges are partly attributable to issues outside of the control of partner provider staff. For example, model fidelity data collectors frequently note that partner provider staff only miss one contact (e.g. missed the required face to face contact during one week), and the missed contact can be due to family cancellations or refusal to meet.
- Item-level model fidelity data also confirms strengths in service delivery, such as partner agency staff consistently addressing the Waiver Safety Assessment Plan during their contact with families, staff completing required progress reports on time in Phases 2 and 3, and staff convening Family Team Meetings (FTM) on time (meetings that include the family, Protect MiFamily staff and anyone the family chooses to invite to discuss case progress).

Family Satisfaction

Data from the Family Satisfaction Survey has consistently shown high satisfaction with the program.

- Protect MiFamily Phase 1 survey results continue to suggest that overall satisfaction with program services is positive, with over 91% either agreeing or strongly agreeing that their family was getting the services they need and that they know how to contact other agencies to get their needs met.
- Protect MiFamily Phase 2 results also show high program satisfaction, with over 95% either agreeing or strongly agreeing that their family was getting needed services and nearly 98% indicating that they know how to contact other agencies to get their needs met.
- Protect MiFamily Phase 3 respondents also indicated high satisfaction with over 97% either agreeing or strongly agreeing that their family was getting needed services and over 94% indicating that they know how to contact other agencies to get their needs met.

Outcome Evaluation Findings

The outcome evaluation follows the original evaluation plan and evaluation design submitted by Westat prior to the start of Protect MiFamily. Our analyses compare all the control and treatment group families, regardless of their level of participation or compliance in services. This approach to evaluation is commonly referred to as intent *to treat* design. That is, families are randomly assigned and their outcomes are monitored regardless of the services they receive.

Removal from the Biological Family Home

- Overall, 13.3% of families experienced the removal of at least one child from the biological family home. The risk of removal varies somewhat by county.

- On average, children were removed from the biological family home at 189 days from the date of random assignment. There was no difference when comparing the time to removal between the treatment and control groups.

- Children in the treatment group whose families received the full dose of Protect MiFamily (i.e. completed all three phases of PMF), were significantly less likely (4.6%) to be removed from the biological family home as compared with children in the control group (10.8%). This finding suggests that families are more likely to remain together when families are capable of completing Protect MiFamily services.

Children whose families received the full dose of Protect MiFamily were significantly less likely (4.6%) to be removed from the biological family home.

- On average, there were no statistically significant differences when comparing the control (220 days) and treatment (177 days) groups in terms of time to removal from the family home (i.e. number of days between random assignment and first child removal).

Maltreatment Recurrence

- Overall, 23.3% of the families were associated with at least one subsequent allegation of maltreatment (category I, II or III). There were no statistically significant differences between the control and treatment group.

- On average, children were exposed to a subsequent and substantiated report of maltreatment at approximately 37 days. There was no difference when comparing the time to subsequent maltreatment between the treatment and control groups.

- When comparing the treatment families that completed all three phases –the Protect MiFamily full dose – with the families that were in the control group, there was no significant difference with regard to subsequent maltreatment.

Risk Assessment

- With regards to risk assessment, there were no cases initially classified as low or moderate risk. The vast majority of cases decreased in risk over time. For example, of the cases that started out as "high risk" – 75% moved to "low risk" and 19% moved to "moderate risk" by the time of re-assessment. Similarly, of the cases that opened at "intensive risk" – 63% moved to low risk and 26% moved to moderate risk. There were no statistically significant differences when comparing changes in risk over time between the control and treatment groups.

- Big effects were observed in the relationship between changes in risk assessment scores and subsequent removals and substantiated reports of maltreatment. Specifically, the risk of removal and maltreatment were significantly decreased when family risk levels

were improved (e.g. family moving from high risk to low risk). Fifty-four percent of families that experienced no change in risk scores had at least one child removed from the biological family home. In comparison, only 9% of families experienced a child removal when their risk score improved. With regard to subsequent maltreatment, 43% of families with no improvement in risk score were associated with subsequent maltreatment – as compared to only 22% of families that experienced at least some improvement in risk score.

Child Well-Being

- Overall, 30% of children who completed Protect MiFamily had statistically significant improvement in their well-being based on the Devereux Early Childhood Assessment Total Protective Factors score.

Overall, 30% of children who completed Protect MiFamily had statistically significant improvement in their well-being.

- The Devereux Early Childhood Assessment findings indicate that 30% of children showed statistically significant improvement in well-being at the post-assessment and about 42% of children whose pre-test behavior indicated "Area of Need" or "Typical" showed improvement in behavior at the post-test.

Protective Factors

- Families who completed Protect MiFamily showed improvement in protective factors between the pre-survey and post-survey.

Families who completed Protect MiFamily showed improvement in protective factors between the pre-survey and post-survey.

- Overall, families who completed Protect MiFamily showed statistically significant improvement on three of the four Protective Factors Survey subscales and on three of the five Knowledge of Parenting/Child Development items.

Cost Evaluation Findings

Cost data is very preliminary; therefore, no major findings can be reported at this time.

Changes to the Proposed Demonstration and Evaluation Plan

No major changes have been made to the demonstration or the evaluation since the initial design of the demonstration and the evaluation plan approved by the U.S. Department of Health and Human Services, Children's Bureau.

I. Introduction and Overview

Background and Context

For several years prior to the waiver, Michigan fell short of the national average on key measures related to child safety. The Child and Family Services Review noted that Michigan needed to improve in the area of repeat maltreatment and services to protect children in the home. The Child and Family Services Review concluded that Michigan's lack of prevention services contributed to recurrent maltreatment; it also noted that children remaining in their own homes continued to be at risk either because services were not provided or the services provided did not target key safety concerns.

Purpose of the Waiver Demonstration

Michigan's Title IV-E Child Welfare Waiver Demonstration, called "Protect MiFamily," seeks to enhance the safety and explicitly improve the well-being of children and families by providing an innovative array of prevention services to families with young children who are at high or intensive risk for maltreatment as determined by Children's Protective Services (CPS) following allegations of abuse or neglect. The Michigan Department of Health and Human Services (MDHHS) offers prevention programs and family preservation services, but none contain the combination of evidence-based interventions or resemble the characteristics of those services delivered in the waiver demonstration project. The Michigan DHHS sought federal approval for a Title IV-E Waiver to provide funding for prevention services for the following reasons:

- To fill a gap in prevention and preservation services to meet the complex needs of families that require longer-term intensive interventions and services to make sustainable progress.
- To decrease overrepresentation of young children in foster care. Statistical trends indicate that Michigan needs to do more to effectively support families with very young children to prevent abuse and neglect and entry into foster care.
- To remedy Michigan's high rate of maltreatment victimization and recidivism, particularly among the younger children.
- To allow the State to align federal funding with the Michigan child welfare priorities through the use of Title IV-E funds to incentivize prevention and preservation services as well as community supports to keep children safely in their own homes and improve family functioning, well-being, and independence.
- To improve the State's performance on the Child and Family Services Review.

The waiver demonstration, Protect MiFamily (PMF), expands the secondary and tertiary prevention service array provided to families with young children determined by CPS to be at high or intensive risk for maltreatment. Specifically, Protect MiFamily fills a service gap for families that require longer-term, more risk-specific interventions to prevent maltreatment and

removal of children from home. The intensity and duration of family engagement is based on the family's needs and progress as determined by risk and safety assessments and re-assessments, measures of child trauma and child development, progress reports from treatment providers, and continuous concrete measures of improved child and family functioning, and caregiver protective factors.

The Protect MiFamily project was designed to increase child safety, strengthen parental capacity, and improve child well-being.

Protect MiFamily operates in three sites: Kalamazoo, Macomb, and Muskegon counties. MDHHS established contracts with Lutheran Social Services of Michigan and Catholic Charities of West Michigan to identify families' strengths and needs, coordinate timely referrals to community providers, provide clinical and evidence-based interventions, and directly engage families in their own homes to build strengths and reduce risk. The Protect MiFamily project was designed to increase child safety, strengthen parental capacity and improve child well-being. It is expected that the demonstration will result in a reduction in child maltreatment and recidivism, a decrease in the number of young children placed in out of home care, and a measurable increase in social and emotional well-being of children.

MDHHS contracted with Westat and the University of Michigan, School of Social Work to carry out a rigorous evaluation of Michigan's demonstration project. The evaluation team's activities involve developing the evaluation plan and methodology and performing the evaluation. The evaluation includes random assignment, statistical measurements and outcome analysis methodologies designed to evaluate the demonstration's success on established outcomes. The team leads the process and outcome evaluations, collects primary and administrative data, provides outcome measurement and analysis, performs cost-effectiveness analysis, and prepares necessary reports.

The Evaluation Framework

Intervention and Theory of Change/Logic Model

The waiver features the following components designed to create an environment that promotes optimal child and family development and reduces child abuse and neglect:

Strengthening Families, Protective Factors approach to build family strengths. Partner agency contractors are responsible for providing direct intervention with families and establishing a link to evidence-based home visiting programs, resources, and strategies in order to build the following protective factors: 1) social connections; 2) parental resilience; 3) knowledge of parenting and child development; 4) concrete support in times of need and 5) social and emotional competence.

Reliance on the use of evidence-based programs and interventions whenever feasible. Specific evidence-based interventions to which families assigned to the treatment group may be referred include Nurse-Family Partnership, Early Head Start, Healthy Families America, and Trauma-Focused Cognitive Behavioral Therapy, among others.

Targeted screening for domestic violence, substance abuse, and mental illness with immediate links to supportive community services and treatment. Partner agency contractors with appropriate clinical training administer a Family Psychosocial screen to the parent(s) in the family's home within seven days of referral to Protect MiFamily (see Bright Futures Pediatric Intake Form and MDHHS Psychosocial Screen/DV Supplement in Appendix B). Referrals to the appropriate community service provider(s) are made based upon the screening results.

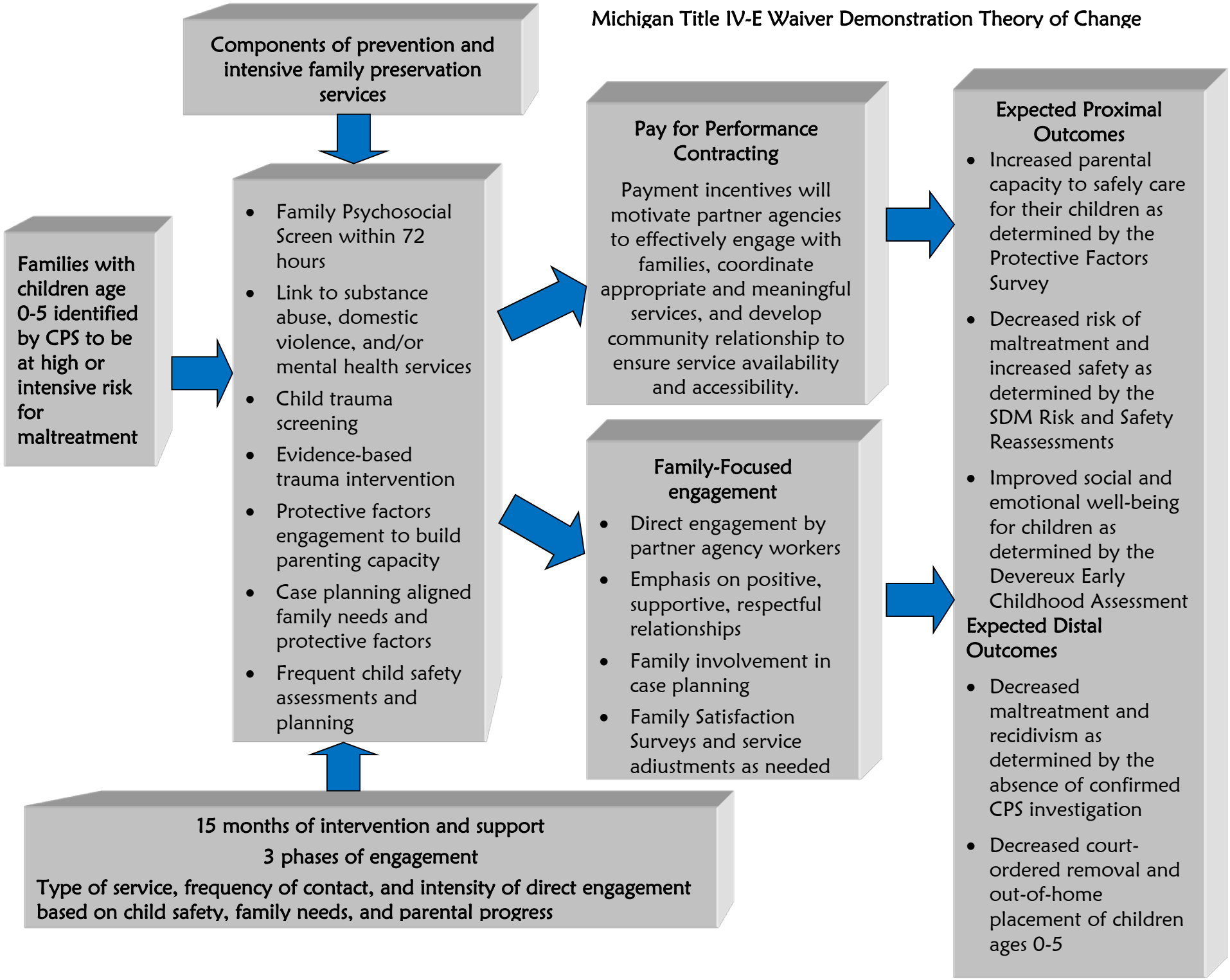
Child trauma screening and trauma informed practice. Children ages 0-5 who are referred to the waiver demonstration are screened for trauma within 30 days of the family's referral using the Trauma Screening Checklist (see Appendix B). Based upon the assessment completed and in consultation with parents, referrals are provided for Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, or other appropriate intervention such as Head Start or Parent-Infant Psychotherapy.

15 months of family support with variable intensity of engagement based on family needs, strengths, and progress.

Payment to assist families with immediate needs and short-term stressors. Waiver project funds may be used for payment for goods and services to reduce short-term family stressors and help divert children from out-of-home placement (e.g., transportation, respite care, household needs, etc.).

Pay for Performance Contracting. Protect MiFamily utilizes performance-based contracting that incentivizes achievement of identified outcomes related to child safety and well-being. Each month, the partner agency is paid 75% of their approved expenses according to the established hourly rate, with the remainder of payment held in abeyance. Twelve months after the family was referred for Protect MiFamily services, the partner agency is eligible to bill for 50% of the money held in abeyance if the family maintains participation in the project and does not experience confirmed maltreatment or court-ordered removal from the home. At 15 months, the partner agency is eligible to bill for the remaining 50% of the money held in abeyance if the family has not experienced confirmed maltreatment or court ordered removal from the home, and the children exhibit increased well-being as determined by the Devereux Early Childhood Assessment (DECA) post-test. The Michigan Title IV-E Waiver Theory of Change diagram is shown below.

Michigan Title IV-E Waiver Demonstration Theory of Change



Overview of the Evaluation

The evaluation methodology is designed to test the overarching hypothesis of Michigan's Title IV-E waiver demonstration. The overarching hypothesis is that connecting families with well-targeted and effective services (i.e. evidence-based services that reflect family needs and strengths) will improve family functioning, decrease the risk of subsequent maltreatment and prevent the placement of children in foster care. The evidence-based services are the mechanisms of change noted in the logic model (Appendix A).

Eligible families for this demonstration project include all new Category II and Category IV child abuse/neglect cases with high to intensive risk levels as determined by CPS in three Michigan Counties: Macomb, Muskegon and Kalamazoo on or after August 1, 2013. A Category II case is when there is a preponderance of evidence of child abuse/neglect and the risk assessment indicates a high or intensive risk. Services must be provided by CPS, in conjunction with community-based services. A Category IV case is when a preponderance of evidence of child abuse/neglect is not found. However, MDHHS must assist the child's family in voluntarily participating in community-based services commensurate with risk level determined by the risk assessment.

To be eligible, at least one child (focus of the allegation) must be 0-5 years old. Of all those eligible, cases are then randomly assigned to the waiver study. Random assignment occurs at the individual family level within each of the three counties at the time a Category II disposition or Category IV disposition with high to intensive risk is confirmed with the child protection supervisor. In very rare circumstances, some cases require immediate in-home services and waiting for a supervisor's approval of the case disposition is not feasible. For these cases, random assignment occurs when the child protection investigating caseworker determines an eligible case to be a Category II disposition or a Category IV disposition with a high or intensive risk level.

This classic experimental design was selected because it is widely considered the "gold standard" for creating equivalent comparison groups and for making claims (confident claims that is) about the causal effects of services. Cases will remain in their assigned groups (treatment or control) for the duration of the child welfare case and for the life of the Michigan waiver demonstration. It is important to note that this is not a "no treatment" design in that families assigned to the control group will receive services as usual (i.e. services that would have been available in the absence of the demonstration waiver).

Our Process Study includes the analysis of services data. These are important so that we can monitor and help minimize design contamination – that is – control group families receiving services that are similar to those families in the treatment condition. Contamination should be less of an issue in Kalamazoo and Macomb Counties, as these contracted agencies are serving only control or treatment group families. However, in Muskegon County, the contracted agency is providing services to both control and treatment group families. In this agency, the workers will be assigned as either treatment (waiver demonstration services) or control (services as

usual) and will not provide both treatment and control services. Our evaluation will pay particular attention to the service provision in Muskegon County.

Sampling Plan

Eligible families are randomly selected for participation in the waiver. Initially, the probability of selection was set so that 90% of the families selected for the waiver are Category II cases and 10% are Category IV cases. The 90%-10% split was selected based on the number of available cases and to reduce the risk that the contractor takes on due to projected family attrition—Category IV being non-abuse or neglect cases (a preponderance of evidence that shows abuse or neglect did not occur). The 90%-10% split is revised based upon caseload trends and the participation rates of both categories of cases. Families selected for the waiver are randomly assigned to the treatment and control groups using a 2:1 sampling ratio (a 1/3 probability of assignment to the control group and a 2/3 probability of assignment to the treatment group). The 2:1 sampling ratio should be maintained throughout the waiver. Based on this sampling ratio, it was anticipated that there would be enrollment of at least 300 families per year assigned to the treatment group and 150 families per year to the control group over the five-year demonstration period, for a total sample of at least 2,250 (1,500 treatment and 750 control). Although a 1 to 1 sampling ratio provides the greatest power for detecting differences in outcomes, the 2 to 1 ratio does not significantly compromise the power.

Random assignment is ongoing, and cases are randomized to three conditions: treatment, control, and unselected.[1] The selection probabilities were set initially to (roughly) achieve the target number of cases. Among the treatment and control cases, the targets were designed to keep the number of treatment cases about twice the number of control cases and the number of Category IV cases at 10% of the number of cases assigned to treatment or control. The current proportion of cases in each assignment category is reasonably consistent with the target assignment probabilities; however, the proportion assigned to the treatment group is somewhat less than twice that assigned to the control group in Kalamazoo County. Cases are roughly evenly divided among the three counties, consistent with the project objectives.

In the first 28 months, 759 cases have been assigned to the treatment and control groups. This number falls short of the expected 1,050 cases; thus, the rate at which cases are assigned to the waiver study is behind the 28 month target. Effective November 24, 2015, the Protect MiFamily central office program staff revised the assignment probabilities to increase the number of Muskegon County Category II cases assigned to the treatment and control groups.

A review of the number of eligible cases over the course of the study indicates that the number of newly eligible Category II cases is less than anticipated. If all eligible Category II cases had been assigned to either treatment or control, the total number would still fall short of the

[1] To meet the target number of control and treatment cases, the random assignment process assigns cases to the control, treatment, or, if there are more expected cases in a period than needed to achieve the target, these cases are assigned a category called the unselected group.

original target (135 per year in each county). The evaluation team has encouraged Michigan to revise the assignment probabilities so that 1) all Category II cases are assigned to either treatment or control; and 2) more Category IV cases are assigned to treatment and control.

To date, six crossover[2] cases have been identified (Kalamazoo, 1; Macomb, 4; Muskegon, 1). These six cases will continue to receive Protect MiFamily services but will not be counted in the numbers reported for the DECA, PFS, and Protect MiFamily data. These cases will also be identified separately for the outcome analyses.

As of November 30, 2015, a total of 495 cases had been randomized to the treatment group, 264 (including the six crossover cases) randomized to the control group, and 826 unselected, as described in Table III-1.

Table I-1. Families Randomly Assigned to the Waiver Demonstration by Complaint Disposition Category, Group, and County as of November 30, 2015 (N=1,585)

Random Assignment	Category II	Category IV	Total
CONTROL	**236**	**28**	**264**
Kalamazoo	**98[1]**	**9**	**107**
Macomb	**68[2]**	**11[1]**	**79**
Muskegon	**70[3]**	**8**	**78**
TREATMENT	**451**	**44**	**495**
Kalamazoo	**168**	**12**	**180**
Macomb	**148**	**13**	**161**
Muskegon	**135**	**19**	**154**
TOTAL T/C	***686***	***73***	***759***
UNSELECTED	**121**	**705**	**826**
Kalamazoo	**23**	**226**	**250**
Macomb	**59**	**298**	**357**
Muskegon	**39**	**181**	**220**
TOTAL	**808**	**777**	**1,585**

[1] - includes 1 crossover
[2] - includes 3 crossover
[3] - includes 2 crossover

[2] A crossover is a case that was randomly assigned to the control group but was erroneously referred to the Protect MiFamily Provider Agency for treatment services. These cases are tracked separately to prevent disruption of services that have already begun for the family.

Data Sources, Data Collection Methods and Data Analysis

Process Study

The process evaluation examines implementation of the waiver demonstration. The process evaluation also includes a measure of program implementation fidelity. Throughout the demonstration, process data provides feedback to assess whether the demonstration is proceeding as intended and to identify barriers encountered and any changes needed for successful implementation.

Quantitative and qualitative data analysis techniques are utilized in the analysis of process data due to the various forms of data collection procedures. The analysis of administrative data used for the process evaluation includes descriptive information such as who completed waiver training, trained waiver worker demographics, education, experience, and any other pertinent criteria about the waiver staff. In addition, the numbers of visits, services referred and provided are tabulated.

The Family Satisfaction Survey (Appendix B) data are analyzed by computing an overall score and examining differences in scores by phase, case and family characteristics. Internal consistency reliability of the survey items (by computing Cronbach alpha coefficients) and construct validity (using exploratory factor analysis) during the analysis stage are examined. Open-ended questions are reviewed using content analysis looking to see if common themes emerge.

The analysis of interview and focus group qualitative data follows a discovery process exploring systematic patterns in the data through a process of "constant" back-and-forth comparison. Qualitative analysts are always asking themselves a series of questions regarding emergent patterns and common themes in the data that relate to the research questions or issues at hand: What are the main patterns and common themes? How do these help to illuminate the broader study and survey questions? What are the exceptions or deviations from these patterns, and how might these be explained? What are the key stories or illustrative vignettes that emerge from these data? Examined are common themes that occur from the interviews and focus groups, a review of agency documentation (meeting notes, policies and procedures), and an assessment of the formal and informal networks that exist. These process components combined with a review of outcomes (from primary and administrative quantitative data) provide input into the development of a coding structure described below.

The evaluation team uses a modified grounded theory analytical approach, which is guided by the research questions and items of interest. This supports examination of implementation across varying contexts and the inclusion and preservation of multi-level viewpoints as gathered from various stakeholders.[3] The analytic team works together to create a common coding structure or "coding tree" with categories responsive to the major research questions. It

[3] Gilgun, J. F. (1994). Hand into glove: The grounded theory approach and social work practice research. In E. Sherman & W. J. Reid (Eds.), *Qualitative research in social work* (pp. 115-134). New York: Columbia University Press.

will be used deductively during the final stage of analysis wherein two overarching frames, waiver service implementation barriers and facilitators, and service differences between waiver and non-waiver families will be examined. The lack of accurate data has postponed the examination of service differences between waiver and non-waiver families; however, it is hoped that this will be rectified in the near future. The evaluation includes a discussion of observable agency and organizational changes, any changes in communication and/or interaction since the waiver program was implemented, and discusses how organizational dynamics may have affected outcomes.

The evaluation team retrieves and reviews existing **agency documentation**, including agency policy and procedures manual, meeting notes, planning reports, any available needs assessment or community readiness reports, documentation of asset mapping, and other relevant administrative reports and documents.

The evaluation team retrieves **administrative data** from the Protect MiFamily Database, and other sources as needed to examine implementation process and progress. This includes capturing such information as the type of direct services provided to the waiver families and the types of other community or provider services received by the children and families. Service provision for control families are available from the Control Group Expenditure Data Collection form that is completed for cost analysis. Data on services provided are available for control Category II families as long as the case remains open through the administrative data system. Category IV cases often close immediately after the case receives a disposition and the risk and safety assessment is completed. For these families, only the services for those families who accepted services can be collected.

The evaluation team also collects information about the number and type of staff involved in the waiver implementation as well as the level of staff training, experience, and education. This data can be collected by service provider contractors as part of their screening and hiring process and supplemented with attendance logs from training.

The evaluation team conducted two site visits to complete **semi-structured interviews and focus groups** with multi-level informants such as front-line, supervisorial and leadership staff and key stakeholders. Separate focus groups were convened by staff level to ensure that front-line staff, for example, were comfortable in sharing barriers and challenges to implementing Protect MiFamily services. The interviews and focus group protocols include questions related to organizational and service aspects, intra-agency and inter-agency relationships, inter-agency collaboration in the provision of services and communication on client needs, relevant topics, and other topics agreed upon by MDHHS, key stakeholders and the evaluation team.

To minimize data collection burden, the evaluation team examines existing records and agency documentation, such as meeting agendas, notes, and key policies as well as available data such as community-specific information in preparation of interview and focus group protocols that provides further context for the interview and focus group data.

Partner agency provider staff administers the **Family Satisfaction Survey** (Appendix B) at the end of each family team meeting scheduled at the end of each phase. The evaluation team proposes that the primary caregiver be strongly encouraged to complete the self-administered survey prior to leaving the family team meeting and that the service provider sends the surveys back to Westat on a monthly basis. To ensure the primary caregiver respondent that his/her information remains confidential, the evaluation team provides the respondent a postage-paid Westat envelope that can be sealed with a "special" sticker that they place on the sealed envelope. Respondents are told that the seal will only be broken by the individual inputting the survey data at Westat. The respondent can then complete the survey, place it in a Westat self-addressed envelope provided, place a label seal (or initial the back seal), and place it in a box in the provider's office for the provider to send back to the evaluators. If for some reason the respondent prefers to complete and mail the survey back at another time, he/she can use the same self-addressed envelope provided and place the survey in an outside mailbox.

The theory of change supporting the Michigan demonstration project is based on the timing, intensity and duration of services. Thus, it is critical that these elements are measured. Standardized screenings and evidence-based programming serve as the foundation for change, but this foundation will only support the weight of developmental gains if services are well targeted, families are connected with providers in a timely manner and treatment is delivered at a sufficient dosage (i.e., duration). The core components of the Protect MiFamily model are contained in the **Model Fidelity Checklist** (Appendix B). The evaluation team uses the quarterly Model Fidelity Checklist for primary assessment of adherence to the waiver model for treatment group service provision. Central office Protect MiFamily staff complete the Checklist from documentation in the treatment families' case folders containing case notes and completed copies of the child and family assessments, screeners and service records.

The evaluation team also works in collaboration with MDHHS to best utilize activity and report level **Quality Service Review** (QSR) data as supplemental to the Checklist data to assess fidelity. QSR activities include annual and site specific interviews, case file reviews, and administrative data analyses. Activities are provided in a narrative report.

Outcome Study

The Michigan waiver demonstration outcome evaluation addresses the research hypotheses outlined below.

When compared to families assigned to the control group:

- Parents and or caregivers in the treatment group will make positive changes in protective factors as determined by the **Protective Factors Survey (PFS)** (Appendix B) completed before, during and after waiver intervention. The Protective Factors Survey is a product of the Friends National Resource Center and the University of Kansas Institute for Educational Research and Public Science.
- Children in the treatment group will demonstrate improved well-being as determined by the **Devereux Early Childhood Assessment** (e-DECA) (Appendix B).

- Children in the treatment group will experience fewer subsequent maltreatment episodes in the 15 months following acceptance into the demonstration, as determined by the absence of a confirmed CPS complaint investigation (Category I, II, or III). (Michigan Statewide Automated Child Welfare Information System, **MiSACWIS)**
- Children in the treatment group will remain safe in their homes 15 months following acceptance into the waiver, as determined by a "safe" or "safe with services" designation on the **Safety Re-Assessment**.
- The risk of future maltreatment for children in the treatment group will be reduced to low or moderate and will not elevate in the 15 months following acceptance into the waiver, as determined by the **Structured Decision-Making (SDM) Risk Re-Assessment (MiSACWIS)**.
- Children in the treatment group will remain in their homes throughout waiver intervention and 15 months following acceptance into the waiver, as determined by the absence of a court-order authorizing the children to be taken into protective custody. **(MiSACWIS).**

The Protective Factors Services data is collected from the treatment group caregiver/parent three times during the waiver period, at each phase of the waiver, by partner agency workers. Protective factors outcomes are measured by reviewing caretaker responses in five areas – family functioning/resilience, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. Responses are provided at the family, caretaker, and child levels. Part III, a subpart in the Core Protective Factors questions, requires that the parent focus his/her responses on one child in the household that will benefit most from participation in the services. The survey results are designed to provide a snapshot of the family's protective factors (for evaluation purposes) at the time the survey is completed.

The Devereux Early Childhood Assessment requires a pre- and post- assessment administered by the waiver worker and completed by the parent or caregiver for each child preschool age in the household and by the child's teacher for school-aged children, usually at the post-assessment.

Items from the assessment of individual children are calculated into percentiles and t-scores. The differences in children's scores from pre-test and post-test (in pre-post tables) will be examined to determine improvement in social–emotional well-being.

With regard to the analysis of administrative outcomes, the evaluation tests the hypotheses as they relate to child safety and permanency. The key measure of safety is the subsequent report of maltreatment. The hypothesis to be tested is that children in the treatment group will experience significantly fewer subsequent maltreatment episodes following acceptance into the demonstration, as determined by the absence of a confirmed CPS complaint investigation (Category I, II, or III) as compared to children in the control group. The evaluation team utilizes the allegation data from MiSACWIS, comparing the treatment and control groups.

The evaluation team specifically looks at all allegations/reports of maltreatment that occur subsequent to random assignment (i.e. the date the parents enrolled in the waiver). The random assignment procedures were effective in creating equivalent groups. This is presented in a subsequent allegation (and removal) descriptive table that captures (1) the overall risk of subsequent maltreatment for the treatment and control groups and (2) the overall rates of subsequent maltreatment for the treatment and control groups.

The permanency hypothesis is that children in the treatment group will be more likely to remain safely in their homes following acceptance into the waiver. Similar to the analyses with the maltreatment data, the evaluation team uses the administrative data (e.g. substitute care records) from MiSACWIS to create figures that capture placement rates for both the treatment and control groups. The evaluation team explores the overall risk of entry into substitute care settings and the timing of entry into substitute care.

The major outcome analyses focus on safety and permanency. It is critical to note that the analyses focus on the waiver demonstration as a whole and on individual counties. Significant county differences may emerge.

With regards to family risk, the evaluation team analyzes the risk assessment data to understand whether or not families are improving – with regard to reducing risk factors and strengthening protective factors. These analyses provide a general sense of whether the Protect MiFamily program is achieving the primary outcomes of interest. The SDM re-assessment of risk data is contained in the administrative data system, MiSACWIS, and the evaluation team performs analysis of the SDM risk levels at time of referral for services, treatment services and control services as usual, compared to the risk level determined in subsequent SDM re-assessments. Risk levels are intensive risk, high risk, moderate risk, and low risk.

Cost Study

For this study, the approach to *cost analysis* starts with examining services and resource utilizations both in the control group and in the treatment group. The evaluation team works closely with MDHHS to identify and obtain program costs in key categories, including development costs, costs related to investigations, ongoing services, clinical and support services, and family preservation and placement related services. The evaluation team obtains agency administrative data on payment records for all Protect MiFamily and control families. This includes spending from all funding sources available, including federal, state and county sources. The analysis will primarily utilize data that appears in the state's financial records as billed amounts. In addition, the analysis considers only billed amounts after waiver assignment and the corresponding date for the comparison group.

The analyses explore how the cost of services to families in the treatment group and cost of services for families in control group are different and how these costs change over time. The evaluation team analyzes any shift of costs between line accounts since it is expected there will

be reductions in costs for reinvestigations and out-of-home placements and increases in cost for direct services. The discussion of results explicitly state any caveats and limitations due to variations in data measurements and availability of data.

In a future cost effectiveness analysis, the evaluation team expects key outcomes for this analysis to include the number of subsequent maltreatment episodes and the number of children remaining safe in their own homes for 15 months without foster care placement. After identifying the major outcomes for which a statistically significant difference is identified, the evaluation team will perform cost-effectiveness analysis to examine whether the costs of intervention services are justified by the outcomes. Thus, the cost effectiveness ratio, *Costs (Intervention – Comparison) / Outcomes (Intervention-Comparison)*, associated with Protect MiFamily relative to the comparison group. Such a ratio, for example, would reveal the difference in costs between the treatment and control groups for each additional child remaining safe in home for 15 months without maltreatment or placement into foster care.

Evaluation Timeframe and Implementation Status

The evaluation began with the approval of the Evaluation Plan by the Children's Bureau on July 18, 2013. On August 1, 2013, Michigan implemented Protect MiFamily in all three demonstration sites, Macomb, Kalamazoo, or Muskegon counties. Random assignment of eligible families in all three counties, as well as referrals to each of the three partner agencies continues on a regular basis as does the work on the evaluation components: process, outcome, and cost studies.

Based on outputs as of January 31, 2016, the project has served 523 families. A total of 143 families were maintaining treatment services meaning they have an open case with Protect MiFamily. As of January 31, 2016, a total of 123 families have completed 15 months with Protect MiFamily. There were some challenges in reaching the target number of 300 treatment families during the first year due to issues with the implementation of MiSACWIS. It has been determined that the target number will be lower than originally anticipated; however, the lower number is not expected to have a negative impact on the evaluation. Central office Protect MiFamily staff continues to meet with the MDHHS Data Management Unit (DMU) to discuss estimated numbers and to make necessary adjustments to the randomizer to assure that appropriate numbers are met for the remainder of the project.

Data collection and analyses for each component of the evaluation continues on a regular schedule. The evaluation progress and descriptive statistics are reported to MDHHS in quarterly progress reports, with the first completed in December 2013 and the most recent in December 2015. The evaluation team also reports on the evaluation status, progress, descriptive statistics, and outcomes in semi-annual reports, the first completed December 2013 and the most current in March 2016. The evaluation team will continue preparing these quarterly and semi-annual reports until the final semi-annual report is due in August 2018. The evaluation is scheduled to conclude with the approval of the final report due on January 31, 2019.

II. The Process Study

Process Study Key Questions

The process evaluation plan was designed in collaboration with the Protect MiFamily steering committee. Based on discussions prior to the implementation of the project, the process evaluation has focused its activities to address several domains listed below:

1. Organizational or contextual facilitators and barriers that hinder and/or enhance the implementation or the provision, accessibility, availability, or quality of service.
2. Inter-agency relationships as they relate to the quality of service provision, collaboration, communication, and successful outcomes that include; State MDHHS-Child Welfare, Local MDHHS-Child Welfare, Protect MiFamily Services Providers, other service providers in community, and community partners.
3. Social, economic, and political factors affecting replicability or effectiveness of intervention services.
4. Staff training and experience.
5. Adherence and compliance to model protocol for service provision related to outcomes for children and families.
6. Family satisfaction with Protect MiFamily services.

In addition to these evaluation domains, the waiver resulted in identification of additional outputs that included examining the planning and administrative support for the project, which includes ongoing monitoring, oversight, and problem resolution at various organization levels. The process evaluation was designed to detail the planning and implementation of the Protect MiFamily project and provide context to the outcome data and insight into the Protect MiFamily agencies' ability to provide and coordinate services, effectively engage families in collaboration with community agencies to meet identified family needs, address family satisfaction, and follow fidelity to the service delivery model.

Process Study Data Sources and Data Collection

Evaluation findings from the process evaluation are based on multiple sources of data. These include:

1) Interview and focus group data from CPS, Protect MiFamily, MDHHS and selected community service providers.
2) Agency documentation, which included project implementation plans, project reports, meeting minutes, training materials, telephone observation of coaching calls, etc.;
3) Family Satisfaction Survey data from treatment families.
4) Model Fidelity Checklist data.
5) Services Data as documented in the Protect MiFamily database and for control cases from administrative data and case-by-case county reports on services provided.

Interviews and Focus Groups. The evaluation team developed on-site data collection plans that included data collection interview, focus group protocols, guides and a respondent consent form. Interview guides included questions related to organizational and service aspects of both the child welfare system and Protect MiFamily, intra-agency and inter-agency relationships and collaboration, challenges and strengths of the program model and assessment tools, training and supervision, and a variety of other topics including the evaluation protocols, random assignment and consent procedures. The evaluation team received Institutional Review Board (IRB) approval for these materials along with approval for the Family Satisfaction Survey and the Model Fidelity Checklist.

Two site visits occurred—the first in September 2013 and then again in October, 2015. During both site visits, interviews and focus groups included all Protect MiFamily partner agency workers, supervisors and directors, however, only a sample of CPS workers and CPS supervisors were interviewed. The local MDHHS CPS staff included those with investigative and/or ongoing cases. There were four focus groups conducted at each demonstration site (one with CPS investigative and ongoing workers, one with CPS supervisors, one with partner agency workers, and one with partner agency supervisors and directors). In addition, in 2013 a focus group was held with the family preservation program staff from the Families First program in Muskegon County that offers families intensive, short-term crisis interventions and family education services in their home for four to six weeks. MDHHS central office staff who were interviewed included those involved in planning and implementation of the project and a sample of staff who served on the steering committee.

In September 2013, the evaluation team conducted site visits to each of the three Protect MiFamily counties and the MDHHS central office to collect information about the waiver demonstration program and local MDHHS CPS operations at baseline and assess early implementation of the project. At the conclusion of the 2013 site visit, the evaluation team debriefed the Protect MiFamily Project director and staff at the State office and as a result, evaluators conducted training for Protect MiFamily workers on research and evaluation interviewing techniques in November 2013.

The second site visit in October 2015 focused on assessing the ongoing implementation of the waiver demonstration program. Selected MDHHS staff and community service providers in each demonstration county were interviewed via telephone. The MDHHS staff interviewed represented the same positions as those interviewed during the 2013 site visit. Service provider interviews were added as an additional group of respondents in 2015 in an attempt to assess any effect of the project in the service provider community or gain insight into additional facilitators and barriers. A prospective sample of service providers were identified for interviews during focus groups with waiver workers and managers as part of the fall 2015 process evaluation. Four service providers were interviewed with at least one representing each treatment county. The service providers varied in their focus and included a provider that works with children with developmental delays from birth to 36 months, a domestic and sexual violence center, a drug detoxification center, and a life skills training program.

Services Data Collection. The evaluation was challenged with the ability to capture accurate and complete service data for both treatment and control cases to support the outcome analyses. The evaluation initially hoped to collect data on services assessed, referred and received. However, it became clear that for treatment families, the service data was being overwritten each time the service status for a family changed from needed, referred, or received. The database was originally designed to capture service data at the "final" level the family attained for the specific service i.e. individual counseling was referred. If the individual counseling was originally entered in the database as a "needed" service on July 1, 2014, then it was "referred" on July 31, 2014, the only date for that service that would show in the final data was July 31, 2014. The evaluation team wanted to track service provision more specifically by tracking the date it was determined to be a need, then also tracking the date it was referred and finally tracking the date the service was actually provided. This system allows us to evaluate service provision in relation to the length of time the need was determined to the date the service was able to be referred for the family as well as when the service was actually able to be provided. Additionally, the service data was not being collected at the client-level as was originally intended. For these treatment families, a design limitation to the Access database prevented the collection of service data on individual family members and, instead, only offered a broader picture of services to the treatment family as a whole. More specifically, the treatment database restricted the recording of a given service to a single (unidentified) family member, i.e., to record a second family member receiving the same service would necessitate overwriting the sequential progress (need/planned, referred, provided) of a preexisting, earlier entry. As a result, data entry protocols were revised to prevent overwriting, and service data is now recorded in the database at a family level, as opposed to the client level.

In addition, for the treatment families, much of the service data was missing early on and the evaluation team learned this was due to a problem with the program used to merge databases prior to submission to the evaluation. Central office staff were able to adjust their concatenation and correct this problem.

As it became clear that the plan to report on services needed, referred and provided over the course of service delivery would not be possible, in 2014 the evaluation team convened meetings with the central office staff and with representatives from Kalamazoo to better understand the data collection and data entry process. During this time of exploration, the central office staff developed a new services tab to try and address the issue, however, in the end, the evaluation team decided that the structure of the new services tracking tab would not work for evaluation purposes for the following reasons:

- The new tab did not address the concern that the service status was being overwritten.
- Data entered into the new tab would not populate into the same table that the existing service data is currently displayed in, which would make data entry for existing cases more complicated to monitor.
- Data entry staff reported that the new tab was substantially more time-consuming to use because only one service and one date could be entered at a time and sometimes the service dates can get out of order during data entry, which causes data entry error in the

service table. Also, the new tab did not allow staff to see all of the available services for a family on one page or what had been previously entered. These concerns would increase data entry errors and be likely to cause delays in receipt of updated information that need to be reported in the semi-annual and annual reports.

The evaluation team decided that modifying the Protect MiFamily database to be able to capture services at the client-level would not be feasible. Thus, the decision was to recommend that Protect MiFamily sites continue to enter service data the same way they had been entered before (i.e., using the services tab and not the new services tracking tab). The evaluation team sent an update to the partner agencies about this decision and advised them to proceed with entering data into the old service tab. In addition to an (end) code of "Provided," new codes of Referred but Denied, Referred but Declined to Participate, Referred but Ineligible for Service, Referred and Participated but Did Not Complete Service, and Completed were added to the services data collection form and database.

In an effort to integrate the documentation of services into existing practices, workers now complete the revised form less frequently on a quarterly basis, when progress reports are due for the family. In the Fall of 2014, the Protect MiFamily central office program staff agreed to provide a cumulative file to the evaluation team on a monthly basis and in January 2015 the evaluation team disseminated detailed instructions for the Protect MiFamily workers to make sure the services forms are being completed consistently and in the same manner across the different sites.

Community, provider, and concrete services provided to control families are reported to the evaluation on a case by case basis on the Control Group Expenditure Data Collection form shown in Appendix B.

Model Fidelity. Families receiving Protect MiFamily services are randomly selected for the quarterly model fidelity review. This review entails completion of the Model Fidelity Checklist. The Model Fidelity Checklist consists of 20 questions that assess partner agency staff members' adherence to service provision procedures (the service model). The checklist was developed in collaboration with Protect MiFamily central office staff. The evaluation team conducted initial training on the checklist in October 2013. Two Protect MiFamily central office analysts participated in the training. Training topics included a review of appropriate item-level responses (yes/no/N/A), sources of information for each item and instructions on retrieving the sample and submitting completed checklists to the evaluation team.

In November 2013, two Protect MiFamily central office staff rated a random sample of 30 cases each (10 per county per rater) and submitted checklists for an assessment of inter-rater reliability. The purpose of the assessment was to establish the reliability of the analysts' ratings. During the assessment, an evaluation team member reviewed the checklists, provided by each analyst per case, to determine the amount of consistency between item-by-item ratings. Next, the evaluation team member compared total model fidelity scores. Total scores were compared using Cohen's kappa coefficient, a measure of rater agreement suggested for use with nominal

scales and when there are two raters (Hoyt, 2010). The first inter-rater reliability test did not achieve acceptable results; there was low agreement between the raters (K=.15. p=.000). The minimum suggested level of acceptable agreement is Kappa≥ .6 (Landis & Koch, 1977).

The evaluation team met with the central office staff to discuss item level divergences. The staff stated that the referral and service start dates were not precisely identified on the referral form (MDHHS-892-FEW), a source of data for checklist. Use of different dates by case resulted in different ratings. Further, items on the checklist corresponded to activities occurring in different phases of service. One of the staff was not clear on whether the item should be rated if the service activity occurred outside of the correct phase. Finally, staff informed the evaluation team of two service changes. The time limit for the first phase of waiver services changed from "up to 45 days" to "up to 60 days." Also, per the Protect MiFamily Case Flow document, workers are to update the Protect MiFamily Safety Assessment Plan at each home visit; however, workers were advised by Protect MiFamily central office staff that they could use the original safety plan if it was still applicable in addressing any safety concerns. When the analysts reviewed the safety plan during the model fidelity ratings, they could not always determine if the plan had been updated during the face to face visit between workers and families. After the analysts and the evaluation team met the following changes were made:

- The referral form was revised to include both the referral date and the start date of services.
- A referral date field was added to the checklist so that the raters could document the correct referral date.
- The pertinent phase of service was added to each checklist item.
- Protect MiFamily central office staff requested that partner agency staff provide case notes on how the safety plan was addressed even if the plan was not changed from visit to visit.

The central office staff planned to repeat the inter-rater reliability process in December 2013. However, one of the analysts went on leave. The other analyst completed the revised checklists in February of 2014. To accommodate the single data collector, the evaluation team reduced the sample to one set of 30 cases (10 per county). The cases were randomly selected from those that were assigned to Protect MiFamily as of August 2013.

Another checklist revision occurred in April 2014. This revision was in response to the change in timing for the administration of the Family Psychosocial Screening. Partner agency staff were advised that they had 7 days, instead of 72 hours, to complete the screening. The single analyst completed the last round of checklist ratings for year one in April-May of 2014.

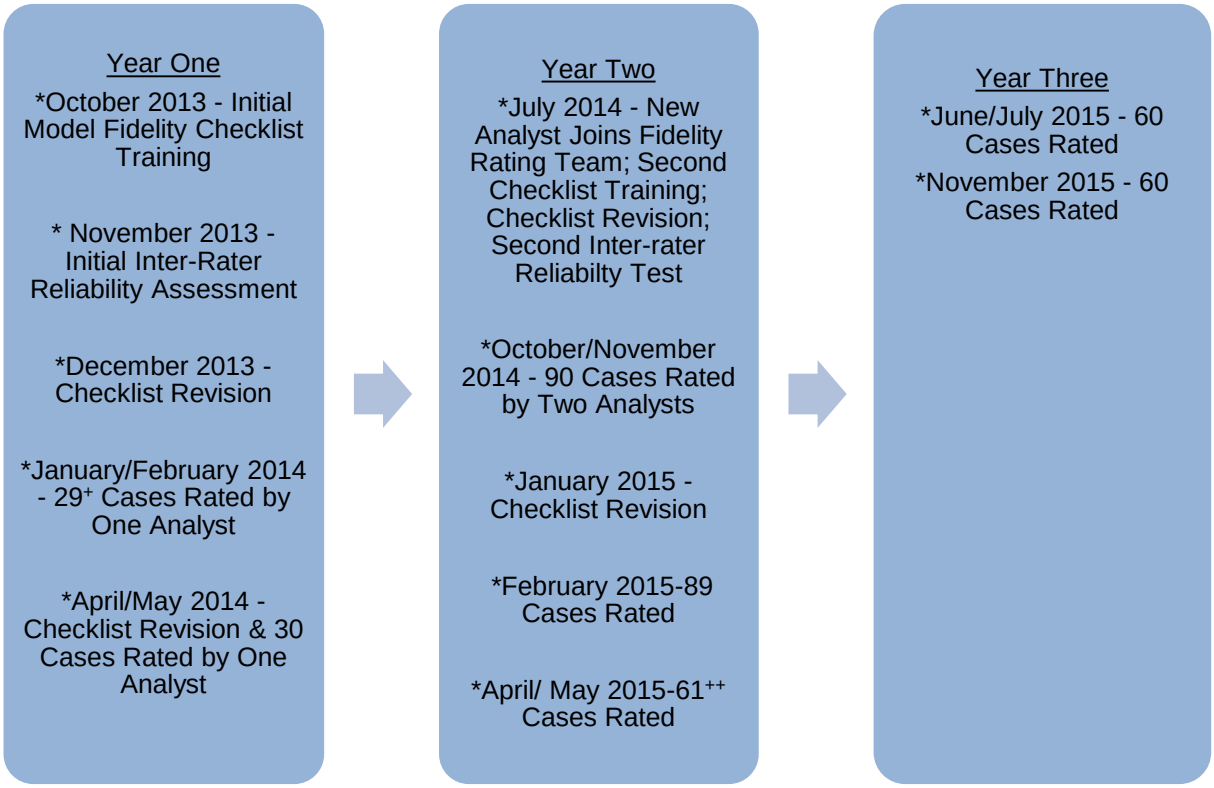
In July 2014, a second Protect MiFamily central office staff became available to serve as a fidelity data collector. The evaluation team trained both data collectors on July 17, 2014. Discussions during training pointed to the need for further revisions to the checklist. It was determined that the checklist required instructions that were more specific as to the appropriate use of the "not applicable" rating.

After training, the staff rated the second randomly selected inter-rater reliability sample. This sample was reduced (n=15 cases; 5 per county) to facilitate timely completion of the reliability assessment, which in turn, helped the analysts re-align with the original data collection schedule moving forward. The second inter-rater reliability test, completed at the end of July, achieved desired results. There was perfect agreement between the two raters (K=1.00, p=.000). Due to the high level of reliability (or agreement between raters), quarterly fidelity ratings could then be completed by two data collectors. The two data collectors rated the first of two larger samples (90 cases) in December 2014. Sample sizes were increased to catch up with the number of ratings that should have occurred by that point in the project.

A January 2015 meeting with Protect MiFamily central office staff resulted in further checklist revisions. The meeting focused on continued low fidelity around family contact standards. Protect MiFamily staff stated that issues outside of the control of partner agency staff affected the contact standards. For example, some families refused to participate initially in Protect MiFamily and/or canceled face-to-face appointments.

Protect MiFamily staff also advised that most challenges with the contact standards occurred with Phase 1 and 2 cases; these phases have requirements that are more stringent. As a result of the meeting the checklist was revised to include two measures on the standards for worker contact with the family. The first measure retained the original contact criteria by treatment phase: Twice every seven days in Phase I and once every seven days in Phase 2. If the first standard is not met then the data collectors complete the second item. The second item measures whether the family contact standard is met within an acceptable time range: Twice every eight to 10 days in Phase 1 and once every eight to 10 days in Phase 2. The Protect MiFamily Project Manager and central office staff provided guidance on the most appropriate range of time for the item. The data collectors were trained on the new checklist items in January 2015, and used checklists, with the new items, to rate 90 cases in February 2015. In April – May, and June-July of 2015, data collectors rated the standard number of cases per rating period (n=60). The current Model Fidelity checklist is available in Appendix B, Protect MiFamily Data Collection Forms.

Figure II-1. Model Fidelity Activity to Date, October 2013 – November 2015



+Data retrieval for the 30th case extended beyond the rating period
++A case selected in February had to be reviewed in April/May.

Family Satisfaction Survey. As part of the process evaluation, a Family Satisfaction Survey was developed to assess program participants' satisfaction with waiver funded program and services. The survey was designed for Protect MiFamily staff to administer at the end of each phase of the program. Clients are given a postage-paid envelope to mail the survey directly back to the evaluation or place the survey in a survey collection box located at each Protect MiFamily site for batch mailing. Evaluators conducted training for Protect MiFamily staff on how to administer the Satisfaction Survey. The Family Satisfaction Survey is available in Appendix X, Protect MiFamily Data Collection Forms.

Process Study Data Analysis

Data analysis was conducted on all data sources for the process evaluation. Interview and focus group data were transcribed and reviewed to identify major themes guided by the main domains of interest identified in the process evaluation plan. In 2015 these data were analyzed with the aid of NVivo qualitative analysis software program. Agency documentation such as MDHHS reports, steering committee and county director meeting notes, and training agendas were also reviewed to provide relevant information for the process evaluation.

Services Data Analysis. To this point, service data analysis has been limited to understanding the extent to which data captured represents services need/planned, referred and provided for both control and treatment cases; identifying gaps in service documentation together with the

underlying factors that prevent a full picture of the role of services in the demonstration. As stated earlier, the challenge of capturing service data, fully and accurately, has been the focus of much discussion and effort - although there have been refinements to the services element of the Protect MiFamily Access database as well as an examination of existing documentation practices and obstacles. Protect MiFamily sites have made strides in the overall volume of service data collected and the number of families for whom service data exists; however, there is still insufficient service data for both the Protect MiFamily cases and control cases to conduct meaningful analysis. However, this report provides a slightly better picture of what occurs after a family member is referred for a service than reported in earlier reports.

Model Fidelity Data Analysis. Checklist items were aggregated to derive a fidelity score representing the extent to which the services partner agency staff (worker) delivered to a family adhered to the Protect MiFamily model. County level model fidelity scores were then derived by computing a per-worker mean, and using the worker's mean to calculate the county's average score (grand mean). County level scores ranged from zero to 100 (maximum score), and the desired level of fidelity, as identified by Protect MiFamily project manager, was 95.

The evaluation plan discussed investigation of possible predictors of model fidelity scores at the mid-point of the evaluation. The evaluation team determined that the data available, as of the interim reporting period, would allow for an assessment of whether family characteristics observed at baseline predicted model fidelity scores. Regression analysis was used to identify family characteristics that are significantly related to or predict the fidelity score. The analyzed sample included 108 families with closed cases and available baseline data from the Family Psychosocial Screening and the Trauma Checklist Screening (Appendix B). A family can be selected multiple times for model fidelity review, and the longer the service period, the more likely it is that a family will be selected one or more times for review. If more than one fidelity score was available for a family then the score from the review that was closest to the time of referral was used in the analysis. A weighted regression analysis was used where the weights adjusted for the different probabilities of selection for model fidelity review. Because only closed cases were used, the probability of selection is proportional to the length of time the cases was open and the analysis weight is proportional to the inverse of the probability of selection. The analysis weight was scaled to have a mean of 1.0.

The data file had one record per child in each family and included child age, date of referral to Protect MiFamily, date of Checklist completion, number of days served, and measures of trauma (Trauma Checklist) and risk (Family Psychosocial Screening). Trauma and risk assessment data were used because this information was used at intake by partner agency staff to develop a service plan. The data sources used in the analysis are listed in Table II-1.

Table II-1. Sources of Data in the Analysis File

Data Source	Value or Range	Level of Measurement
Devereux Early Childhood Assessment (DECA) pre score	1 = 'Area of Need', 2 = 'Typical', 3 = 'Strength'	Child
Family Psychosocial Screening Item - Caregiver Identified as Abused/Neglected as Child	0=Abuse/Neglect Not Identified 1=Abuse/Neglect Identified	Caregiver
Family Psychosocial Screening Item - Caregiver Depression Identified	0=Depression Not Identified 1=Depression Identified	Caregiver
Family Psychosocial Screening Item - Caregiver Experienced Domestic Abuse	0=Domestic Abuse Not Experienced 1=Domestic Abuse Experienced	Caregiver
Family Psychosocial Screening Item - Caregiver Drug or Alcohol Abuse Identified	0=Drug or Alcohol Abuse Not Identified 1= Drug or Alcohol Abuse Identified	Caregiver
Family Psychosocial Screening Item - Support Person Identified	0=Person Not Identified 1=Person Identified	Caregiver
Child age	0-5	Child
Date fidelity checklist completed	January 2014 – November 2015	Family
Date referred to Protect MiFamily	August 2013 - August 2014	Family
Number of days the case was served (case completed program)	189-514	Family
Fidelity checklist score closest to but after date of referral	0-1[4]	Family
Number of Family Psychosocial Screening Items identified	0, 1, and 2 or more	Caregiver
Known trauma or concerns identified by the Trauma Checklist Screening [Trauma]	0 = Worker indicated no known trauma and no trauma concerns for child 1 = Worker indicated known trauma but no trauma concerns for child 2 = Worker indicated no known trauma but indicated at least one trauma concern for child 6 = Worker indicated known trauma and at least one trauma concern for the child 7 = Worker indicated known trauma and all trauma concerns for the child	Child

[4] For the purposes of this analysis, fidelity scores were scaled from zero (no fidelity to the model) to one (highest level of fidelity to the model).

The fidelity score is an assessment for each case, thus, for the analysis, the evaluation team created one record per case. For cases with multiple children the evaluation team calculated case-level summary statistics for variables that varied among children (trauma, child age, DECA pre score). Since the original trauma variable is a combination of two concepts ("Known" versus "No known" trauma, and trauma concerns) and the assessment of trauma concerns is coded as none, at least one, and all[5], we created two trauma variables for this analysis: one for known trauma (Known Trauma, 0= no known trauma or 1=known trauma) and another for the number of trauma concerns (0, 1, or 2 or more, see Table II-2). Across children in each family, the evaluation team calculated the maximum of these trauma variables (Max known trauma and Max number of trauma concerns), the mean age of the children, the mean DECA pre score, and the number of children per family (or per case). The maximum trauma variables were used, as opposed to the mean, on the assumption that the greater number of trauma concerns per case was more important than trauma averages in service planning. The combinations of worse case measures of known trauma (Yes/No) and number of trauma concerns (0, 1, All) were combined to create a max-trauma case-level variable (Max Trauma), with the coding similar to the original trauma variable. Using the case data, the evaluation team also calculated the number of years from being referred to Protect MiFamily to completing the fidelity review (time to fidelity review), the number of risks identified in the Family Psychosocial Screening (risk n as zero to 5), and the number of risks excluding whether a support person was identified (risk_n4 as zero to 4). Table II-2 shows the original and derived variables used in the analysis.

Table II-2. Variables in the Analysis File

Variable description	Value or Range
Family Psychosocial Screening Item - Caregiver Identified as Abused/Neglected as Child	0=Abuse/Neglect Not Identified 1=Abuse/Neglect Identified
Family Psychosocial Screening Item - Caregiver Depression Identified	0=Depression Not Identified 1=Depression Identified
Family Psychosocial Screening Item - Caregiver Experienced Domestic Abuse	0=Domestic Abuse Not Experienced 1=Domestic Abuse Experienced
Family Psychosocial Screening Item - Caregiver Drug or Alcohol Abuse Identified	0=Drug or Alcohol Abuse Not Identified 1= Drug or Alcohol Abuse Identified
Family Psychosocial Screening Item - Support Person Identified	0=Person Not Identified 1=Person Identified
Date referred to Protect MiFamily	August 2013 to August 2014
Number of days the case was served (case completed program)	189-514
Number of Family Psychosocial Screening items identified	0, 1, and 2 or more
Mean of Devereux Early Childhood Assessment (DECA) pre score	1-3
Mean child age	0-5

[5] See Table II-2, Known trauma or concerns identified by the Trauma Checklist Screening [Trauma], code 7.

Variable description	Value or Range
Number of children in a family	1-4
Any known trauma from the Trauma Checklist Screening [MaxKTrauma]	0 = None, 1 = known trauma for at least one child
Maximum number of trauma concerns across children [MaxNCTrauma]	0, 1, 2 or more
Worst case for known trauma or concerns [MaxTrauma], based on the combination of [MaxKTrauma] and [MaxNCTrauma]	0 = No known trauma and no trauma concerns for any child 1 =Known trauma for at least one child but no trauma concerns for any children 2 = No known trauma but indicated at least one trauma concern one or more children 6 = Known trauma for at least one child and at least one trauma concern one or more the children 7 = Known trauma for at least one child and all trauma concerns for at least one child
Number of Family Psychosocial Screening items identified	0, 1, 2, 3, 4, or 5
Number of Family Psychosocial Screening items identified, excluding "Family Psychosocial Screening Item - Support Person Identified" which has a positive rather than negative implication	0, 1, 2, 3, or 4
Years between referral date and fidelity Checklist completion date	0.08 to 2.19

After creating the case level variables, stepwise regression was used to identify variables that were significant predictors of the fidelity score. The stepwise selection (using the SAS GLMSELECT procedure) used the default setting for the search algorithm. The variable selection was preformed both with and without the weights. All variables in Table II-2 were included as predictors (17 predictors).

Family Satisfaction Data Analysis. Family satisfaction data was analyzed to produce frequencies by question numbers. In addition to looking at satisfaction by question, evaluators derived an overall satisfaction score by averaging responses to all satisfaction survey questions.

Process Evaluation Results

Results of the process evaluation are presented below. First the evaluation team report data from the two site visits conducted as well as telephone interviews with MDHHS and service providers. This analysis also included a review of agency documentation and the evaluation team's participation in the Casey Convening, Shared Learning Events, project steering committee meetings, and county director calls. Next, service data results are presented both for the treatment families and the control families. Results from the Model Fidelity Checklist are then presented and lastly, the results of the Family Satisfaction Survey.

Interviews and Focus Groups

Facilitators and barriers to implementation. There are several key areas the evaluation team identified as organizational facilitators and barriers to the ongoing implementation of Protect MiFamily. When compared to the findings from the baseline site visit in 2013, current analysis results show significant efforts resulted in progress in overcoming many barriers and in strengthening the facilitators seen at initial implementation. Some barriers still remain to be addressed. The most significant topical areas identified include:

- Administration and use of Protect MiFamily assessments.
- Phase movement and early case closure.
- Client engagement.
- Services.

Each area will be addressed below.

Other significant areas where barriers and facilitators emerged include the working relationship between Protect MiFamily and the local MDHHS (CPS) agency; staffing and training; and the role of the Protect MiFamily central office. Results from these areas will be addressed under their own major domain headings later in this section.

Research Question: Do the Protect MiFamily assessments accurately assess the families' needs and risks?

Interim Findings:

Concerns that Protect MiFamily administered baseline assessments that rely on parent self-reporting do not provide accurate results. This could impact case planning as well as evaluation results.

Nearly one third of assessments are not completed within the required timeframe. The most common causes cited were crises in the family, scheduling issues and clerical delays.

Administration and use of Protect MiFamily assessments. During the first evaluation site visits in 2013, partner agency staff expressed several concerns regarding the required assessment tools to be used with treatment families:

- Staff were concerned that assessments were required to be completed before the worker had sufficient time to engage the caregiver and build trust with them, potentially resulting in misleading assessment results.
- Staff did not feel confident in their own knowledge of how to administer the assessments.

- Staff did not feel confident in their own knowledge of how to interpret the results from the assessments and use them in their case planning.

In late 2013, the MDHHS central office and the evaluation team provided additional training on administering and using the assessment tools in response to staff concerns. Two years later most workers and supervisors stated that they felt confident both administering the assessments and using them to identify needs to address in case planning.

The MDHHS central office and Protect MiFamily steering committee have continued addressing issues with the assessments throughout the first two years of implementation. For example, the partner agencies felt that the psycho-social instrument did not capture all the information needed to assess the needs of families and plan appropriate services for them. In 2015, the central office program staff worked with the partner agencies to add a second page to the instrument to capture additional information (see Bright Futures Pediatric Intake Form and MDHHS Psychosocial Screen/DV Supplement in Appendix B). During focus groups with Protect MiFamily workers and supervisors in 2015, the evaluation team heard that the psycho-social instrument is now working better.

Some issues, however, appear unable to be fully addressed. In the most recent site visit, workers and supervisors again expressed concern about inaccurate assessment results on the DECA and the Protective Factors Survey arising from parents not yet feeling comfortable enough with their worker to answer honestly. For example, one Protect MiFamily worker shared, *"Sometimes it's difficult... when you get the results, and what they've said is one thing and what you're seeing is another...How do you point out the results, when the results do look wonderful?"* Workers also related difficulties using the DECA to measure improvement if the child turned 6 and thus moved into the age range for the Devereux Student Strengths Assessment-mini (DESSA-mini), as the two instruments do not use the same measurements. Although the MDHHS central office has discussed these issues many times with the Protect MiFamily steering committee, the partner agency directors, and the assessment tool purveyors, an ideal solution does not seem likely to emerge.

An additional timing issue with the assessment tools emerged from evaluation data, which has shown on average that nearly 30 percent of assessments were completed within the required timeframe. During site visit focus groups, Protect MiFamily staff agreed that this was common and felt it arose largely from the nature of working with families who are often in crisis when they enter the Protect MiFamily program. *"I don't want to sit down and answer a bunch of questions when I don't know where I'm going to sleep tonight, and I don't know where I'm going to eat,"* a Protect MiFamily supervisor said in reference to why some clients have been unable to sit through an assessment interview. Another shared, "*Our workers feel that priority becomes servicing the family, and when we're able to sit down, we will then do this assessment*." Delays in engaging with a family or scheduling problems were also mentioned as a reason for late assessments, along with clerical delays in entering the data so that it appears missing.

Research Question: Is the duration and intensity of engagement and service intervention based on the family's identified needs?

Interim Finding:

CPS and Protect MiFamily staff confusion on decision-making criteria for phase progression, although there is agreement that that flexibility in phase movement based on the family's needs, risk, and progress is desirable.

Nearly one third of Protect MiFamily cases close before completing the full 15 months.

Inability to engage all family members listed on the referral due to barriers such as scheduling or the family member's reluctance to engage with the program.

High caseload burden (over eight or nine cases) create a barrier to client engagement and may also be a factor in worker turnover. Burden is exacerbated when cases contain children in multiple households, causing the worker's need to visit several homes to satisfy the visitation requirement for a single case.

When Protect MiFamily workers do engage treatment families, they have been successful in building relationships with the families.

Phase movement and early case closure. The three-phase structure is the backbone of the Protect MiFamily program, and during the October 2015 site visits, the evaluation team heard from both CPS and Protect MiFamily staff that the phase structure works well for most families. However, the team also heard some confusion and diverging opinions in all three sites, both from CPS and Protect MiFamily staff, regarding how families progress from one phase to the next. In response to the evaluation team asking about the criteria for moving a family into a new phase, answers varied and fell into three major categories:

1. Phase movement is determined only by the number of days the family has been in the program.
2. Phase movement is determined only by the progress the family has made in lowering their risk level.
3. Movement between Phase 1 and Phase 2 is strictly time-based (at 45 days), but movement between Phase 2 and Phase 3 is more flexible based on the progress and needs of the family.

Most CPS and partner agency staff agreed that flexibility is desirable in phase progression decisions. This feeling stemmed largely from the number of home visits required during each phase. Some CPS staff expressed that, for particularly high-risk or high-need cases, they would feel more comfortable if the family remained in Phase 1 so as to receive two visits per week from the Protect MiFamily worker. Protect MiFamily staff agreed that high-risk cases could pose

a challenge in the normal case progression. *"Sometimes with the phase progression... for the most part it works well, but then there are some cases sometimes where it's hard to move them from phase to phase if the risk hasn't lowered," a Protect MiFamily supervisor said. "Sometimes that's an issue, but we still move them because we have to."* Phase progression was also mentioned as a challenge for lower-need cases, for which the frequency of weekly Phase 2 visits could become unnecessarily burdensome for both the family and the worker if most of the family's needs had already been addressed.

Visitation burden was also one factor commonly mentioned by Protect MiFamily staff to explain early case closures. Evaluation data showed that nearly 30 percent of Protect MiFamily cases closed before families completed the full 15 months of program intervention. During the October 2015 site visits, the evaluation team asked Protect MiFamily staff at all three partner agencies to describe the major factors in their experience that caused cases to close early. The most significant factors mentioned included:

- CPS removed the child(ren) from the home.
- Change of physical custody from one parent to another family member.
- Family moved to a different county, often due to housing crises.
- Family declined further services.
- Family became non-responsive to worker contact attempts for more than 30 days.

The last two bullet points mentioned above may be informed by discussions the evaluation team heard about the length of the program. At the time of the baseline site visit in 2013, CPS and Protect MiFamily widely agreed that the 15-month duration was the most unique and promising aspect of the program. Two years later, the site team heard more mixed opinions on whether a set period of 15 months is appropriate for all families. CPS staff cited the length of the program as a barrier to families agreeing to participate in Protect MiFamily. *"We've been taking cases to court, because they don't want to do Protect MiFamily and they're cases that I don't think necessarily need to go to court,"* one CPS supervisor said. "*These are compliant people. They just don't want to do Protect MiFamily because 16 months freaks them out or something."* One Protect MiFamily supervisor noted: "*We found that eight months to be that perfect spot for a lot of the families. You have families that they come to the attention of CPS, and they do have some things that they need to work on, and they get that crisis down in the first month or two…. Now, they fall off the program, not because they weren't successful, but because they have a life to live, and they've dedicated their time to what they needed to fix*." A CPS supervisor expressed a similar view: *"The families want to fix things, but they want to fix things until they're fixed. They won't want to fix things and then be stuck with you staring at [them] for an hour a week."*

CPS and Protect MiFamily staff reported that keeping Category II families in particular engaged in the full length of the program can become more difficult after CPS closes their case. However, as one CPS supervisor noted some families do need the longer period of services: *"It just really depends, but I think when you're talking about families, chronic situations, chronic concerns, reoccurring themes, the longevity of the program is key for a family's future success."*

Client engagement. Cornerstone of the Protect MiFamily program is the level and quality of engagement between the worker and the family, including children and secondary caregivers in the home. Protect MiFamily staff cite client engagement as a critical facilitator for accurate needs assessment, case planning, service provision, and program retention. CPS staff appreciated the relationship building Protect MiFamily workers were able to accomplish, though some felt that engagement came at the expense of putting CPS-priority services in place, accountability for high-need clients, or the relationship between CPS and the client.

In the 2015 focus groups, Protect MiFamily staff described a number of useful client engagement facilitators, such as assisting the family with immediate concrete needs, sharing a meal with the family, providing emotional support and encouragement, using assessment results to facilitate conversation about family needs, or offering the clients strategies to use with their children. One Protect MiFamily worker described an example of the rapport built between worker and client*: "For her, she gets so excited to tell me about the progress that she's made, or, 'Guess what I did this week?' ...I hold her accountable for things and I also validate her progress and her feelings. She likes that, because she can have social supports with the school and stuff, but they don't quite do that part of it like we do."*

Protect MiFamily workers also described a number of barriers to successful client engagement. One significant barrier is a high caseload; although per contract, Protect MiFamily workers can take up to 12 cases at a time, staff in one agency reported that client engagement begins to suffer when a worker has more than nine cases, particularly if the worker has more Phase 1 or Phase 2 cases, with more frequent visitation requirements. *"When you have a high caseload, there's just not a lot of time to do all that [engagement],"* a Protect MiFamily supervisor explained*. "Then it takes away from the quality, I feel, of an intervention... engaging when you've got countless kids that you've got to see every week. You're going place to place, and there's not a lot of time."* An exacerbating factor mentioned by all three sites is that many cases contain children in multiple households, meaning the worker may need to visit several homes to satisfy the visitation requirement for a single case. One Protect MiFamily program manager explained: *"If families are in multiple households, which most families are, and most of these families are large because those are our at most risk families with multiple dads, because again those are our at most at risk families. Two times a week turns into six different visits in that week for one family."*

The Quality Services Review (QSR) completed in October 2014 found that workers engaged mostly with the primary caregiver, usually the mother, and did not spend much time with the children or other family members listed on the referral. *"They're definitely engaging families,"* the program manager from one site said during a 2015 interview*. "I think the QSR was more about documentation."* Workers from all three sites agreed that they attempt to spend about half their visitation time working with the children and find that engagement helpful in assessing the needs of the family. One worker explained it this way, *"You can kind of get an idea from the kids too on what's going on in home, if the mom is cursing and being belligerent, if the dad is not there, if there's some domestic violence in the home."* Family dynamics, however, can present challenges to engagement with other referred family members, particularly

fathers. *"It is a problem across the state in all of our programs that we just don't engage dads the way we should."* A Protect MiFamily worker at a different site explained*: "Sometimes it's a dad that...does not want to engage during the services when they're supposed to, when they're on the referral. A lot of times they go to another room, or even leave the house, because they do not want to engage. We have to explain it to them in the beginning, and also throughout the time: 'You're a part of this also. It's very important to participate.' That doesn't always happen that way."*

Research Question: Are the agencies providing and managing services to effectively engage the families, coordinating meaningful and effective services, and developing community relationships that ensure available and accessible services to meet the families' needs?

***Interim Findings**:*

A significantly lower rate of referral to community services than expected. The low rate of referral to community services presents challenges to the success of Protect MiFamily because a core element of the Protect MiFamily model is to connect families with community services and supports that can sustain their progress and well-being after they leave Protect MiFamily. The low rate of referral may be due to Protect MiFamily staff providing most services (mainly psycho-educational) themselves in the home. Referrals are primarily used for clinical services (substance abuse treatment, mental health) that require specialized professional or certified providers. The low rate of referral to community services is also influenced by client reluctance to go, transportation or scheduling barriers, service availability, and the cost of outside services.

Service availability remains a significant barrier, particularly mental health, temporary shelter, and affordable housing.

The lack of formal service referrals causes tensions with CPS, who need documentation of qualified services in order to either close the case or take cases to court.

Services to Families. Treatment services are the heart of both the waiver and the evaluation, and perhaps the greatest challenge surrounding the evaluation has been the appearance, as suggested by available treatment service data and as noted in the October 2014 review of Protect MiFamily by MDHHS (QSR), that, in many cases, Protect MiFamily workers *"are taking on all of the family's needs themselves and not linking families with community service providers that can continue to support the family long term."*

As noted in the QSR, the Protect MiFamily partner agencies are making relatively few referrals to other service providers. This observation is supported by the current services data, which if accurate as documented reveals a clear underutilization of services that make up the Protect MiFamily service menu for treatment families. The central office staff raised the issue of

whether the partner agencies are attempting to provide most of the services themselves with the Protect MiFamily partner agency program managers in early 2014.

The program managers considered service provision by the Protect MiFamily workers to be an acceptable interpretation of the program model, and at the April 2014 Casey convening, they asked for clarification on the program philosophy on service provision. MDHHS central office distributed a refresher handout on strengthening families and protective factors to all demonstration sites to encourage the use of community resources/referrals for Protect MiFamily families so they will continue to have access to those services when their participation in Protect MiFamily ends. In the most recent MDHHS interviews, the evaluation team heard that referrals to community services is lower than anticipated and despite some improvement, needs to be strengthened. The central office raised this matter again at the Shared Learning Event March 8, 2016. Each site was recognized for their efforts to collaborate and discussed collaboration goals for the remainder of the year.

During the 2015 site visits, the evaluation team asked the Protect MiFamily partner agency staff in all three sites for further explanation of what appears to be a fundamental misunderstanding of the program model as it pertains to service delivery. Workers, supervisors and managers in all three sites did not seem to see a significant conflict or misinterpretation of the program model. They agreed that the Protect MiFamily workers provide services themselves as much as possible, and only refer out to community service providers if the family has clinical needs (mainly substance abuse and mental health) that exceed the qualifications of the worker to handle.

As one worker described it: *"We make the decision to refer if CPS is making us or if it's an extreme need."* A worker at a different site explained: *"Services that require more licensure, like substance abuse, therapy, and mental health therapy, those are definitely services that we refer out. Because we know that we're not trained, licensed professionals in those areas. The clients need those services to be able to help them."* With the exception of these more "serious" problems, the Protect MiFamily staff did not see a great difference in where the family received services, and articulated several reasons why providing services directly, mainly psycho-educational services, was often preferable or even necessary. As one Protect MiFamily supervisor explained: *"In supervision it's case by case. In several cases, we'll come to a decision where this is a high need for this client, and it's either you're going to do it or we're going to get them to go to the referral. We talk about both sides, pros and cons."*

The most significant issue effecting service delivery, mentioned at every level at all three sites, was the cost of referring to outside service providers. The partner agencies have a budget of $600 for each family for the entire 15-month Protect MiFamily program, and any service not covered by MDHHS or insurance must be paid for out of that $600. *"The State, they don't always think when they give you a contract,"* one partner agency staff explained*. "In reality they don't realize how much it costs to do this work and do it well, to pay staff, to pay mileage. We've been pushing back that in any other program out there, the State picks up [the service cost]."* One worker with a background in foster care agreed: *"I've never seen any other service*

provider when I would refer families in foster care to fork over whatever kind of assistance that they were giving the families ... Our program, on the other hand, is pulling out of the family's budget for some reason." Even insurance, like Medicaid, does not always offer a solution, as one program manager explained: *"Medicaid is an issue because it only offers so many weeks of payment towards mental health or substance abuse, and because we... don't have the money to fund ongoing services for our clients in that way. We tried to get them started. It's like a Catch-22. You really don't want to get them started on something they can't finish or keep up with."* This has required the partner agencies to creatively adapt their approach to service provision. *"We try to figure out frugal alternative ways to do things. Backdoor ways. How can we get a psych eval done for free?"* one Protect MiFamily worker explained*. "[CPS] don't have to worry about their budget and their money as much as we do. We're like the frugal shoppers... What can you do for this family on a bargain ...?"*

Other Protect MiFamily staff felt that budget was not the most significant reason they provide services directly to the family, but rather there are other barriers such as transportation, scheduling, and client unwillingness to go to a referral. *"It's not, do we have money for that service? It's the willingness of the client to do that service,"* a Protect MiFamily supervisor said. A supervisor at another site noted: "*It's not that we haven't offered [a service referral], that we haven't told the client about it. A lot of times we meet with resistance. Either they don't want to do it or they don't feel like they can for one reason or another... They don't have the time, the transportation, or they don't want to do it."*

Service availability also remains a significant barrier, as the evaluation team first noted during the baseline site visit. As in 2013, the most significant service gaps discussed in the 2015 CPS and Protect MiFamily focus groups included mental health, temporary shelter and affordable housing. Insurance and transportation issues can present serious barriers to accessing mental health services. Housing, temporary or permanent, often is not available at all in any of the three counties. *"All the homeless shelters are so full. Every time you call, they're full, and it's almost like they laugh at you when you call,"* a Protect MiFamily worker at one site said. Another worker at the same site noted*, "You get a domestic violence [victim], you're trying to get her away from him, and you call the shelter. They only take 15 people, and they're filled up. You only got that one shelter for domestic violence in the whole county."* This presents a disconnect with the view the evaluation team heard in interviews with MDHHS staff, who described domestic violence shelters as being readily available in all three demonstration counties.

Service referrals continue to be a point of contention between CPS and the partner agencies with two main issues identified: (1) CPS needs a record of services in order to take a case to court, and (2) CPS staff do not always know or trust the qualifications of the Protect MiFamily workers to provide services equivalent to other service providers. *"Let's say it does come down to, we may have to remove,"* one CPS supervisor explained*. "What do we have to be able to indicate [the family] have been offered this particular service?"* A central office staff member noted*: "Some ... CPS staff, they want certificates. They want to be able to go to court and say... this family had that. I don't understand that thought process because we are no different than*

Families First or Family Reunification in terms of, we provide a service and the case can go in through a family court judge and say, 'This family had Families First and had that knowledge.'" According to one group of CPS supervisors, the difference is knowing whether the worker is qualified to provide a service: *"We had a situation where it was a domestic violence [case]...The father had had an assessment and it was necessary that he [take a] domestic aggression course. The Protect MiFamily worker was indicating, 'We provide that.' What is it that you are providing? At this point we don't know what they are trained in.... We need a specific curriculum. Are they a certified domestic violence provider?"* Though frustrated by not seeing the service referrals they expect, CPS also expressed understanding of the budgetary issues involved. *"They are rule-bound. They have X number of dollars, whereas we could just, frankly, write a check if it's a need and it relates to safety,"* a CPS supervisor explained. *"We're not balancing, six months down the road in order to preserve this family, do we have assets available?"*

Whether families will have sustainable supports after Protect MiFamily, no matter where the family received services during the program, is an unanswered question for the partner agencies as much as for the evaluation. *"We do make efforts to try to connect people to services that will go beyond our time with them,"* one Protect MiFamily supervisor noted. *"However, we have a lot of clients with... transportation and childcare barriers that continue to be an issue. Maybe we can give rides, but we can't always be the ride.... We can sometimes get them connected initially, but not always long-term."* Another supervisor had a more optimistic view: *"I feel like for the most part they are better connected. They know about the resources that are available to them and who to turn to for help."* Workers also help families identify and connect with natural supports during the program, with the goal of building a long-term support structure. *"We identify those [natural supports] right from the beginning. We're constantly referring back to them throughout the entire time,"* a Protect MiFamily worker explained. *"If they ran out of money, we're going to encourage them to look to the community or look to their social supports first before relying on us, if we're able to do it."*

Research Question: Are interagency relationships facilitating the delivery of treatment services to the families in need?

Interim Findings:

Collaboration between CPS and Protect MiFamily still faces significant challenges; however, successful CPS and Protect MiFamily staff teaming is occurring in several areas.

Both MDHHS and the partner agencies have begun positive steps toward greater communication.

Interagency Relationships. The second major domain for the process evaluation investigated is the relationship among the various organizations involved in the waiver demonstration, which includes the local MDHHS agencies, the partner agencies providing the Protect MiFamily

services, the Protect MiFamily central office at the State MDHHS, and other service providers and community partners.

CPS and Protect MiFamily Working Relationship. Perhaps the most important interagency relationship identified is the ongoing working relationships between the CPS staff at the local MDHHS agencies and the Protect MiFamily staff at the partner agencies. Two years ago, the evaluation team heard overwhelming testimony from both agencies at all three sites that the CPS-Protect MiFamily relationship had gotten off to a rough start. When the team returned in 2015, it was apparent that this particular interagency relationship still faces significant challenges in several of the same areas initially identified, especially:

- Confusion and expectations about roles and responsibilities.
- Confusion and lack of buy-in from CPS about the Protect MiFamily program model.
- Confusion and lack of trust by CPS in the qualifications of Protect MiFamily workers.
- Concern about privatization of child welfare services and loss of CPS jobs.
- Communication between CPS and Protect MiFamily on both the managerial and worker level.

When the evaluation team spoke with CPS staff in 2013, staff expressed near-universal confusion regarding the roles and responsibilities of the Protect MiFamily worker, as well as what role the CPS ongoing worker should play during a Category II case still open with CPS. The MDHHS central office program office distributed clarification in 2014 on CPS and Protect MiFamily roles during the referral process, but at the Casey convening in April 2015, sites again requested clarification on roles and responsibilities as well as more information for CPS on what the Protect MiFamily workers do with their clients. Six months later, the evaluation team asked CPS staff to articulate what they thought Protect MiFamily did. *"I'm going to say that we're, even this far in, it's still unclear, what their role is,"* a CPS supervisor responded, which the site team heard as a strong message in all three counties. While both CPS and Protect MiFamily staff agreed that the Protect MiFamily worker is supposed to take over some portion of the CPS ongoing worker's job, opinions varied widely about the specific roles, both in theory and in practice. A CPS supervisor noted: *"Initially... the way the project was represented was that the case would go over there, and they pretty much would do everything, that we would have minimal contact in the case.... They take on quite a bit with the case, but they still are more of a service provider. Then we're pretty much the CPS end of things."*

From the perspective of the Protect MiFamily staff interviewed during the most recent site visit, they attribute CPS confusion as less about day-to-day responsibilities and more about a lack of understanding and buy-in to the fundamental philosophy of the Protect MiFamily program. *"I still think when you hear they don't know what Protect MiFamily does...it still has to do with that role philosophy,"* a Protect MiFamily program manager shared. *"There's not an understanding of what is the vision behind putting this program in place other than to take my job. If I were a CPS worker I would be asking that today. I get why they're still asking it." A* Protect MiFamily program manager in another county described role clarification as an extended process: *"[It was] a lot of looking after roles and who is doing what to let them know*

that we weren't trying to take over, we were working together, more of a collaboration. That was a big piece, because initially they thought 'oh, we're supposed to hand over our cases to them, we don't have any input anymore.' It scared them." The central office program staff also shares this view, as one staff member shared: *"What I would say is that CPS has still not bought into this program, and also there's an overall belief that if this program makes it that ongoing CPS staff will not be needed, so that they'll be losing their jobs."*

The fear of handing over cases to the control of Protect MiFamily seems to stem in part from ongoing worries about privatization based on MDHHS utilizing contracted providers for foster care in Kent County. That concern was one of the most prominent themes identified in the 2013 site visit, and when the site team arrived for the 2015 site visit, an article had just been published in the Lansing State Journal in which the union that represents CPS employees said Protect MiFamily is the first step in privatizing child protective services. *"When we ask for role definition to help workers understand exactly what their philosophical work is, it's just not forthcoming. I don't think it's the way that the state is thinking about the contract,"* noted one Protect MiFamily program manager. *"Because having a better handle on that, if the roles are what they are in my head, would reduce some of the fear that I think is still felt by protective service workers about their job."*

While the privatization issue has colored the emotional atmosphere around Protect MiFamily at the local MDHHS agencies, a more substantial concern expressed by CPS staff related to the management of cases with high risk and intensive needs. One CPS worker stated: *"I think the program overall, depending on the worker, can be a really good support. I don't think it was ever created to take these high-risk and very intensive cases and run it alone."* CPS concerns focus on two issues: (1) divergent opinions about priorities for case planning and services and (2) protective service responsibility and trust. *"I think the difference is that we approach families from a more strength-based approach,"* a Protect MiFamily program manager noted. *"We approach families as partnering with them and walking them through this process and getting over this crisis and looking at long term planning... CPS's approach is more assess the immediate risk right now, deal with that issue, and they're not really concerned or focused on long term support."* One CPS supervisor expressed a similar view: *"It's frustrating for our workers because we have a different time-frame. We're getting pressure to get things done, get on, move out of there, because we have the next referral coming in."* Another CPS supervisor said, *"It's been very difficult. We recently had a meeting with our ongoing staff. Overall, what we are hearing is that it's more work for them, because they don't feel like the workers are making the referrals and following up with the families and doing all the things that they need to be doing to get the families back on track."*

In some of the more extreme cases, disagreements on priorities or lack of confidence in a particular worker can develop into a lack of trust that a high-risk family is safe under the supervision of Protect MiFamily. Although the Protect MiFamily worker assumes day-to-day responsibility for the case, the Protect MiFamily worker is not a protective services worker, and the legal burden for the safety of the children still rests on the CPS ongoing worker. *"If there's a baby death, who is going to take the fall for that? Are they going to take the fall for it? No, it's*

going to be me," one CPS ongoing worker explained. *"They're a good support, but the intense services are just not there. The ongoing monitoring, I don't feel, is enough."* One Protect MiFamily supervisor reflected: *"Can we handle that level of client well? We're not designed to do Category I type work. So when clients are in such high crisis that they are pushed into a Category I situation, we do have to partner with our CPS friends because our staff do not have the training for court issues, petitioning, for that high level of accountability."* Both CPS and Protect MiFamily staff indicated that the more intensive, borderline-Category I cases may simply not be a good fit for the Protect MiFamily model.

However, during the 2015 focus groups, the evaluation team also heard an equal or greater number of accounts of positive working relationships between CPS and Protect MiFamily workers. As related from both perspectives, the key facilitators for good collaboration include:

- The abilities/experience of the Protect MiFamily worker.
- The attitude of the CPS ongoing worker.
- The level of communication between the CPS and Protect MiFamily workers.
- Establishing shared priorities and expectations at the beginning of a case.
- Joint visits to the client.

"It falls back on the competency of the worker, the reliability. I've been lucky with the couple I've had," one CPS worker explained. *"But I've had workers that have really talked to me a lot, communicated well with emails, phone calls, and I've set up a lot of my meetings to go at the same time [as the Protect MiFamily worker] so I can get hands-on. Not just with the family, but with what are the workers doing. What's the engagement level? It just lets you get a full read of everything."* The Protect MiFamily workers also find joint visits helpful, as one worker told the evaluation team: *"One thing that I feel has helped me is doing joint visits with CPS, because they have to go out once a month... I want to make sure we're on the same page...I feel like that's helpful, that team approach."* Another Protect MiFamily worker agreed that joint visits also helped with client engagement: *"I think sometimes our clients almost view me as a friend, and you have to draw that line. When you come in with CPS they remember, 'Oh yeah, they are still a team.'"*

Interviews conducted by the Division of Continuous Quality Improvement (DCQI) for the most recent Quality Service Review (QSR)[6] in October 2015, shortly before the evaluation team's site visit, also indicate that some CPS workers are having positive experiences with Protect MiFamily cases. Six of the eight CPS workers interviewed for the QSR indicated they were satisfied with the program; all eight CPS workers felt involved in the case planning and that the safety and risk factors in the home had been reduced since Protect MiFamily started working with the family. CPS workers described the Protect MiFamily workers as having a supportive and professional relationship with the families in their cases.

[6] The October 2015 QSR is still in draft format as of the writing of this report. Additional findings from the QSR will be presented in future evaluation reports after it is finalized.

From the Protect MiFamily perspective, the level of trust also depends on the CPS worker, as one Protect MiFamily worker explained*: "Some of them are completely open, like us and understand that the family has high needs. They like that there's someone in the home twice a week in the beginning and able to help with different needs that they don't necessarily have the time for, and able to give more attention."* Another Protect MiFamily worker noted: *"Where I felt that I had a good working relationship with the CPS worker often times it's a matter of we are both working towards the same goals, we are trying to prioritize what needs to be done first."*

The CPS staff in one county expressed a higher general level of comfort with Protect MiFamily and attributed it mainly to extensive past experience with the partner agency in the county and their existing positive relationship prior to the Protect MiFamily program. In the other two sites, the interagency dynamic reflects to some degree the lack of that familiarity with the agency and/or with the Protect MiFamily program staff. *"I think it would be a lot easier if the relationship was there. Like, we can give easy feedback between us and Families First because you know the people that come here face to face for those referrals,"* one CPS supervisor noted*. "But what it seems to being done much more so with this group...people don't talk to each other. They want to email, they want to text...It's not effective."* Over the past two years, the main line of communication has been between the CPS and Protect MiFamily supervisors, who try to meet regularly in all three sites*. "I think it starts with the supervisor and the management staff and making sure that they understand what they need to be training and holding their staff accountable for,"* one Protect MiFamily program manager said. Staff described varying levels of success; although supervisors on both sides describe each other as receptive to feedback and problem solving, communication is not as frequent or robust as they would like*. "We've been doing monthly CPS meetings with supervisors,"* one Protect MiFamily supervisor said. *"We've tried to do more frequently. I don't remember how frequently we were doing it at some point, but we found that we were not really a high priority on the agenda."* A CPS supervisor in the same county noted that at the beginning of the project, the two agencies had much better communication: *"Telephone communication, in-person visits, participating jointly on calls or just brainstorming, meetings, et cetera, it's been a drop-off over the past 14 months.... It went from that we were looking at them every day to almost no contact at all."*

However, another CPS supervisor described recent efforts at increased communication: *"Supervisors come over here to our staff meeting once a month as a general rule. Right now, like two weeks ago I went over and we had a joint planning where we're going to be doing a training for them here; that came out of that convening that we had."* The agencies are also working at increasing communication at the worker level by arranging meet-and-greets and encouraging more frequent communication during a case. According to one Protect MiFamily supervisor, *"We're also really trying to have staff contact their individual CPS workers continually, like every week, email or phone call, 'What do you need, what's going on, any input?'"*

MDHHS central office. The Protect MiFamily central office has individual relationships with the local MDHHS offices and the partner agencies in all three demonstration sites, and also

sometimes serves as mediator and facilitator in the relationships between the local agencies. During the October 2015 site visit, partner agency managers and supervisors described the central office program office as easily accessible and responsive, though not always proactive. *"I think that relationship is going well. We stay connected and we keep them informed and we talk to them and engage them whenever we feel like we need to,"* one Protect MiFamily program manager said. *"They are responsive when we ask questions and ask for clarification. Unfortunately I would say that sometimes depending on who you talk to, the answer to the same question could be different."*

Within the last year, central office program staff began visiting the local CPS agencies every quarter to share updates and answer questions, something that has garnered good feedback on the steering committee and county director's calls*. "I just think that the face-to-face gives us more credibility that they know we're there to support them,"* MDHHS Protect MiFamily central office staff said. *"It's not just we're asking them to do extra stuff without giving them support."* When the evaluation team interviewed central office program staff in November 2015, they were engaged in planning for increased technical assistance to the sites, particularly the CPS offices, and intervention in some of the interagency relationship issues described above. Plans include meeting with CPS program managers, supervisors, and staff to share more information about Protect MiFamily and answer questions. *"I would also like to have another get-together with the actual Protect MiFamily staff and the CPS staff, and let's have a do-over on this,"* said one staff member*. "Let's meet each other, let's talk about job shadowing, let's talk about understanding what each other does, and go at this as a team."*

This increased support will likely be welcomed by the local agencies, as the evaluation team heard a desire for an increased local presence from the program managers and supervisors. *"I do think that program office should have more of a presence in the CPS offices or in communicating with the CPS directors, the county directors related to the program,"* one Protect MiFamily program manager said. Another program manager hoped the State MDHHS central office could hold the local MDHHS agencies accountable for their role in the waiver: *"They have a role. This is not a program that Lutheran just sprung on them or that Catholic Charities just sprung on them. This is a part of a large entity that they work for. This is their department. This is their program, and they need to feel a part of that and know that they have a responsible role in it."*

Community service providers. The vision of Protect MiFamily was to meet the needs of families in part by collaborating and coordinating with service providers in the community. Partner agencies all reported outreach activities and working towards developing relationships with key community service providers including attending various types of community coalition or domestic violence or homeless services councils, presenting at programs, and participating in special community project. However, the partner agencies also agreed that outreach and relationship building decreased after the initial implementation push; the central office has identified this relationship building as a priority area to work on in the coming year, beginning with the Shared Learning Event in March 2016. *"I think we're moving from our steering committee to an implementation committee,"* MDHHS central office program staff noted.

"That's where I think the stress is going to be really made on those communities, on the sites to solve some of these issues in the communities and to build on these partnerships in the communities. I think we need that shift in order to get those relationships built."

The evaluation had limited success contacting service providers in the treatment counties and was only able to successfully interview four service providers. Based on interviews with the four service providers who were responsive to requests for an interview, the level of familiarity with Protect MiFamily appears to be relatively low. Of the service providers interviewed, most of them had heard about Protect MiFamily; but only one identified as being very familiar with the program. One service provider stated they had not heard of PMF, but knew of the partner agency where the program is based; however, this respondent had only been at the agency for a few months. Half of the service providers interviewed reported having an ongoing relationship with the partner agency where Protect MiFamily is located however, they were less aware of the actual Protect MiFamily program or the services it provides. In a similar vein, respondents were not able to differentiate referrals from Protect MiFamily program with those from other agencies or CPS, nor did Protect MiFamily constitute a significant source of clients to the services providers. Two of the service providers reported they receive referrals from the partner agency running Protect MiFamily and one service provider identified receiving referrals from CPS. None described anything unique about referrals of Protect MiFamily families.

Communication and collaboration on service provision to Protect MiFamily families did not seem to be significant. One service provider reported that Protect MiFamily had reached out to them to discuss a very serious case and another reported communication with a Protect MiFamily social workers, but in a limited context about sharing information and privacy concerns. This same respondent voiced the opinion that the Protect MiFamily agency does not assist clients to more successfully engage in services at their agency. Another respondent reported the opposite sentiment, stating that Protect MiFamily not only encourages families, but especially in the beginning when they are hesitant to access the provider. Other collaboration described included one agency's experience with Protect MiFamily workers reaching out to the service providers for guidance when dealing with an extreme or severe case, such as high level of lethality. One service provider indicated that the partner agency had social workers take classes there. Several of the respondents expressed a desire to build relationships with the partner agency and increase their overall outreach efforts about the services they provide in the community at large.

Staff training and experience. While speaking with CPS and Protect MiFamily staff at the three demonstration sites during the October 2015 site visit, the most common response the evaluation team heard about staff experience and prior training as it relates to their ability to engage clients in services was, *"It depends on the worker."* This highlights the importance of hiring and retaining qualified workers and supervisors to deliver Protect MiFamily services and providing them with appropriate and consistent training.

Based on the most recent information on staff qualifications received from the central office, all Protect MiFamily supervisors (n=6) have a master's degree in social work and an average of 10

years previous work experience in the human services field. All Protect MiFamily workers for whom data was available (n=25) have at least a bachelor's degree and approximately one-third of workers have a master's degree in either social work or counseling. Approximately half of workers had between 2 and 5 years of previous work experience in the human services field; a little over a quarter of workers had over 10 years of previous experience, and just under a quarter had a year or less of previous work experience.

Research Question: Does staff turnover and hiring of new staff cause barriers to successful implementation of PMF?

Interim Findings:

Like many child welfare programs, staff turnover is high in all three sites. Staff turnover in both Protect MiFamily and CPS causes breakdowns in collaboration.

Hiring qualified candidates in a timely manner is a challenge stemming from competition from other programs as well as the entry level salary offered by Protect MiFamily and that the job is only for the remaining time of the Protect MiFamily waiver (2.5 years).

Staff turnover. When the evaluation team visited the sites at initial implementation, CPS staff in all three sites expressed concern about the youth, lack of diversity and a perceived lack of experience of the newly hired Protect MiFamily workers. The partner agency managers and supervisors had confidence in their workers, though they related that the tight time window for hiring had made finding experienced workers difficult. The second site visit two years later found seasoned and confident workers in the partner agencies, although turnover has been a troubling issue in all three sites, as is common in the child welfare field. Protect MiFamily managers and supervisors identified several contributing factors to the worker turnover:

- Worker burnout.
- Workers finding new jobs with better salary, workload, or commute.
- Workers moving to a different career path/specialization.

"You get a person in there who's got a lot of skills, gets their skills enhanced by the training and the on-the-job experience, and now, they're able to get other jobs that they couldn't get before that pay more," explained MDHHS central office program staff. *"I think a lot of it is about the pay. It's an entry-level job."* MDHHS staff suggested that for future contracts, a minimum pay requirement for workers might help keep experienced workers with the program. One Protect MiFamily supervisor noted the effect of increased workload on worker burnout. *"I do notice at times when caseloads start to get high, if they start to go above eight or nine... it's more difficult for the staff and they will start to consider how hard they are working and what that looks like for their career and if that's something they would like to sustain long term or not."*

Staff from both CPS and the partner agencies in the November 2015 focus groups identified impacts that worker turnover has had on the waiver implementation. The most significant

impacts include disrupted engagement with clients and increased workload on remaining workers. *"It's hard when we have to change workers on a family,"* said one partner agency program manager*. "We're trying really hard to make sure we're finding the right people so we don't have to do that, but it's been a struggle."* A CPS worker from a different site related an example of how changing workers could impact a struggling family*: "They gave the family a brand new worker and the whole thing fell apart. That's the kind of thing, either it can be supportive or it can be not so supportive.* Central office program staff also mentioned noticing the effects of worker change on families while reviewing cases, and noted that more than just the departing worker's cases were affected. *"For example, if you have a new staff member ... [for] that person to ... receive all new cases doesn't make a lot of sense for a new person,"* one staff member told the evaluation team in November 2015*. "What happens is the sites are then trying to even it out, and maybe shift some of the ... Phase 2 or Phase 3 cases to the new person."*

As the evaluation team heard at all three sites, new workers need to start taking cases as soon as possible in order to relieve the extra case load on the rest of the staff. However, hiring a new Protect MiFamily worker is often not a quick or simple task. At the time of the site visits in October 2015, two of the three sites were not fully staffed. *"Trying to find people has been a bit of a challenge. That has left some positions open a lot longer than I'd like to, but I believe in having qualified people,"* one program manager explained*. "I don't want to fill a spot just to have a body in it, and know that I have to replace them because I didn't choose the right person in the beginning."* A program manager in a different county expressed a similar feeling: *"It seems to go in cycles. Sometimes when we have openings, we don't have a hard time at all filling them with qualified applicants and candidates, but other times like right now, we are struggling ... It's hard when we have to change workers on a family. We're trying really hard to make sure we're finding the right people so we don't have to do that, but it's been a struggle."*

In all three counties, CPS staff expressed doubts that the workers being hired had the type of experience needed to work with a high-risk, high-need population like the Category II cases. *"These are young workers ... I think that's part of the issue,"* one CPS supervisor told the evaluation team. *"We're not hiring older folks, we're not hiring people with life experience and it's not a program that provides a living wage, where somebody says, 'This is going to be a career.'"* CPS workers also expressed a lack of confidence in their qualifications; however, this may relate to a general discomfort many CPS workers expressed with not knowing their Protect MiFamily partners as well as they do workers from other programs, such as Families First, whom they meet in person more often over time. This may indicate a need to facilitate a greater familiarity between CPS and Protect MiFamily workers to increase trust and promote a smoother working relationship.

Staff turnover has also had impacts on the CPS side as well as in the central office. Both CPS and Protect MiFamily staff mentioned that worker turnover at CPS contributed to collaboration barriers, as often new CPS workers who receive a waiver case have not had training on the Protect MiFamily policy and procedures. In addition, one local MDHHS office had a significant leadership change, which both the CPS and Protect MiFamily staff in that site identified as

disruptive to interagency communication. *"Often they call us and say, 'This was randomized. What do I do now?'"* a Protect MiFamily program manager said. *"We do our best to keep them updated. But that's a thing, that not knowing. We spent all that time in the work group about establishing a protocol that was, by far, for their benefit, and then, still, they're having a hard time doing it."*

The central program office saw a complete staff turnover in spring 2014 when the previous Protect MiFamily program director moved to another position at MDHHS. Feedback during interviews with partner agency leadership was that the new director and staff were responsive and capable, but that progress in shaping policy and procedure has slowed. This can be attributed to a natural shift in the program implementation cycle, but respondents also noted that while the previous state program director worked only on Protect MiFamily, the new director already had a heavy load of responsibilities when she began with the waiver. *"Sometimes it just becomes a time issue,"* one partner agency staff noted.

Research Question: Does the training provided to workers and supervisors facilitate the successful provision of the Protect MiFamily service model?

Interim Findings:

Training of newly hired Protect MiFamily and CPS workers remains an issue in the successful provision of the Protect MiFamily service model. Staff from the partner agencies expressed a perception that the ongoing training of new workers is not standardized. Partner agency contracts contain requirements for the number of training hours in each topic area, equivalent to the training received by the first cohort of Protect MiFamily workers. The majority of training for new workers is now the responsibility of the Protect MiFamily supervisors.

The central office has been consulting with the state training office, but does not think the state will be able to offer more standardized, in-person training for new workers in the near future due to resource availability.

Areas where Protect MiFamily staff would like additional ongoing training include trauma, domestic violence, homelessness, and mental health issues in children under 5.

Training. At each of the October 2015 CPS and Protect MiFamily staff focus groups, the evaluators asked each worker to talk about their background and experience prior to their current job. The site team found a similar breadth of previous experience, often in social work but rarely in child welfare, among the CPS and Protect MiFamily workers. However, while new CPS workers undergo a rigorous training and job shadowing process before taking on cases, the logistical realities of Protect MiFamily have accelerated the onboarding of new workers. The partner agency contracts specify the number of hours of training new hires are required to receive in various subject areas, but what form that training takes often depends on whether a

MDHHS training class is being offered at the time and whether the new worker can get into it. If a training class is not available, workers view online training videos or receive training from supervisors. Although not mandated, central office program staff have recommended that all three sites add job shadowing as part of their new worker training, which they have added.

Partner agency leadership in all three locations cited training as the one area where they need more support from the central office. *"The state forgot to accommodate new staff with no protocol about how to train new staff,"* one program director explained. *"For a while there, we were winging it. Then, since that time, a large portion of the training has fallen to the supervisor, which could be extremely time consuming."* A program director at another site noted*: "We have a real problem with the training and making sure that the training is standard and done just as well when you add other staff now. I have great supervisors and that in my mind they're running those trainings to the best of their abilities, but they're running them and they're also [supervising workers], so that becomes you have to balance the priority list."*

The supervisors also expressed frustration over the training issue. *"We've asked for a meeting amongst the three counties to try to highlight training as an issue, take a little bit more off of the supervisors by standardizing training a little bit more and having the central office offer more pieces,"* one supervisor told the site team. *"They'll do an orientation that will cover a little bit of the training. It's maybe four to six hours. And then we're left with another 50 hours of sometimes un-reproducible material that we have to somehow come up with.... So we've asked for ways to have more of the training covered by standardized material through central office, and they haven't really come up with any solutions yet."* When interviewing central office staff, the evaluation team heard that a solution to the training issue is still far off. *"We spoke with our training folks the other day. They've got their own issues about the amount of trainings that they put on and what they have available, because we were wondering if maybe we could get some more training available in some of those areas."* One central office staff explained the challenges included contractual issues and stated, *"It didn't seem like there was going to be the potential for that right away because of the resources, because they bring in some experts on the subject and they'd have to redo contracts. Not that it would be impossible down the road, but right now, I don't see that happening in the near future."* One program manager said of the central office, *"I do think they make valiant efforts to try to make sure that our workers are prepared and equipped to deal with a lot of the issues that we face. I think that's an ongoing thing that we work collaboratively on, so I really appreciate that."*

During the October 2015 focus groups, the evaluation team heard mixed reports from newer workers about how quickly they took on a caseload after being hired and whether they felt their training prepared them sufficiently for their work. Most workers felt well-grounded in the program theory, such as the protective factors, but some workers mentioned needing training on reporting, billing and how to use the assessments. *"I think that when we got into the office, and really started doing the actual work, we weren't trained on the specific work that we were going to have to do,"* one worker said. Some had a full month of training and job shadowing, where others had to take on a full caseload in half that time. As caseloads increase, the shorter onboarding period may become the norm, as one program manager noted: *"We are working*

with the program office to look at modifying the training schedule and how we can accomplish that in a shorter period of time in order for those staff to get up and running and take those cases."

One overlooked aspect of training has been the onboarding of new supervisors. Two new supervisors have been hired since initial implementation, one promoted from within the program and one hired from outside. *"New supervisors don't have any training,"* one supervisor explained. *"Had she started from a different program, then the supervisor would have to go through all the worker training. As for what we are supervising, I don't know of anything else in addition that would be provided, so that is problematic... We're left on our own to figure it out."* Supervisors receive some support from their program managers, but depend largely on each other to figure out questions or issues, as one supervisor explained*, "We have meetings with other supervisors from the other counties. We talk to each other."*

The central office program office provides some opportunities for ongoing worker training, such as topical coaching calls and arranging for Protect MiFamily workers to take part in recent MiTEAM and domestic violence trainings. Some workers expressed that the MiTEAM and domestic violence trainings were not useful for their daily work. Another worker noted that the MiTEAM trainings mostly replicated trainings the Protect MiFamily already had. However, most ongoing training takes place within each partner agency. *"I, personally, have taken it upon myself to put together a three hour, in-service that I do quarterly with my staff to make sure that we're still doing what we say we're doing and that we're doing it right,"* one Protect MiFamily program manager noted. *"I've found that the first time I did it, we ...were like, 'We're not doing this right.' We decided that this will be necessary on an ongoing basis."* Another program manager created a training resource for her staff. *"The training was really good but it was more about the model and what the protective factors were...and not how to put it into practice and use it in our work with the families. I made a book and mapped out the strategies, for each protective factor so that they could use and I filled it with interventions like under parental resilience."* Supervisors also take on a great deal of ongoing refresher training, though one worker noted that sometimes led to some workers having knowledge that the others did not, depending on which supervisor they had. The partner agencies also sometimes send workers to training opportunities offered by community partners.

Protect MiFamily staff mentioned a few areas where additional training would be helpful for their work. *"Nobody's wishing for more training,"* one supervisor said. *"Not really, but I do feel that ... trauma training is an absolute must and something to continue to receive ongoing because of the populations of families we serve."* In the worker focus groups, Protect MiFamily workers mentioned domestic violence, homelessness and mental health issues in children under five as areas where more training is needed.

Services Reported

Service data continues to be assessed for accuracy and the extent to which it provides a complete and reliable picture of services in the demonstration.

A total of 401 treatment families reported having received one or more of the services listed on the services data collection tool. As shown in Table II-3, the demonstration sites share a rough parity in the percentages of families reported to be receiving one or more service.

Table II-3. Number and Percent of Treatment Group Families Reported to be Receiving One or More Service

Sites	Number and percent of treatment group families reported to be receiving one or more service
Kalamazoo	36.4% (146)
Macomb	32.2% (129)
Muskegon	31.4% (126)
Total (n = 401)	

The immediate value of these services data may be seen in the types of services provided. Please note these data reflect services actually provided and do not include numbers for families in the earlier stages of service delivery, i.e., families identified as need/planned and/or referred for a given service as the evaluation had originally planned to collect. As seen in Table II-4, 70.1% (281) of the 401 treatment families documented to be receiving one or more service have received Direct Waiver Worker Service – Protective Factors. In second position, Direct Waiver Worker Service – Concrete Assistance (providing goods or services that address safety, reduce risk or improve child well-being such as busy tokens to get to an appointment) has been provided to 61.2% (243 of 401) of treatment families.

Table II-4. Number and Percent of Services Provided to Treatment Families as Recorded in the Protect MiFamily Database (n = 401)

Protect MiFamily Services	Number and Percent of Services Provided
Direct Waiver Worker Service – Protective Factors	70.1% (281)
Direct Waiver Worker Service – Concrete Assistance	61.2% (243)
Direct Waiver Worker Service – Parent Skill Development	51.1% (205)
Direct Waiver Worker Service - Transportation	40.6% (163)
Direct Waiver Worker Service – Communication	39.9% (160)
Direct Waiver Worker Service – Budgeting	34.9% (140)
Counseling - Individual	34.4% (138)
Parenting Education	30.7% (123)
Housing Assistance	29.7% (119)
Education Services (Child)	19.2% (77)
Direct Waiver Worker Service – Time Management	19.0% (76)
Employment Services	18.5% (74)

Protect MiFamily Services	Number and Percent of Services Provided
Trauma Assessment	16.7% (67)
Mental Health Assessment	16.2% (65)
Medical Services (Other)	16.2% (65)
Parent Support/Mentoring	15.7% (63)
Substance Abuse Assessment	12.5% (50)
Transportation Services	11.5% (46)
Early On Assessment	11.5% (46)
(Early) Head Start	11.5% (46)
Substance Abuse Screening/Testing	11.2% (45)
Legal Aid	10.7% (43)
Substance Abuse Outpatient Experimental	10.5% (42)
Domestic Violence Victim Support/Intervention	10.5% (42)
Mental Health – Psychiatric Care	10.2% (41)
Visitation	9.5% (38)
Crisis Support	9.5% (38)
Early On Intervention	8.2% (33)
Domestic Violence Offender Intervention	7.0% (28)
Respite Care/Child Care	6.5% (26)
Home-Based Therapy	6.5% (26)
Early Intervention Program (EIP)	6.2% (25)
Counseling – Family	6.0% (24)
Education/Literacy Services (Adult)	5.2% (21)
Social Support for Parents	5.2% (21)
Mental Health Services - Inpatient	5.0% (20)
Family Planning/Pre-natal Services	4.5% (18)
Counseling – Group	4.2% (17)
Parent-Child Interaction Therapy	3.7% (15)
Trauma-Focused Intervention	3.7% (15)
Healthy Baby, Healthy Start / Healthy Families	3.0% (12)
Wraparound	2.7% (11)
Family Resource Center	2.5% (10)
LINK Program	2.2% (9)
Substance Abuse Inpatient Experimental	2.0% (8)
Trauma-Focused Parenting Support – NCTSN	2.0% (8)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	1.5% (6)
Parent-Child Psychotherapy	1.0% (4)
Nurse-Family Partnership	1.0% (4)
Parents as Partners	1.0% (4)

Protect MiFamily Services	Number and Percent of Services Provided
Incredible Years	0.5% (2)
Parent Cafés	0.5% (2)
Other (Not specified)	*21.7% (87)*

Service data is documented for 58.0% (149) of the 255 control families listed in the control service data file. For the balance of cases (42.0% or 106 families), service data are either unreported or the families did not receive services. See Table II-5 for the Status of Service Data for Control Families.

Table II-5. Status of Service Data for Control Families

County	Cases	Cases w/ service data		Cases w/o service data	
	n	**#**	**%**	**#**	**%**
Kalamazoo	**104**	71	68%	33	32%
Macomb	**75**	43	57%	32	43%
Muskegon	**76**	35	46%	41	54%
TOTAL	**255**	**149**	**58%**	**106**	**42%**

Closed without service data. The service data also indicate that 169 cases have closed, including 63 cases (37%) for which there are no service data. Of these cases, 23 families are category IV cases which commonly open and close on the same date and which typically do not receive any services. The balance of closed cases (40) without service data are category II cases; these cases were open for varying periods and it is reasonable to believe that most would have received at least some services. If this is, in fact, true, then these cases should be viewed as having unreported service data – a significant loss of data. It should be noted that central office program office regularly requests information on services for cases without service data, especially closed cases, and these requests routinely go unanswered. See Table II-6 for the Status of Service Data for Closed Control Cases.

Table II-6. Status of Service Data for Closed Control Cases

County	Closed	CAT 2 w/o service data		CAT 4 w/o service data		Total closed w/o service data	
	n	**#**	**%**	**#**	**%**	**#**	**%**
Kalamazoo	**56**	5	9%	6	11%	11	20%
Macomb	**56**	11	20%	10	18%	21	38%
Muskegon	**57**	24	42%	7	12%	31	54%
TOTAL	**169**	40	24%	23	14%	**63**	**37%**

Service categories for control families are provided differently than those in the treatment database, and many services must be up-coded or categories of service developed. Central

office program staff and the evaluation team have worked together to improve comparability of these services across conditions, and central office program staff drafted a new, more encompassing list of services for the control expenditure collection form.

As reported in Table II-7, 49.6% (74) of 149 control families documented to be receiving one or more service have received Counseling – Individual and Substance Abuse Screening/Drug Testing. In second position, Families First (FFM) has been offered to 42.9% of control families (64 of 149). As with the treatment service data, the immediate value of these data may be seen in the types of services provided.

Table II-7. Number and Percent of Services Provided to Control Families as Recorded in the Control Group Service File (n = 149)

Control Services	Number and Percent of Services Provided
Counseling - Individual	49.6% (74)
Substance Abuse Screening/Drug Testing	49.6% (74)
Families First (FFM)	42.9% (64)
Concrete Assistance	40.9% (61)
Parenting Education/In-home, Group or Class	28.8% (43)
CPS Ongoing	26.1% (39)
Mental Health Assessment /Psychological Evaluation	24.1% (36)
Housing Assistance	10.7% (**16)**
Household Management/Homemaker	8.7% (13)
Families Together, Building Solutions (FTBS)	8.0% (12)
Early On Assessment and/or Intervention	8.0% (12)
Mental Health/Psychiatric Consult/Medication Review	8.0% (12)
Counseling – Family	7.3% (11)
Domestic Violence Victim Support/Intervention	6.0% (9)
Transportation	6.0% (9)
Employment, Education, Literacy (Adult)	5.3% (8)
Counseling - Group	4.6% (7)
Special Education Services/Tutoring	4.0% (6)
Inpatient Drug Treatment	3.3% (5)
(Early) Head Start or other preschool	2.6% (4)
Medical Services (Not specified)	2.6% (4)
Respite Care/Child Care	2.0% (3)
Visitation	2.0% (3)
Before/After School Care Program	2.0% (3)
Early intervention Program (EIP)	2.0% (3)
Wraparound	2.0% (3)

Control Services	Number and Percent of Services Provided
Supportive Opportunities for Families (SOF Program)	1.3% (2)
Legal Aid	1.3% (2)
ARC Guardianship Services	0.6% (1)
Incredible Years	0.6% (1)
Family Resource Center (FRC)	0.6% (1)
Medical Services - Child	0.6% (1)

Model Fidelity Checklist

The county-level model fidelity scores are provided in Table II-8. Scores from the first year should be interpreted with caution because there was only one data collector completing checklists, the sample rated was lower than desired (n=30 vs. n=60 per quarter), and during that time the evaluation team was not receiving timely updates about changes in practice, meaning selected checklist measures were not current with service provision. Nonetheless, fidelity scores improved between quarter 1 and quarter 2 of year one. Scores in two counties (Kalamazoo and Macomb) decreased in the first quarter of year two while scores in Muskegon increased in each quarter. After the first quarter of year two, scores in Kalamazoo continued to increase. Scores in Macomb continued to fluctuate. The evaluation team expected to see steadily improving fidelity scores in year two as the partner provider staff developed increased competency in service delivery. However, staff turnover can affect fidelity. Newer staff must develop competency in service delivery. Staff turnover may have affected scores in Macomb. Overall, seven new partner provider staff members were hired in 2014; five of those workers were hired in Macomb. The evaluation team also expected to observe stability in the model fidelity scores in year two. More cases were rated per review period in year two and larger sample sizes allow for better approximation of service delivery. Data collection also became consistent in year two, with the use of the same data collectors, allowing for better observation of trends. Scores in every county decreased between the rating periods in year three. There was less adherence to contact standards in quarter two of year three, and that decrease in standards may be contributing to the decreases in county fidelity scores.

Table II-8. Model Fidelity Checklist Quarterly Scores

County	Year 1 Quarter 1 (n=29)	Year 1 Quarter 2 (n=30)	Year 2 Quarter 1 (n=90)	Year 2 Quarter 2 (n=89)	Year 2 Quarter 3 (n=61)	Year 3 Quarter 1 (n=60)	Year 3 Quarter 2 (n=60)
Kalamazoo	64	87	80	81	89	94	85
Macomb	49	83	79	68	79	86	82
Muskegon	37	65	76	86	87	89	85

As reported in Table II-9, there is still a challenge with maintaining Phase 1 and 2 contact standards despite the use of within-range ratings. The majority of the data collectors' comments for items 1a and 1b indicated that the contact standards were due to family issues (e.g. family did not show up for an appointment). Data collectors also frequently noted that partner provider staff only missed one contact (e.g. missed the required contact during one week). Though contact standards are proving challenging it should be noted that the initial Quality Services Review (QSR) of 10 cases, conducted by MDHHS' Division of Continuous Quality Improvement, found that family needs were met even when contact standards were not met.

Table II-9. Model Fidelity Checklist Family Contact Items for Phase 1 and Phase 2 Cases That Did Not Meet Contact Standards

	Year 2 Quarter 1 (n=90)	Year 2 Quarter 2 (n=89)	Year 2 Quarter 3 (n=61)	Year 3 Quarter 1 (n=60)	Year 3 Quarter 2 (n=60)
Family Contact Items	**Did not meet standard % and # of cases**				
1a. Did the waiver worker maintain contact standards with the family as required for this phase? (Twice every 7 days in Phase 1; once every 7 days in Phase 2; once a month in Phase 3)	67% (60)	66% (59)	52% (32)	48% (29)	62% (37)
1b*. If the waiver worker did not maintain contact standards with the family as required for this phase, was the family contacted twice every 8-10 days in Phase 1, or once every 8-10 days in Phase 2?	N/A, item was not available during first quarter reviews	60% (29 out of 48 applicable cases)	63% (19 out of 30 applicable cases)	38% (8 out of 21 cases)	30% (18 out of 27 cases)

* Item 1b is only answered when the contact standard is not met in Item 1a.

Item-level ratings on the checklist, by county, provide further information on areas where model adherence is and is not occurring. Aggregated item-level ratings by county, for the most recent rating period, are displayed in Table II-10. Items are grouped by the following practice areas: Contacts and Assessments, Family Team Meetings, and Worker Service Delivery. Item responses should be interpreted with caution when fewer than 10 cases per county were rated. Strengths, as reported in the Contacts and Assessments portion of Table II-10, include 100% adherence to the model in addressing the waiver Safety Assessment Plan. The majority of partner agency staff are also completing required progress reports in Phases 2 and 3. There is only one item measuring family team meetings and a small number of cases were rated during the current data collection period; however, all partner provider staff convened FTMs on time. Following the trend from past years, adherence to the model appears strongest in the area of

Worker Service Delivery. Partner provider staff largely demonstrated model adherence across all four items in this area. Adherence may be an artifact of the sizable (typically greater than 10) number of cases rated per item in this area, and the number of cases rated is affected by the activities being reviewed. Three out of the four items in the Worker Service Delivery practice area feature activities that are required in all phases.

Table II-10. Model Fidelity Checklist Items by County, Year 3 Quarter 2 (n = 60)

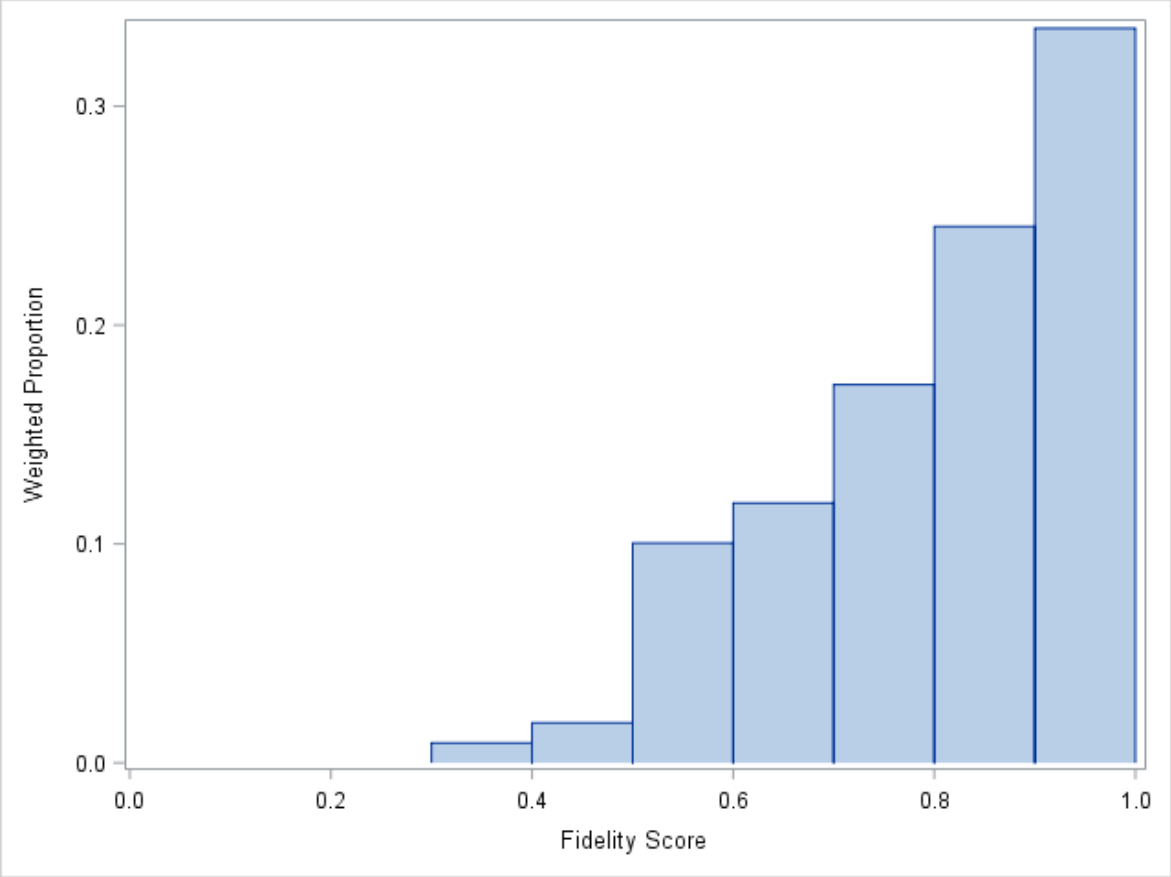
Model Fidelity Checklist Items	Kalamazoo			Macomb			Muskegon		
	N	Yes	No	N	Yes	No	N	Yes	No
Contacts and Assessment Items									
1a. Did the waiver worker maintain contact standards with the family as required for this phase? (Twice every 7 days in Phase 1; once every 7 days in Phase 2; once a month in Phase 3) ALL PHASES	20	50% (10)	50% (10)	20	30% (6)	70% (14)	20	35% (7)	65% (13)
1b. If the waiver worker did not maintain contact standards with the family as required for this phase was the family contacted twice every 8-10 days in Phase 1, or once every 8-10 days in Phase 2? PHASES ONE & TWO ONLY	8	38% (3)	63% (5)	12	33% (4)	67% (8)	13	62% (8)	38% (5)
2. Was the Family Psychosocial Screen administered within 7 days of referral? PHASE ONE ONLY	3	67% (2)	33% (1)	1	100% (1)	N/A (0)	2	50% (1)	50% (1)
3. Did the waiver worker develop an initial written safety plan within 7 days of the family's referral to the waiver project? PHASE ONE ONLY	3	67% (2)	33% (1)	1	100% (1)	N/A (0)	2	N/A (0)	100% (2)
4. Did the waiver worker administer the Protective Factors Survey as required for this phase? ALL PHASES	6	100% (6)	N/A (0)	4	100% (4)	N/A (0)	5	100% (5)	N/A (0)
5. Did the waiver worker administer the Devereux Early Childhood Assessment to each child in the household ages 0-5 as required for this phase? PHASES ONE & THREE	6	83% (5)	17% (1)	4	100% (4)	N/A (0)	5	100% (5)	N/A (0)

Model Fidelity Checklist Items	Kalamazoo			Macomb			Muskegon		
	N	Yes	No	N	Yes	No	N	Yes	No
6. Did the waiver worker administer the Trauma Screening Checklist to each child in the home ages 0-5 within 30 days of the family's referral to the waiver project? PHASE ONE ONLY	2	100% (2)	N/A (0)	1	100% (1)	N/A (0)	0	N/A (0)	N/A (0)
7. If appropriate for case status (open/closed) or case category, did the waiver worker complete the Risk Re-Assessment as required for this phase? PHASES TWO & THREE	9	89% (8)	11% (1)	13	92% (12)	8% (1)	10	100% (10)	N/A (0)
8. Did the waiver worker provide the designated family member with the waiver family satisfaction survey as required for this phase? ALL PHASES	5	100% (5)	N/A (0)	3	100% (3)	N/A (0)	5	100% (5)	N/A (0)
9. Is there evidence that the waiver worker addressed the Waiver Safety Assessment Plan as required for this phase? PHASES TWO & THREE	17	100% (17)	N/A (0)	18	100% (18)	N/A (0)	18	100% (18)	N/A (0)
10. Did the waiver worker complete the Safety Re-Assessment at 15 months? PHASE THREE ONLY	4	100% (4)	N/A (0)	3	67% (2)	33% (1)	5	100% (5)	N/A (0)
11. Did the waiver worker complete a written case plan with the family no later than 45 days after the family was referred to the waiver project? PHASE ONE ONLY	1	100% (1)	N/A (0)	1	100% (1)	N/A (0)	0	N/A (0)	N/A (0)
12. Did the waiver worker complete the progress report as required for this phase? PHASES TWO & THREE	17	94% (16)	6% (1)	18	94% (17)	6% (1)	16	94% (15)	6% (1)
13. Did the waiver worker complete the Final Progress Report? PHASE THREE ONLY	5	100% (5)	N/A (0)	4	100% (4)	N/A (0)	5	100% (5)	N/A (0)
14. Did the waiver worker complete the Case Close Notification? ALL PHASES	8	100% (8)	N/A (0)	11	91% (10)	9% (1)	10	100% (10)	N/A (0)

Model Fidelity Checklist Items	Kalamazoo			Macomb			Muskegon		
	N	Yes	No	N	Yes	No	N	Yes	No
Family Team Meeting Item									
1. Did the waiver worker convene a family team meeting as required for this phase? ALL PHASES	5	100% (5)	N/A (0)	4	100% (4)	N/A (0)	5	100% (5)	N/A (0)
Worker Service Delivery Items									
1. Were the provided community service referrals related to family's identified risks and needs? ALL PHASES	19	100% (19)	N/A (0)	19	95% (18)	5% (1)	18	100% (18)	N/A (0)
2. Did the waiver worker advance the family through this phase in accordance with the time allotted for this waiver phase? PHASES TWO & THREE	17	94% (16)	6% (1)	18	94% (17)	6% (1)	18	94% (17)	6% (1)
3. Did the waiver worker refer and link the family to concrete services that addressed either child safety, risk, or well-being? ALL PHASES	18	100% (18)	N/A (0)	15	100% (15)	N/A (0)	18	100% (18)	N/A (0)
4. Did the waiver worker send the letter summarizing progress to the family no later than 7 days after case closure? ALL PHASES	9	67% (6)	33% (3)	11	82% (9)	18% (2)	10	90% (9)	10% (1)

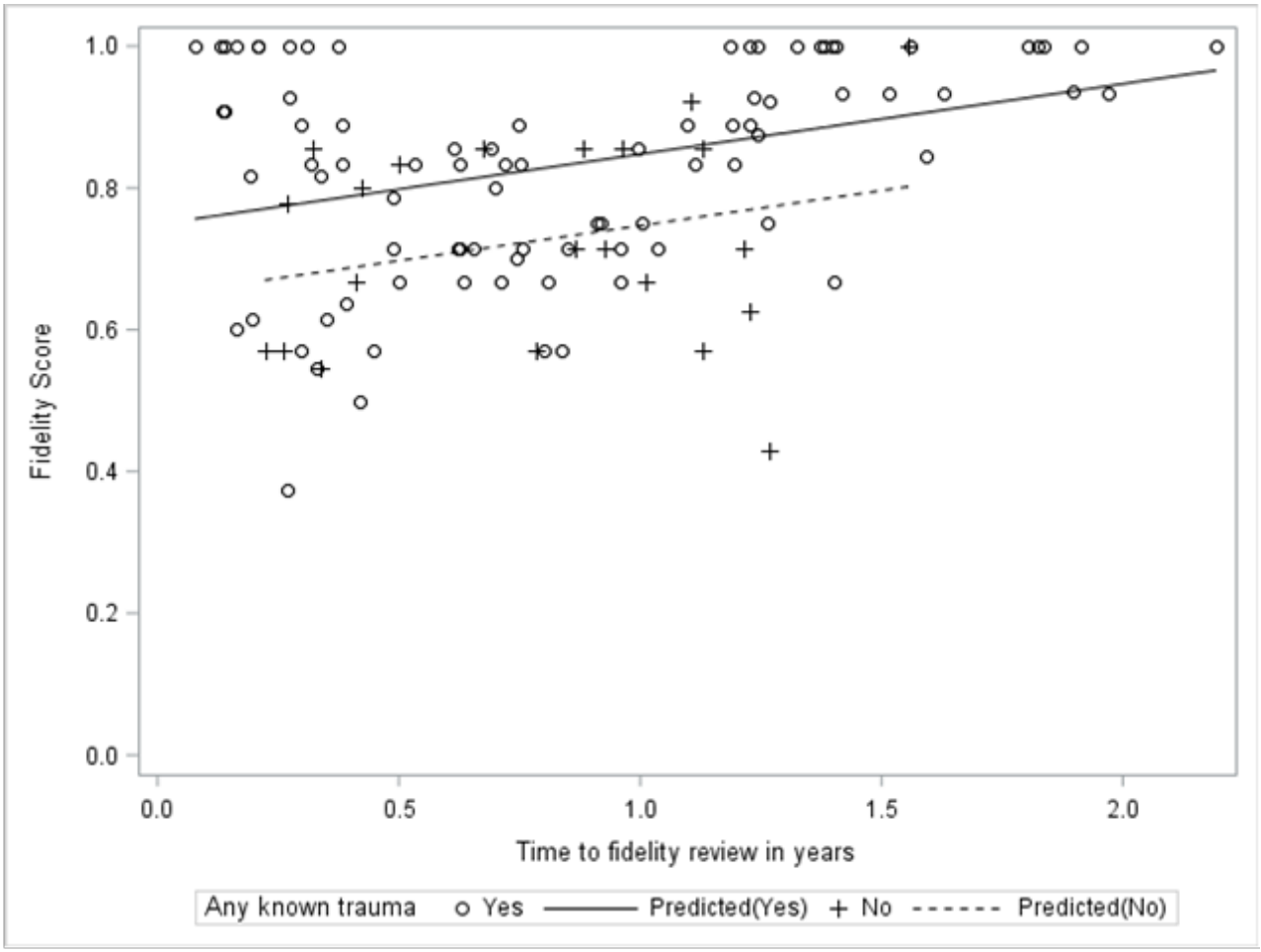
With regards to the investigation of predictors of the model fidelity score, time from referral to Protect MiFamily and completing the fidelity review (time to fidelity review) and the indicator of any known trauma (Max known trauma) were the only predictors that were selected as being related to the fidelity score, and they were selected in both the weighted and unweighted stepwise selection. After time to fidelity review and known trauma were selected, the SAS software survey regression procedure (SURVEYSELECT) was used to calculate the p-values for the effect of time to fidelity review and any known trauma on the fidelity score. Figure II-2 shows a weighted histogram of the fidelity scores representing the distribution of fidelity scores across cases. The smallest fidelity score is 0.375 and the maximum is 1.0; 24 of 108 fidelity scores are equal to 1.0. The weighted mean fidelity score is 0.82.

Figure II-2. Weighted Histogram of the Fidelity Scores



The time to fidelity review (p = 0.0005) and known trauma for any child (p = 0.0049) are both significant at the 5% level. Figure II-3 shows the fidelity score versus time to fidelity review and the predicted fidelity score versus time to fidelity review (on the horizontal axis) and any known trauma (Yes shown as o, No shown as +).

Figure II-3. Relationship between Time to Fidelity Review, Any Known Trauma and Fidelity Score



This analysis suggests that the fidelity score is related to known trauma and time to fidelity review; however, the ability to quantify that relationship is problematic. Other ways to summarize trauma across children or including another predictor or excluding a predictor may give different results. The p-value, although less than 0.05, is for a variable selected using stepwise regression and thus it is not really interpretable as a probability. Nevertheless, the p-value is small enough that there appears to be a definite relationship between fidelity score and trauma (higher fidelity score associated with known trauma for at least one child) and fidelity score and time to fidelity review. This association with any known trauma may indicate that workers are prioritizing cases on their caseload based on the trauma assessment. The relationship with time to fidelity review may indicate that as a worker spends more time with a family, he or she has a better understanding of how a family's needs can be met within the Protect MiFamily service model. The relationship with time to fidelity review may also be an artifact of the type of service activities rated near the end of case in comparison to those activities rated nearer the beginning of a case. For example, raters have continuously documented low fidelity around Phase 1 and Phase 2 family contact standards. These phases have requirements that are more stringent than Phase 3 contact standards.

Family Satisfaction Survey

The Family Satisfaction survey was developed to assess program participants' satisfaction with Protect MiFamily- funded program and services. The evaluation received 493 surveys for clients enrolled in the project between August 1, 2013 and November 30, 2015. Frequencies and satisfaction scores were available from 435 surveys. Fifty-eight of the surveys had a missing, truncated or incorrect ID entered on their survey, or were missing the phase number, which rendered them unusable for analysis. As shown in Table II-11, Family Satisfaction Survey Totals, there are significant differences in the number of surveys received by the counties.

Calculating a response rate for the Family Satisfaction Survey has been a challenge. While great improvement has been made, the data on the number of families that moved through the different phases is inconsistently documented in the Protect MiFamily database. This hinders the ability of the evaluation team to compute exact response rates for each phase since there is not an accurate denominator. Identifying in what phase of treatment a family is receiving services is critical to assessing fidelity to the service model and whether model fidelity benchmarks are met. Receiving this information is also critical to determining if fidelity to the service model provides evidence of good outcomes as well as continued client satisfaction with services. The evaluation team identified some potential reasons for these discrepancies including the following: (1) movement between phases is not being accurately logged in the Protect MiFamily database; (2) some surveys may be marked with the incorrect phase number; (3) some families may be completing more than one Phase 2 survey. In 2014, the evaluation team raised the issue of recording the dates when clients move to each of the phases with the Protect MiFamily central office program staff in a phone call and subsequent memo. In fall 2014, MDHHS central office program staff sent a directive to the partner agencies asking them to consistently enter phase data in the Protect MiFamily database.

Table II-11. Family Satisfaction Survey Totals as of November 30, 2015

Number of Surveys in Analysis [7]	#	Percent of Surveys
Total	**353**	
Number of Surveys by County		
Kalamazoo	195	43.9%
Macomb	91	23.9%
Muskegon	149	32.3%
Total All Phases	**435**	
Number of Phase 1 Surveys by County	**#**	**Percent of Phase 1 Surveys**
Kalamazoo	103	43.2%
Macomb	41	23.5%
Muskegon	71	33.3%

[7] An additional 58 surveys were received with missing phase numbers, no ID number or an ID number that did not match any case in the compiled sample. These were not analyzed.

Number of Surveys in Analysis [7]	#	Percent of Surveys
Total Phase 1	**215**	
Number of Phase 2 Surveys by County	**#**	**Percent of Phase 2 Surveys**
Kalamazoo	61	48.8%
Macomb	29	23.3%
Muskegon	44	27.9%
Total Phase 2	**134**	
Number of Phase 3 Surveys by County	**#**	**Percent of Phase 3 Surveys**
Kalamazoo	31	36.6%
Macomb	21	26.8%
Muskegon	34	36.6%
Total Phase 3	**86**	

Data from the Family Satisfaction Survey has consistently shown high satisfaction with the program. The evaluation team computed cumulative frequencies on all surveys by phase. Phase 1 survey results continue to suggest that overall satisfaction with program services is positive with over 91% either agreeing or strongly agreeing that their family was getting the services they need and that they know how to contact other agencies to get their needs met. Phase 2 results also show high program satisfaction, with over 95% either agreeing or strongly agreeing that their family was getting needed services and nearly 98% indicating that they know how to contact other agencies to get their needs met. Phase 3 respondents also indicated high satisfaction, with over 97% either agreeing or strongly agreeing that their family was getting needed services and over 94% indicating that they know how to contact other agencies to get their needs met.

Over 84% of Phase 1 respondents agreed or strongly agreed that the project helped them and their families reach their goals; for Phase 2 respondents, this number rose to nearly 99% agreement and almost 98% for Phase 3 families. Consistent with the prior reports, substance abuse and housing assistance were not rated as highly as others. Overall in all phases, these service categories had significant numbers of non-applicable (N/A) responses (across all phases, nearly 42% checked N/A on questions about substance abuse and 35% checked N/A on questions about housing assistance) suggesting those families did not need the service. See Appendix C for family satisfaction results by survey question across the three counties and for each individual county.

In addition to looking at satisfaction by question, evaluators derived an overall satisfaction score by averaging responses to all satisfaction survey questions. This analysis showed that satisfaction remains high with services overall (a score of 4.45 out of 5). The evaluators also derived satisfaction subscale scores for three areas: (1) satisfaction with the Protect MiFamily worker, (2) satisfaction with statements that implied a service-worker interaction and/or something the worker taught helped the family and (3) statements that reflected a client was

referred or likely to be referred to a service in the community (e.g., housing, mental health, and/or substance abuse). Satisfaction scores by these categories also have been consistently high: satisfaction with worker (4.70 this reporting period and 4.68 prior), satisfaction with service worker interactions (4.33 this reporting period and 4.32 prior), and services received within the community (4.23 this reporting period and 4.22 prior). The subscale satisfaction scores overall and by county are provided in the following Tables II-12 and II-13.

Table II-12. Family Satisfaction Survey Subscale and Overall Scale Scores[8]

Satisfaction Scores	Mean	# of Respondents	# Missing or N/A [9]
Average score of questions on satisfaction with worker (Questions 13, 14, 15, 16, 17)	4.70	434	1
Average score of questions on satisfaction with services and worker interaction (Questions 2, 3, 4, 5, 6, 7, 11, 12)	4.33	425	10
Average score of questions with services/received primarily within the community (Questions 8, 9, 10)	4.23	295	140
Average score (all satisfaction questions)	4.45	401	34

[8] Scores ranged from 0-5.

[9] This column represents the number of non-applicable (N/A) responses to one or more of the questions in the subscale grouping or missing data. These were excluded from analysis when deriving satisfaction subscale and overall scores.

Table II-13. Family Satisfaction Survey Subscale and Overall Scale Scores by County

Overall Satisfaction Scores – By County		Mean	# Missing or N/A
Kalamazoo (n=195)	Average score of questions on satisfaction with worker	4.73	0
	Average score of questions on satisfaction with services and worker interaction	4.32	2
	Average score of questions with services/received primarily within the community	4.18	67
	Average score of all satisfaction questions	4.45	15
Macomb (n=91)	Average score of questions on satisfaction with worker	4.68	1
	Average score of questions on satisfaction with services and worker interaction	4.27	1
	Average score of questions with services/received primarily within the community	4.17	21
	Average score of all satisfaction questions	4.40	4
Muskegon (n = 149)	Average score of questions on satisfaction with worker	4.67	0
	Average score of questions on satisfaction with services and worker interaction	4.38	7
	Average score of questions with services/received primarily within the community	4.34	52
	Average score of all satisfaction questions	4.48	15

III. The Outcome Study

Characteristics of Families and Children in the Waiver

The Protect MiFamily Demonstration population consists of 495 treatment group families and 264 control group families for the Interim Report period. This section reports the demographic characteristics of the treatment and control groups in the Demonstration population.[10] Table III-1 presents the family characteristics and Table III-2 presents the child characteristics for the population overall, and for each site.

The demographic data show that generally, families and children in the demonstration have the following characteristics:

- About one-half of the children are White, and about 40% are Black/African American and of other races.
- The average age of the family's primary caregiver is 29 years.
- Fewer than 50% of the families have more than one parent/caregiver.
- More than 80% of families have multiple children and nearly 1 in 5 families have more than 4 children.
- The average age of children is 6 years old.
- Over one-half of the families have more than 1 child in the family age 0-5 years.
- Child gender in the population is evenly split between males and females.

Additionally, the overall characteristics of families and children are very similar to the characteristics of families and children in each site with only a couple of variations among the Control Group families:

- The number of children 0-5 years in control group families across the sites;
- The race differences of control group children across the sites.

[10] Note that not all families and children have demographic characteristics due to data quality issues with the demographic data provided by MDHHS.

Table III-1. Population description overall and for each site, for treatment and control groups

Sample Characteristics	All Families	Kalamazoo County	Macomb County	Muskegon County
Family characteristics				
Number of families[1]	754	287	240	232
Treatment	492	179	159	154
Control	262	105	79	78
Number of children in the household				
Treatment				
1 child	14% (67)	14% (25)	16% (26)	10% (16)
2-4 children	68% (335)	70% (126)	64% (102)	70% (107)
5-7 children	16% (81)	14% (26)	17% (27)	18% (28)
More than 7 children	1% (6)	1% (1)	1% (2)	2% (3)
Missing	1% (3)	1% (1)	1% (2)	—
Control				
1 child	17% (44)	20% (21)	10% (8)	19% (15)
2-4 children	68% (179)	63% (66)	70% (55)	74% (58)
5-7 children	12% (31)	14% (15)	14% (11)	7% (5)
More than 7 children	2% (6)	1% (1)	6% (5)	—
Missing	1% (2)	2% (2)	—	—
Number of children ages 0-5 years in the household				
Treatment				
1 child	47% (229)	46% (82)	48% (77)	46% (70)
2-4 children	51% (253)	52% (93)	48% (77)	54% (83)
More than 4 children	1% (3)	1% (1)	1% (2)	—
Missing	1% (7)	1% (3)	1% (3)	<1% (1)

Sample Characteristics	All Families	Kalamazoo County	Macomb County	Muskegon County
Control				
1 child	44% (117)	50% (53)	35% (28)	46% (36)
2-4 children	53% (138)	45% (47)	63% (50)	53% (41)
More than 4 children	1% (2)	1% (1)	1% (1)	—
Missing	2% (5)	4% (4)	—	1% (1)
More than one parent/caretaker in the household				
Treatment				
Yes	45% (223)	43% (77)	45% (72)	48% (74)
No	54% (264)	55% (99)	54% (85)	52% (80)
Missing	1% (5)	2% (3)	2% (2)	—
Control				
Yes	45% (118)	39% (41)	47% (37)	51% (40)
No	54% (142)	59% (62)	53% (42)	49% (38)
Missing	1% (2)	2% (2)	—	—
Average age of primary caretaker (at CPS or Protect MiFamily referral)				
Treatment	29 years	29 years	30 years	30 years
Control	29 years	29 years	31 years	28 years

Table III-2. Population description overall and for each site, for treatment and control groups

Sample Characteristics	All Families	Kalamazoo County	Macomb County	Muskegon County
Child characteristics				
Number of children				
Treatment	1,547	554	483	510
Control	805	314	278	213
Child race				
Treatment				
White	50% (767)	43% (240)	49% (236)	57% (291)
Black/African American	39% (608)	46% (252)	40% (191)	32% (165)
Other races[2]	1% (20)	1% (6)	1% (5)	2% (9)
Unable to determine	1% (14)	1% (8)	1% (4)	<1% (2)
Missing	9% (138)	9% (48)	10% (47)	8% (43)
Control				
White	47% (382)	31% (97)	54% (151)	63% (134)
Black/African American	40% (320)	53% (167)	36% (100)	25% (53)
Other races[2]	<1% (4)	1% (2)	<1% (1)	<1% (1)
Unable to determine	1% (10)	1% (4)	1% (3)	1% (3)
Missing	11% (89)	14% (44)	8% (23)	11% (22)
Child sex				
Treatment				
Male	50% (780)	50% (276)	50% (241)	52% (263)
Female	48% (739)	50% (276)	47% (229)	46% (234)
Missing	2% (28)	<1% (2)	3% (13)	3% (13)
Control				
Male	49% (396)	48% (151)	51% (141)	50% (104)
Female	49% (391)	50% (158)	46% (129)	50% (104)

Sample Characteristics	All Families	Kalamazoo County	Macomb County	Muskegon County
Missing	2% (14)	2% (5)	3% (8)	<1% (1)
Average age of child (at CPS or Protect MiFamily referral)				
Treatment	6 years	6 years	6 years	6 years
Control	6 years	6 years	6 years	5 years

[1] The total N for all families and children, and for each site, may not be the same as the total number of families assigned to the Demonstration due to crossover cases and some data quality (ID) problems in the data.
[2] Other races include Asian and American Indian/Alaska Native

Treatment Group Families. In addition to the overall family and child characteristics for the treatment and control group families, Tables III-3 and III-5 provide information about the status of treatment group families, including their overall status in the Protect MiFamily program, and time families typically spent being served by the program. Table III-3 shows that overall, 28% of families referred to the Protect MiFamily Program were served and completed the 15 month course of services. However, a larger proportion of families overall (30%) were referred and did not complete services, leaving the Program early. In Kalamazoo County only, the proportion of cases closing early falls slightly below the proportion of families completing services. Keeping families engaged is critical for a program whose success is based on providing extended intensive services to benefit families. Moreover, this leaves a significant gap in the information available to examine outcomes for the program evaluation.

Table III-3. Protect MiFamily Status for Treatment Group Families at Interim Report, November 30, 2015

Treatment families	All Families	Kalamazoo County	Macomb County	Muskegon County
Family randomly assigned and referred to Protect MiFamily Demonstration	445	165	142	138
Family currently receiving services	**35%** (163)	**41%** (71)	**25%** (37)	**38%** (55)
Family completed Protect MiFamily services	**28%** (128)	**29%** (49)	**31%** (45)	**23%** (34)
Case closed without completing services	**30%** (138)	**21%** (36)	**38%** (56)	**32%** (46)
Cases closed:				
<1 month	**5%** (6)	**0%** (0)	**9%** (5)	**2%** (1)
1-3 months	**33%** (46)	**44%** (16)	**23%** (15)	**37%** (17)
4-6 months	**27%** (37)	**17%** (6)	**27%** (15)	**35%** (16)
7-9 months	**12%**	**14%**	**9%**	**15%**

Treatment families	All Families	Kalamazoo County	Macomb County	Muskegon County
	(17)	(5	(5)	(7)
10-12 months	**16%**	**11%**	**25%**	**9%**
	(22)	(4)	(14)	(4)
13 or more months	**7%**	**14%**	**7%**	**2%**
	(10)	(5)	(4)	(1)
Unable to determine[2]	**3%**	**5%**	**3%**	**2%**
	(16)	(9)	(4)	(3)

[1] The numbers reflect families randomly assigned and referred for service. There were about 30 families not referred after random assignment. An additional 19 families were referred but did not receive services from the partner agencies.

[2] Status cannot be determined due to data quality issues.

To get a better picture of who the families are leaving the Protect MiFamily program and whether they are different from the treatment group families overall, Table III-4 provides demographic characteristics for the families who left the program. As you can see, the data indicate that this group of treatment families, except for a couple of characteristics, is very similar to the treatment group overall with some minor differences — the families leaving are slightly more likely to have non-white children (i.e., Black/African American or other races) (47%) than the overall treatment group families (40%), and the leaving families are slightly more likely to have one caregiver in the household (58%) than the overall treatment group (54%).

A review of risk factors (data not shown) reveals that a higher proportion of these families have a caregiver with depression, substance abuse, and a lower proportion of caregivers with at least two supports to help them. This information can help Protect MiFamily central office and partner agency staff to better understand the families at risk of leaving the program, and consider if there are steps they can take to limit early exits by families.

Table III-4. Characteristics of Families Who Did Not Complete Protect MiFamily Services

More than one parent/caregiver per household	
Yes	41%
No	58%
Missing	1%
Number of children in the household	
1 child	17%
2-4 children	69%
5-7 children	14%
More than 7 children	<1%
Missing	0%
Number of children in the household ages 0-5 years	
1 child	50%
2-4 children	48%

More than 4 children	1%
Missing	1%
Average age of caregiver	28 years
Average age of children in the household	6 years
Race of children	
White	47%
Black	42%
Other races	3%
Unable to determine	1%
Missing	7%
Gender	
Male	49%
Female	50%
Missing	2%

Table III-5 presents the typical amount of time a family received Protect MiFamily services while in the program. The Protect MiFamily model recommends 15 months of service, so it is not surprising that the median time spent in the program for families who complete services, overall (and also for each county site), is 15 months (with a minimum of 13 months and a maximum of 17 months). The median time spent in the program for families who do not complete the program, overall, was 5 months. The county sites were similar on this measure, with a median service period of 4 or 5 months.

Table III-5. Service Period for Treatment Group Families

Families who completed Protect MiFamily Services	Median number of months served	15
Families who did not complete Protect MiFamily Services	Median number of months served	5

Outcome Evaluation Key Questions, Data Analysis, and Results

Research Question: Did families in the treatment group demonstrate improvement in their Protective Factors after receiving Protect MiFamily Services?

Interim Findings:

Families who completed the Protect MiFamily Program showed improvement in protective factors between the pre-survey and post-survey, although the improvement did not meet the MDHHS benchmark of 95%.

Overall, families who completed the Protect MiFamily Program showed statistically significant improvement on 3 of the 4 Protective Factors Survey subscales and on 3 of the 5 Knowledge of Parenting/Child Development items.

Data Source and Data Collection. The Protective Factors Survey (PFS) assesses multiple family protective factors against child abuse and neglect. Developed by the Institute for Educational Research and Public Service at the University of Kansas, the instrument measures family-level protective factors in five areas: (1) Family Functioning/Resilience, (2) Social Emotional Support, (3) Concrete Support, (4) Nurturing and Attachment, and (5) Knowledge of Parenting/Child Development.[11]

Protective Factors Survey (PFS) Measures:
Family Functioning/Resilience
Social Emotional Support
Concrete Support
Nurturing and Attachment
Knowledge of Parenting/Child Development

For all treatment families served by Protect MiFamily, parents were to complete an initial PFS (pre-survey) within 15 days from the date the family was referred to the Program. The parent then completed a PFS post-survey in the final phase of the Program, prior to case closure, which for most families was between 13-15 months. MDHHS set a timeline for the PFS pre-survey completion. Partner agency workers were to have parents complete the pre-survey within 15 days from the date the family was referred to Protect MiFamily.

PFS Scoring. The PFS provides a number of questions that are grouped into five areas or domains. The parent responds to the questions using a 7-point Likert scale with a range from Strongly Agree to Strongly Disagree. Each subscale area is made up of multiple questions, and the responses are tallied to calculate scores for each subscale area with the exception of

[11] The Protective Factors Survey is included in Appendix B. For a discussion of the instruments used to validate the PFS and the Psychometric Properties of the PFS, see *A Guide to Administering the Protective Factors Survey* available through the Friends National Resource Center for Community Based Child Abuse Prevent website at http://friendsnrc.org/protective-factors-survey.

Knowledge of Parenting/Child Development, which has 5 individual items (not tallied to create one subscale score) due to the complexity of the construct.

A challenge when using a survey like the PFS with parents very early on in a program is "ceiling effects." This occurs when pre-survey responses are high, and as a result, there is no room to improve in the post-survey. Ceiling effects can limit the ability to see pre-post differences for families. A similar challenge is when clients do not feel comfortable answering questions about the family's strengths and weaknesses early in a program, or do not understand the questions so may overestimate the family's capabilities when responding to the pre-survey. Then, as parents learn more about family functioning from participation and services in the program, there is a risk that the parent will answer the post-survey questions lower on the Likert scale, resulting in a decrease between their pre-post scores. In our analysis, we will provide pre-post results for families, as well as look at both of these survey challenges as possible influences on the outcomes.

Data Analysis. The PFS analysis is limited to families who: (1) had completed Protect MiFamily Services; and (2) who had a completed PFS pre- and post-survey within the interim reporting period (November 30, 2015). You will recall that 30% of families in the treatment group, who were provided Protect MiFamily services, left the program early. Of the 128 treatment group families who completed Protect MiFamily services, 110 families met the pre- and post-survey criteria for outcomes analysis. ***It is critical to keep in mind that this protective factors analysis represents about 25% of the families who were served by the program, and is not representative of the overall population of families served by the program.*** In the next sections, we will first review the methodology and results of the 110 families in the PFS outcome analysis.

Methodology. The PFS purveyor provides an application that calculates and produces reports that include comparison of the pre- and post-survey mean scores and standard deviations for each PFS area (family functioning, social emotional support, concrete support, nurturing and attachment, and knowledge of parenting/child development), for all families, and for the families at each program site (Kalamazoo, Macomb, and Muskegon). The application also calculates whether there is a statistically significant difference between the pre- and post-survey mean scores, using a paired two sample for means. This calculation is done aggregately for **all families** (it does not calculate statistical significant differences for individual families or for each program site).

Results. For the analyses, the evaluation team will first present PFS post-survey improvements on the five areas. That will be followed by a presentation and discussion of the statistical analysis of the differences in families' pre/post PFS survey improvements in the five areas.

MDHHS set an evaluation outcome benchmark for the PFS that *95% of the parents/caregivers in the treatment group will demonstrate improvements on the PFS subscale (area) scores at post-survey by 15 months after waiver assignment*. A reminder that the families included in outcomes analysis are those families who completed Protect MiFamily Services.

Table III-6 presents the proportion of families who improved in each of the PFS areas, based on a comparison of the score change between the pre-survey and post-survey. The proportion of families who improved in the PFS areas ranged from a low of 19% to a high of 55%. The greatest improvements were seen in the areas of family functioning, social emotional support, and concrete support. While families who received Protect MiFamily services made improvements, no proportion of PFS area improvement met the 95% MDHHS benchmark.

Table III-6. The Proportion of Families Who Improved in each of the Protective Factors Survey Areas, from Pre-Survey to Post-Survey

Protect Factors Areas	All Sites (110)	Kalamazoo (45)	Macomb (26)	Muskegon (29)
Family Functioning	55%	62%	56%	45%
Social Emotional Support	45%	47%	53%	34%
Concrete Support	49%	53%	47%	45%
Nurturing and Attachment	31%	36%	28%	28%
Knowledge of parenting/child development				
Item 12 (Parent knowledge)	41%	49%	36%	34%
Item 13 (Help child learn)	34%	36%	44%	17%
Item 14 (Child behavior)	40%	42%	42%	34%
Item 15 (Parent praise)	25%	29%	25%	17%
Item 16 (Appropriate discipline)	19%	20%	17%	21%

Statistical Analysis. Figures III-1 and III-2 below present the PFS pre- and post-survey mean scores for all sites, and for each county site. The graphs also include results of the statistical testing (T-tests) conducted for each PFS area, for all sites.[12] Statistically significant improvement from pre- to post-survey was determined if the T-test confidence level was .05 or less ($p \leq .05$).

Overall, families completing the Protect MiFamily program showed statistically significant improvement in their protective factors in 3 of the 4 areas—family functioning, parent social/emotional support, and parent concrete support—and statistically significant improvement was also seen in 3 of the 5 Knowledge of Parenting/Child Development items (12, 14, and 16). Although statistical testing was not conducted at the county-level, scores for each of the county sites were very similar to the pre- and post-survey mean scores for all sites. In general, mean scores improved from pre- to post-survey; the exceptions were in the Nurturing and Attachment area and in the Knowledge of Parenting/Child Development Item 15

[12] The PFS application does not provide statistical testing for individual study sites.

(Parent Praise), where pre-survey mean scores were nearly or the same, and for a couple of the counties, post-survey mean scores were lower than pre-survey mean scores.

Although at this time the MDHHS benchmark for the protective factors outcome has not been met, the analysis indicating statistically significant improvements for the majority of the PFS areas for those families completing the Protect MiFamily Program do seem encouraging, despite that the outcomes represent only about one-third of the families served by the Protect MiFamily program. There is some indication of a ceiling effect in the results, as mean scores for the pre-survey were quite high overall, ranging from a low of 5.04 to a high of 6.69, on a scale of 1-7. This may be because parents believed from the start of the program that the family's protective factors were high, or it may indicate that parents had a tendency to overestimate their family's protective factors in the pre-survey. The closeness of the mean scores pre-post and those subscales where post-survey mean scores were slightly lower may indicate that as parents learned more about their family's protective factors during the program, they were less likely to overestimate or provided lower scores at the post-survey.

Figure III-1 Protective Factors Survey Area Results: Aggregate Pre-post Survey Mean Scores for all sites, and for each county site; and statistically significant differences in the pre-post mean scores for all sites.

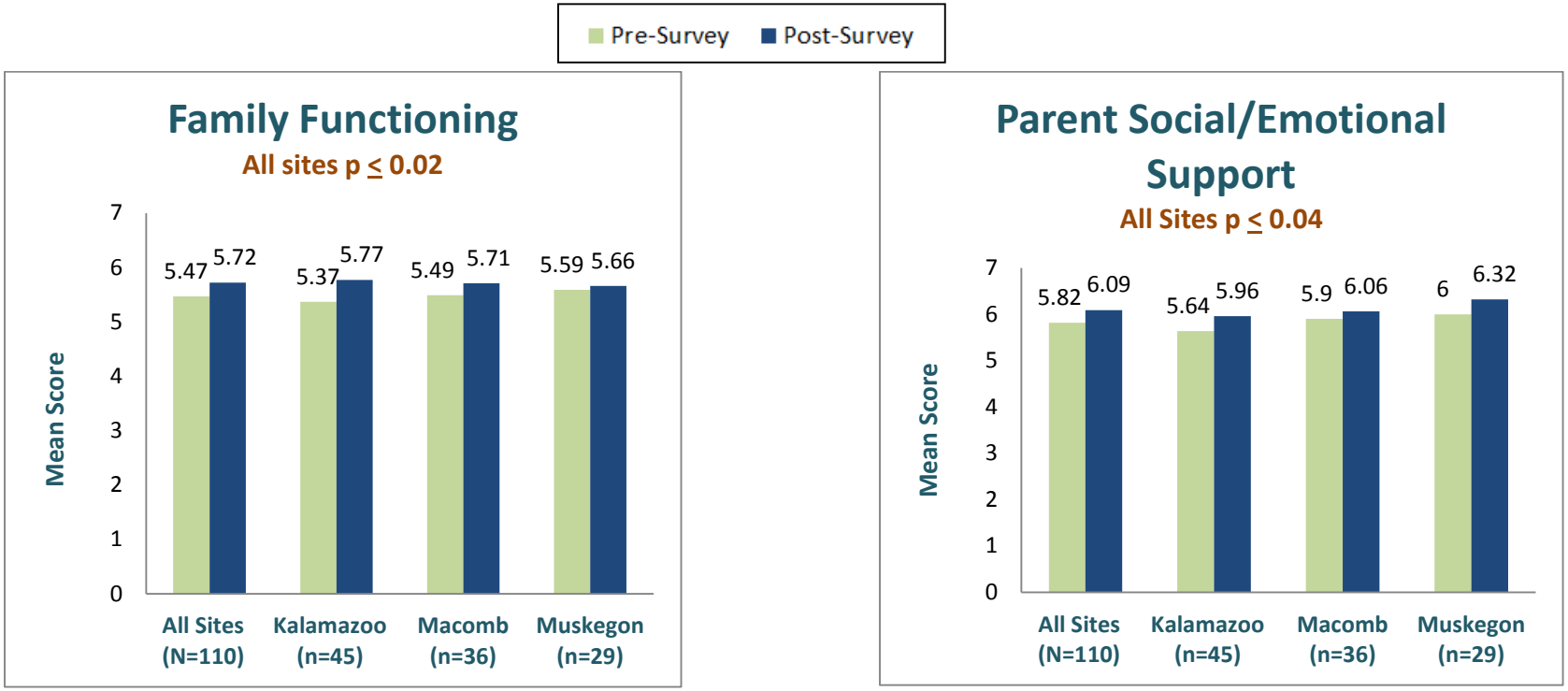


Figure III-1. cont'. Protective Factors Survey Area Results: Aggregate Pre-post Survey Mean Scores for all sites, and for each county site; and statistically significant differences in the pre-post mean scores for all sites.

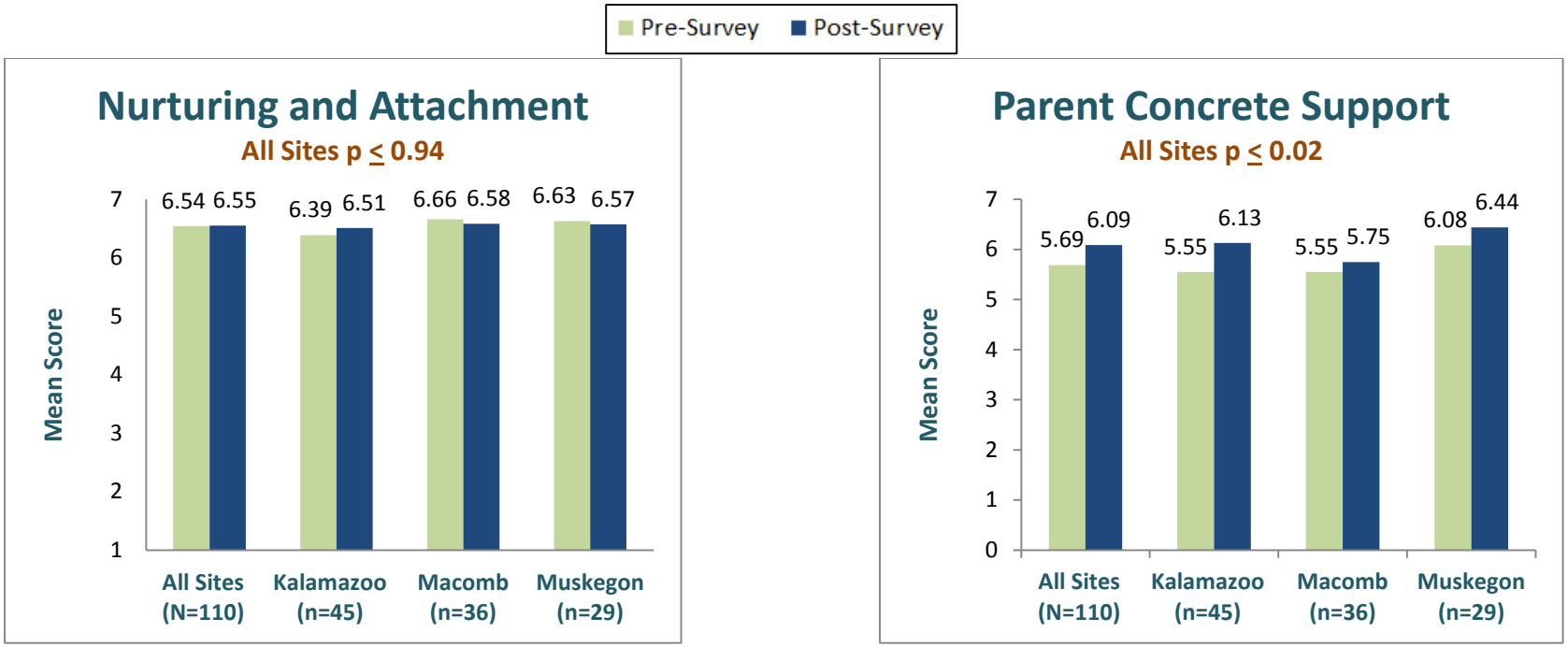


Figure III-2 Protective Factors Survey Area Results: Pre-post Survey Mean Scores for all sites, and for each county sites; and statistically significant differences in the mean scores, pre-post, for all sites.

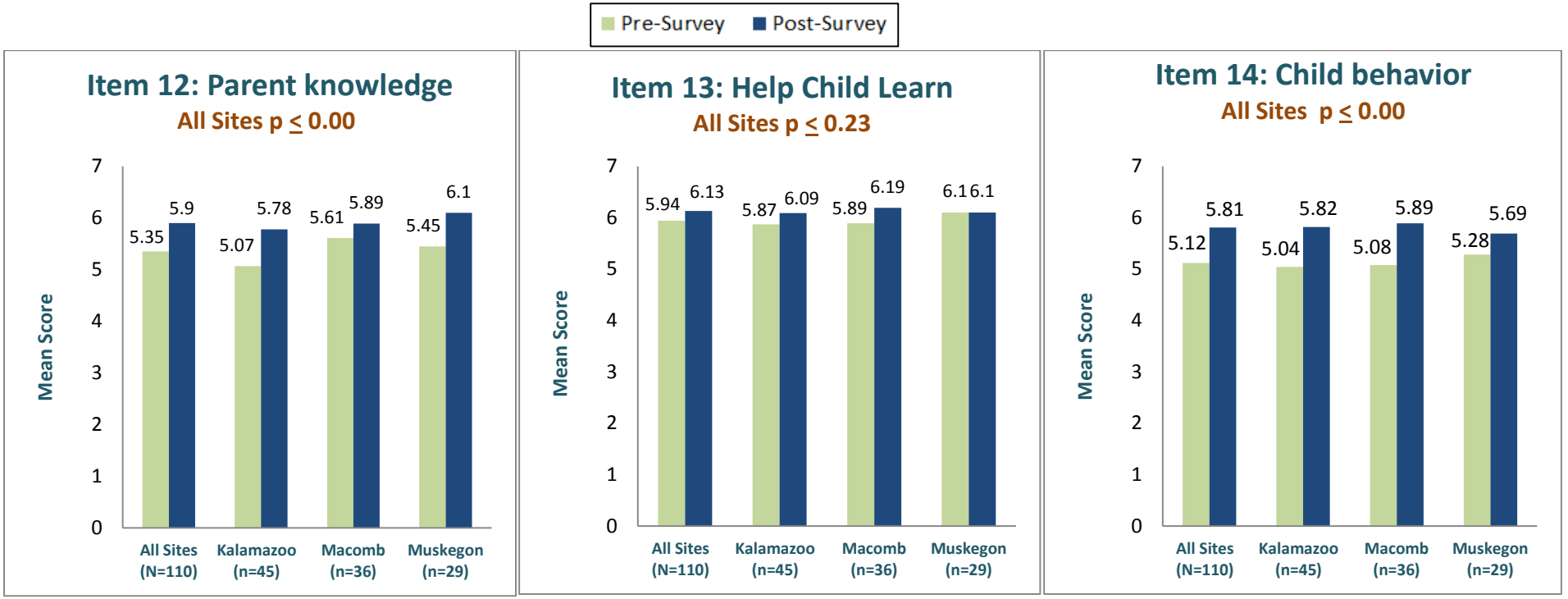
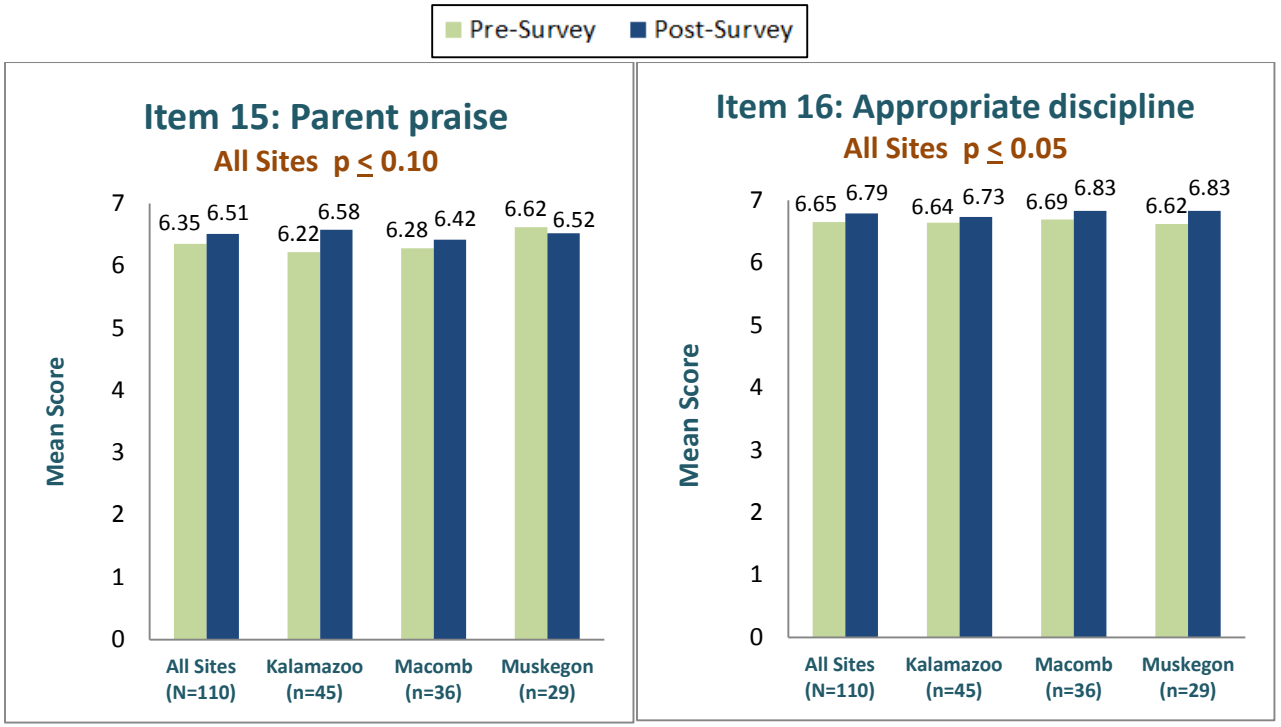


Figure III-2. cont'. Protective Factors Survey Area Results: Pre-post Survey Mean Scores for all sites, and for each county sites; and statistically significant differences in the mean scores, pre-post, for all sites.



Research Question: Did children in the treatment group demonstrate improvement in their well-being based on the Devereux Early Childhood Assessment after receiving Protect MiFamily Services?

Interim Findings:

Overall, 30% of children who completed Protect MiFamily had statistically significant improvement in their well-being based on the Devereux Early Childhood Assessment Total Protective Factors score.

The Devereux Early Childhood Assessment findings indicate that about 42% of children whose pre-test behavior indicated "Area of Need" or "Typical" showed improvement in behavior at the post-test.

The Devereux Early Childhood Assessment findings did not support the MDHHS benchmarks of 70% of children showing statistically significant improvement in well-being at the post-assessment and 90% of children showing improvement in behavior at the post-test.

Data Source and Data Collection. The Devereux Early Childhood Assessment, developed by the Devereux Center for Resilient Children, is an assessment of child protective factors related to resilience and a screener for behavioral concerns. The assessment is used both in home and in classroom settings, completed by parents and/or by teachers, and encompasses a planning system and strategy to promote the healthy social and emotional development and capacity for resilience in children.[13]

The DECA assessment is completed in age-ranges, using age-appropriate behavior items:

- Infant (ages 1 to 18 months).
- Toddler (ages 18 to 36 months).
- Preschool (ages 3 years to 5 years).
- DESSA-Mini (ages 6 and over).

Protect MiFamily uses the online web-based DECA application (e-DECA). The evaluation team acts as the DECA administrator and as part of that responsibility, evaluation team staff conducted DECA user-training and provide ongoing support to Protect MiFamily partner agency staff. The web application provides convenient online entry of assessment information, and administrative capabilities to manage and download data, both for partner agency and evaluation team staff.

[13] The Devereux Early Childhood assessments are included in Appendix B. For a full description of the psychometric properties including development of the assessment items, item standardization, norming procedures, internal reliability, inter-rater reliability, and item validity please refer to the Devereux Early Childhood Assessment for Infants and Toddlers User's Manual, the Devereux Early Childhood Assessment for Preschoolers User's Guide and Technical Manual, and the DESSA Mini Devereux Student Strengths Assessment K-8: A Universal Screening and Progress Monitoring System for Social Emotional Competencies, all available at http://www.centerforresilientchildren.org/.

For all treatment families served by Protect MiFamily, the parent was to complete an initial DECA pre-assessment for each child in the family up to 6 years of age (0-5). The DECA post-assessment was to be completed by the parent in the final phase of services, prior to case closure, which for most families was between 13-15 months. MDHHS set a timeline for the DECA pre-assessment completion. Partner agency workers were to have parents complete the pre-assessment within 15 days from the date the family was referred to Protect MiFamily.

Since the Protect MiFamily service period is 15 months, a proportion of treatment children (about 40%) graduated from one age-appropriate DECA form at pre-assessment to the next level age-appropriate form at post-assessment. For example, a child who was 25 months old and whose parent completed a Toddler DECA form at pre-assessment, would have reached 39 months by the end of the 15 months and so the parent completed a Preschool DECA form (ages 3-5) at post-assessment.

DECA Scoring. The DECA assessment items are standardized into three scales: 1) Self-Regulation, 2) Initiative, and 3) Attachment/Relationships. These three scales are combined to provide an overall estimate of a child's social and emotional competencies (well-being), called the Total Protective Factors. Scoring requires a minimum number of completed assessment items overall, and for the individual items that make up each scale. Raw scores from the assessment items are used to calculate raw scores for each scale. The raw scores are then converted to T-Scores using norm tables (in the case of Protect MiFamily children, the Parent Norm table was used for calculating T-scores since the parent completed the assessment). The Total Protective Factors (TPF) T-score is calculated using the individual T-scores from all three scales. While this process can be done manually, by using the e-DECA web application, the conversions of raw assessment items to a T-score for each child are done by the web application and are then downloaded for analysis.

Methodology. Since the questions across the different levels of age-appropriate DECA forms for the three standardized scales do not correspond directly, analysis of the children who graduate from one DECA form at pre-assessment to the next age-appropriate form at post-assessment is limited to the comparison of their pre- and post-assessment Total Protective Factors (TPF) T-Scores**.** Since 40% of children in the Protect MiFamily Treatment group graduated from one age-level DECA form at pre-assessment to the next age-level at post-assessment, our analysis focuses solely on the differences in the DECA Total Protective Factors (TPF) T-Scores to provide a consistent measure for all children. DECA describes the Total Protective Factors score as the broadest and most reliable index of the child's overall social and emotional well-being. High Total Protective Factors scores are associated with children who are functioning well, tend to have fewer behavioral concerns and are likely to be resilient when faced with risk and adversity.

Data Analysis. The DECA analysis includes children who: (1) had completed Protect MiFamily Services; and (2) had completed DECA pre- and post-assessments within the Interim reporting period (November 30, 2015). You will recall from discussion in the Sample section that 30% of families in the treatment group, who were provided Protect MiFamily services, left the program early. Of the treatment group children who completed Protect

MiFamily services, 183 children met the pre- and post-assessment criteria for outcomes analysis.[14] ***It is critical to keep in mind that this DECA analysis represents about 35% of the children served by the program, and is not representative of the overall population of children served by the program.***

Baseline Information. DECA categorizes the children's TPF T-scores into descriptive ranges, designating whether a child's score is a Strength, is Typical, or is an Area of Need. These categories make it easier to understand and use the T-score measures in casework practice. The ranges are defined as:

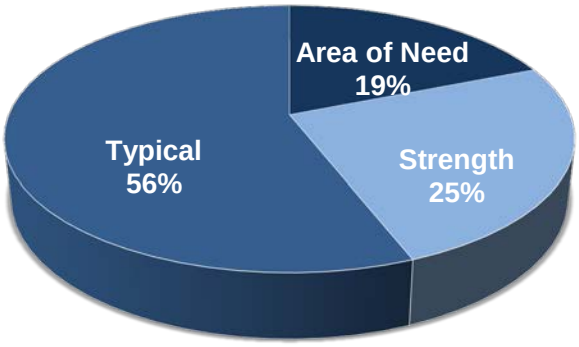
Strength: Children exhibit an unusually high amount of desirable behaviors to indicate a strength.

Typical: Children show a typical amount of behaviors in this area related to resilience.

Area of Need: Children are at risk for exhibiting or developing social and emotional problems.

Figure III-3 presents the pre-assessment or baseline TPF T-score range for all children in the analysis. This is a good barometer of the well-being of the children when starting the Protect MiFamily program. Overall, 8 in 10 children scored in the Strength (25%) or Typical (56%) categories, indicating that these children showed either a typical or high amount of behaviors related to resilience at the time of pre-assessment. The remaining children (19%) started Protect MiFamily services with a TPF T-score in the Area of Need range, indicating that they were at risk for exhibiting or developing social and emotional problems.

Figure III-3. Distribution of the DECA Total Protective Factors Score, for children at pre-assessment



The ideal outcome is for a child is to have a post-assessment TPF T-score in the Strength range. Conversely, a poor outcome is for a child to have a post-assessment score in the Area of Need range.

[14] 185 children had DECA post-assessments; however, 2 children had incomplete post-assessments that could not be included in the analysis.

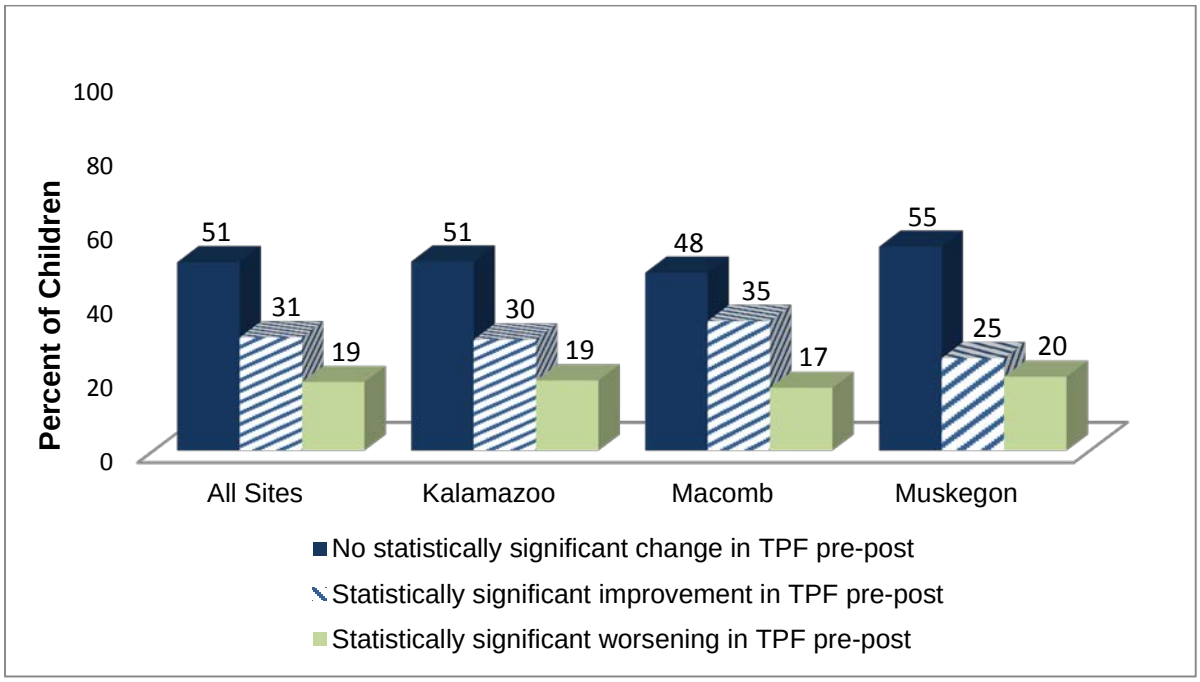
Results. For the analyses, the evaluation team will first present statistical analysis of the differences in children's pre/post assessment TPF T-scores. That will be followed by a presentation and discussion of a descriptive analysis of the outcomes (Strength, Typical, and Area of Need) to better understand how children improved and what that means for children in the Demonstration.

MDHHS has set the following outcome target benchmarks for the DECA:

- 70% of children will show statistically significant improvement in well-being at the post-assessment.
- 90% of children will show improvement in behavior at the post-test.

Statistical Analysis. Figure III-4 presents results from statistical analysis of the differences between children's TPF T-scores at pre-assessment and post-assessment, overall (all sites) and for each county site (Kalamazoo, Macomb, and Muskegon Counties). The results show that 31% of all children demonstrated statistically significant improvement in their TPF T-Score, while 51% of the children had no statistically significant change in their T-scores and 19% of the children demonstrated statistically significant worsening in their TPF T-score. These trends were consistent across each of the county sites as well, with only very slight differences in the percentages. The results fall below the MDHHS target benchmark of 70% statistically significant improvement for children at post-assessment.

Figure III-4. Statistical Analysis of the Differences between Total Protective Factors (TPF) T-Scores at Pre- and Post-assessment



Descriptive Analysis. Now that there is an understanding of the proportion of children who improved and those who did not, the evaluation team will present additional details about the range (Strength, Typical, and Area of Need) changes for children. Table III-7 shows overall, how

children moved between TPF T-score ranges (Area of Need, Typical, and Strength) pre- and post-assessment. Of the 19% of children that had a pre-assessment TPF T-score range of Area of Need, 65% improved their range to Typical or Strength at post-assessment, while 35% still indicated an Area of Need at post-assessment. About one-third of the children who had a pre-assessment range score of Typical improved to a post score of Strength; however, the majority of children with a pre-assessment range score of Typical also had a post-assessment score of Typical (52%). Likewise, the majority of children who had a pre-assessment range of Strength remained in that range at post-assessment (61%), while about 40% worsened at post-assessment to a range of Typical (33%) or Area of Need (6%).

The individual county sites had some differences in pre-post assessment movement from the overall findings, although some differences should be interpreted carefully given the small number of children included in outcomes for each of the individual sites. Kalamazoo and Macomb Counties had a higher proportion of children who improved from an Area of Need range at pre-assessment to a range of Typical or Strength at post-assessment compared to Muskegon County, where the majority of children with an Area of Need pre-score did not improve at post-assessment.

It seems worth noting that nearly 90% of children in Macomb County who were assessed in the Area of Need range at pre-assessment had improved to the Typical or Strength range at post-assessment.

The majority of the children in the typical range at pre-assessment were also in the typical range at post-assessment, while about one-third of the children in the typical range improved to a Strength range at post-assessment. Macomb County was the exception to this trend, showing a higher proportion of children with a Typical range at pre-assessment who improved to a range of Strength at the post-assessment (47%) compared to Kalamazoo and Muskegon Counties (29%).

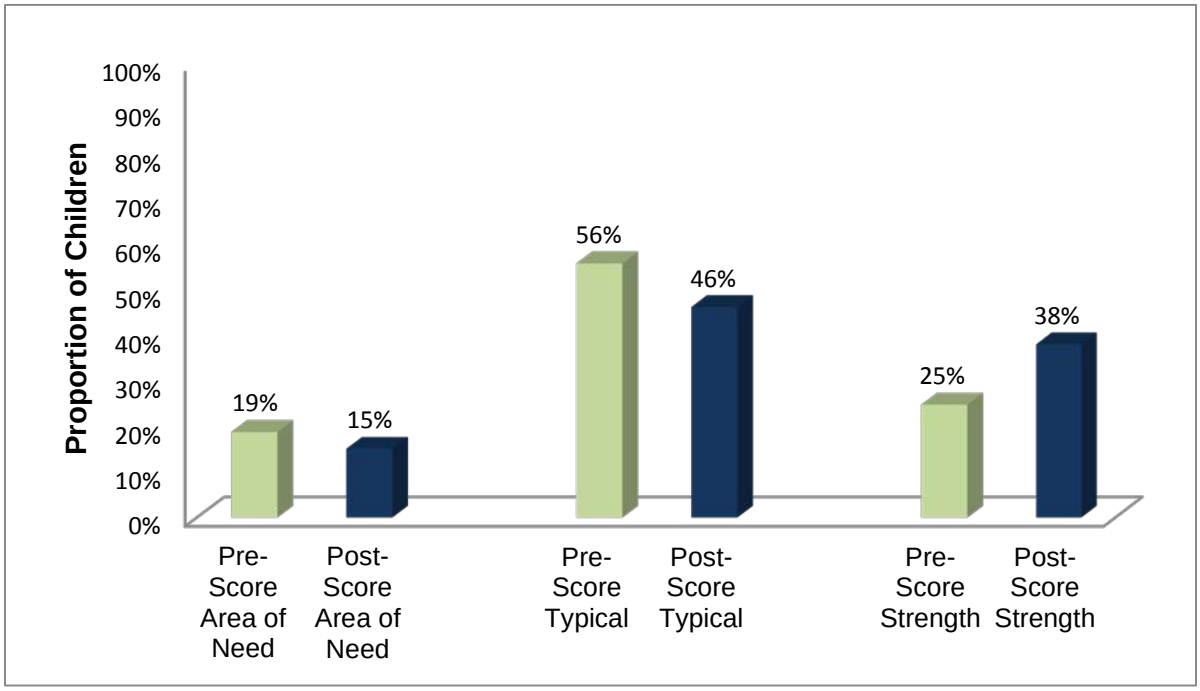
It is also important to note the 17% of children who had a TPF T-score that worsened between their pre- and post-assessments, either from a range of Typical to Area of Need, or from a range of Strength to Typical or Area of Need.

Table III-7. Children's Movement between Well-being Ranges on the TPF

Range Change Details				
	All Sites	**Kalamazoo**	**Macomb**	**Muskegon**
Children with an Area of Need Pre-Assessment Score	(19%) (n=35)	18% (n=14)	13% (n=8)	27% (n=12)
Improved to Typical or Strength post-score	**65%**	79%	88%	33%
Remained the same post-score	**35%**	21%	12%	67%
Children with a Typical Pre-Assessment Score	(56%) (n=102)	57% (n=45)	57% (n=34)	48% (n=21)
Improved to a Strength post-score	**35%**	29%	47%	29%
Remained the same post-score	**52%**	58%	38%	62%
Worsened to an Area of Need post-score	**13%**	13%	15%	9%
Children with a Strength Pre-Assessment Score	(25%) (n=46)	25% (n=20)	30% (n=18)	25% (n=11)
Remained the same post- score	**61%**	70%	56%	55%
Worsened to Typical or Area of Need post-score	**39%**	30%	44%	45%

Figure III-5 presents a comparison of the children's DECA pre- and post-assessment Total Protective Factors range. Overall, the descriptive data support the improvement in children's well-being measure from pre-to post-assessment. The proportion of children with a Total Protective Factors Score in the Area of Need range dropped 4 percentage points, from 19% to 15%. Similarly, the proportion of children in the Typical range dropped from 56% to 46%; and there was an increase in the proportion of children with a score in the Strength range, from 25% to 38%. Results for each of the Protect MiFamily sites were very similar to the overall results presented here.

Figure III-5. Comparison of Children's DECA Pre- and Post-assessment Range Scores for all Children



In conclusion, while the DECA outcomes at this time are below the MDHHS set benchmark, it is encouraging that 30% of the children with completed pre- and post- assessments had statistically significant improvement in their well-being outcomes (TPF), and that a measured proportion of children in the Area of Need range are improving at post-test, to a Typical or Strength range. It is important to reiterate that the *well-being results presented represent 35% of the children served by the program, and should not be interpreted as representing the well-being of the overall population of treatment children served by the Protect MiFamily Program.* As a result, the Evaluation Team is cautious in interpreting the results for the program overall, and hopes that the proportion of children with completed DECA pre- and post-assessments will improve so that the well-being outcomes in the Final Report can better represent the overall population of children served.

The outcome study focuses on risk, permanency and safety. The evaluation team reports both overall risk levels and a breakdown by control and treatment groups. These groups are constructed via random assignment.

The outcome analyses included all children and families associated with the Protect MiFamily demonstration waiver. All families had at least one child that was five years of age or younger. Approximately 58% of the children were reported to be White and 40% reported African American. Kalamazoo had the largest percentage of families (38%), followed by Macomb (32%) and Muskegon (30%).

Data Source and Data Analysis for Administrative Data Outcomes. The data source for the administrative data outcomes is the Michigan Statewide Automated Child Welfare Information

System, MiSACWIS. The evaluation team received and reviewed the administrative data provided by MDHHS for the analysis covering the period from August 1, 2013 to November 30, 2015. The team requested the administrative records for all category II and category IV cases that were associated with the three waiver counties (Kalamazoo, Macomb, and Muskegon). Analyses using administrative data focused on removals (i.e. placement into foster care), the recurrence of maltreatment (i.e. category I, II or III allegation) and changes in risk level at the family level. The evaluation team investigated both the overall risk of removal and the timing of removal (i.e. number of days between random assignment and placement into foster care). The evaluation team also investigated the overall risk of maltreatment recurrence and the timing of recurrence.

Additionally, the evaluation team examined the effects of completing the Protect MiFamily service delivery model (what is called receiving the full-dose of treatment) on the rates of removal and subsequent maltreatment. In this report we attempt to capture both ends of the spectrum. The first is from the "intent to treat" perspective, where everyone assigned, regardless of their participation level, is followed with the administrative data. Given the random assignment, there should be an equal distribution of parents that are reluctant or disinterested in services across both the control and treatment groups. With that said, perhaps the additional services in the treatment group - increase the rate of non-compliance or resistant to services. To address this, we compare those who receive a full dose (phase 3) of the intervention with all control group families. This gives everyone perhaps a better (or more nuanced) understanding of how effective the treatment services are (if one were to fully engage) in relation to "services as usual."

The analyses of the outcomes using administrative data are presented below.

Removal from the biological family home

Research Question 3: How does the risk of removal compare between the control and treatment groups?

Interim Findings:

Children in families in the treatment group who completed Protect MiFamily services were significantly less likely to be removed from the biological family home as compared with children in the control group. This finding suggests that families are more likely to remain intact when families are capable of completing Protect MiFamily services.

Considering all children in the waiver demonstration, no statistically significant differences emerge when comparing the risk of removal between control and treatment families overall and in any of the waiver demonstration counties.

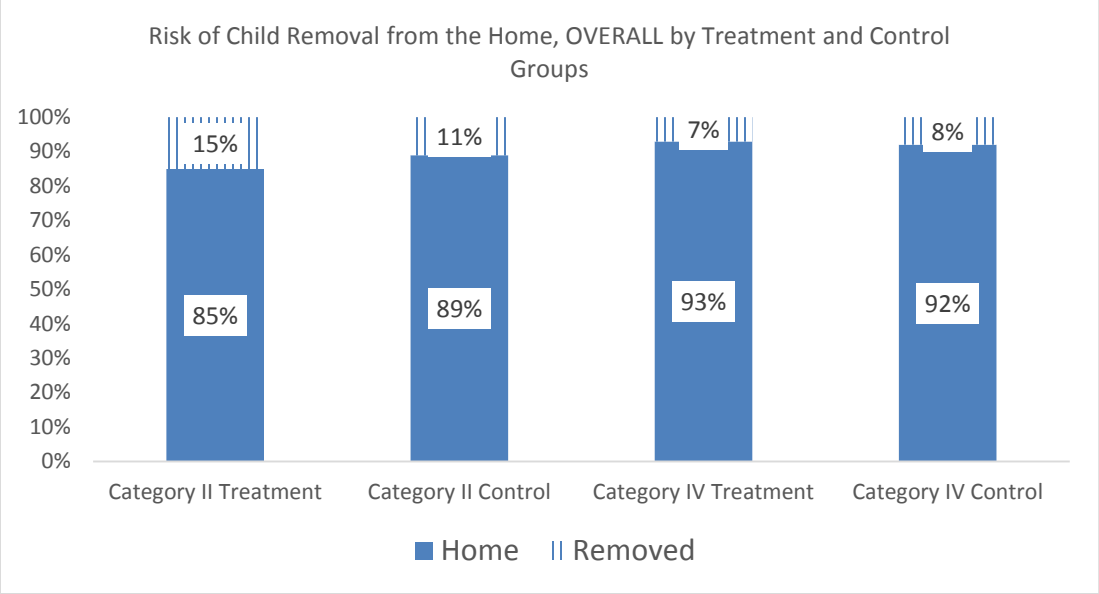
There were no statistically significant differences in time to removal when comparing the control and treatment groups.

One of the primary objectives of the waiver demonstration is to prevent the use of foster care placement associated with category II and category IV cases. The following figures display the risk of removal (subsequent to random assignment). The figures display the overall risk of removal by assignment group and the risk of removal within individual counties.

Overall, 13.3% of families experienced the removal of at least one child from the biological family home. At the last reporting period, approximately 11% of the families had experienced the removal of at least one child.

There was also a fairly large – and statistically significant effect - associated with the "full dose" of services (i.e. completed all 3 phases). Children in the treatment group were significantly less likely (4.6%) to be removed from the biological family home as compared with children in the control group (10.8%). This finding suggests that families are more likely to remain intact when families are capable of completing services.

Figure III-6. Risk of Child Removal from the Home, OVERALL by Treatment and Control Groups



There is some variation when comparing the risk of removal across counties. Yet, no statistically significant differences emerge when comparing the risk of removal by assignment group in any of the waiver demonstration counties. As the sample sizes increase (and the power to detect smaller differences increases) statistically significant differences are likely to emerge, especially in Kalamazoo and Macomb where apparent differences appear larger.

Figure III-7. Risk of Child Removal from the Home, in KALAMAZOO by Treatment and Control Groups

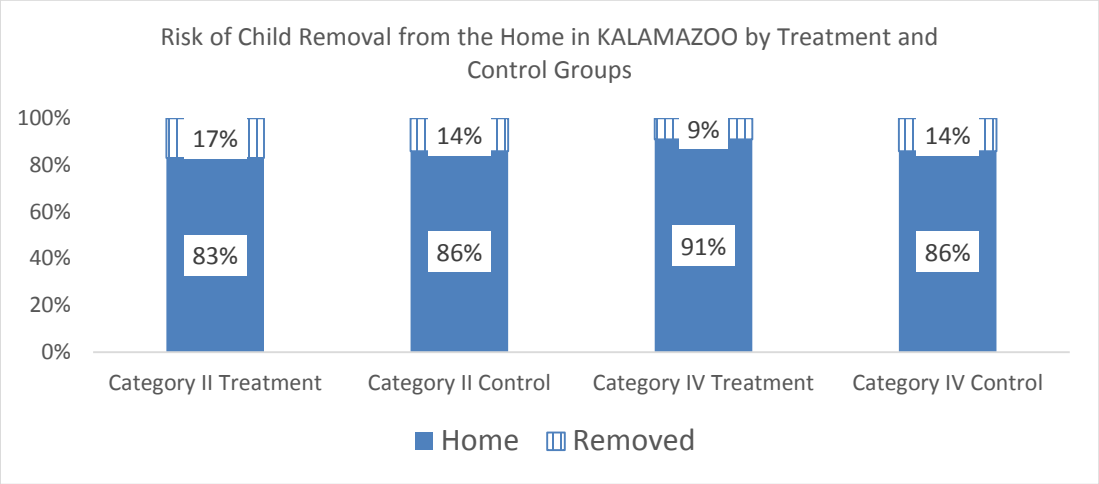


Figure III-8. Risk of Child Removal from the Home, in MACOMB by Treatment and Control Groups

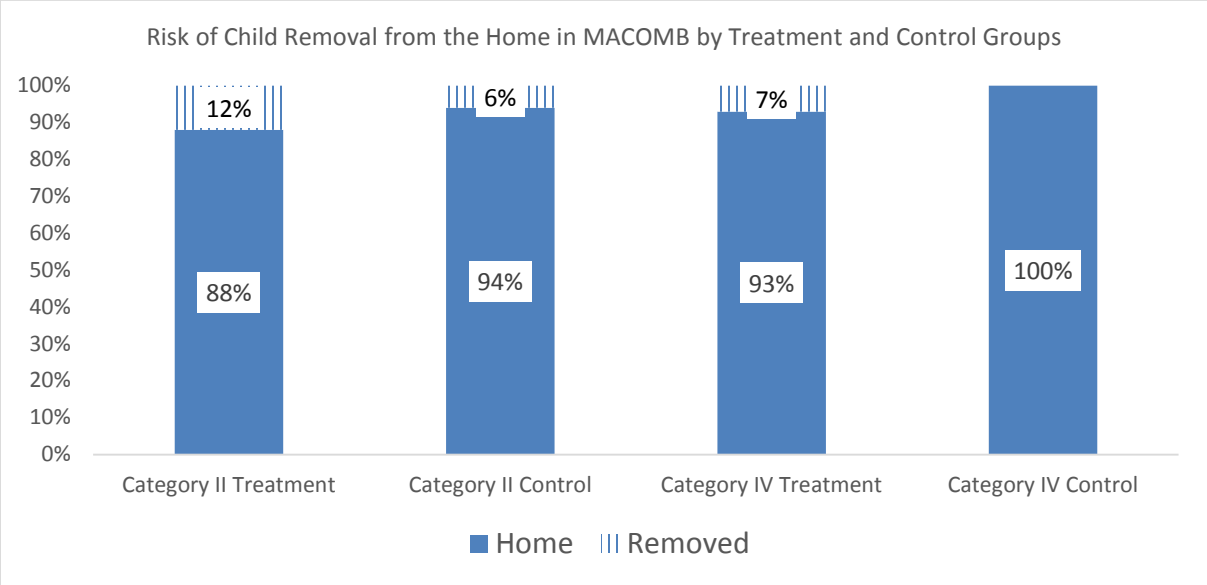
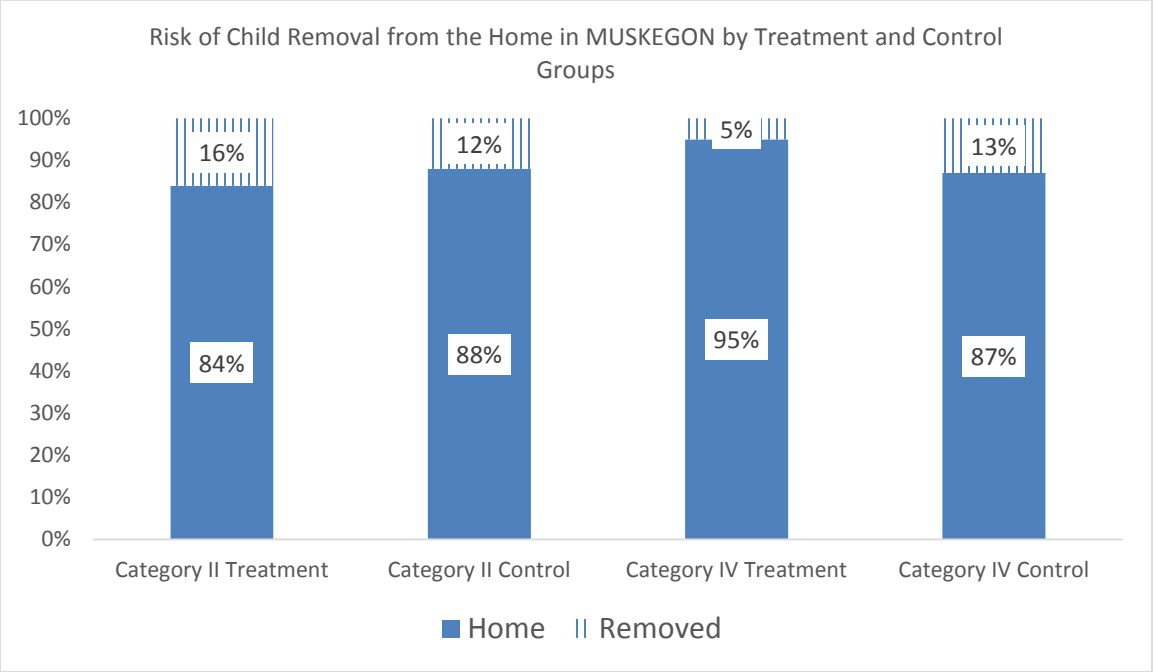


Figure III-9. Risk of Child Removal from the Home, in MUSKEGON by Treatment and Control Groups



Time to First Child Removal

We calculated the time between random assignment and the removal of a child from the family home. On average, there were no statistically significant differences when comparing the control (220 days) and treatment (177 days) groups.

Subsequent Reports of Abuse and Neglect

Research Question: How does the risk of subsequent maltreatment compare between the control and treatment groups?

Interim Findings:

There are no statistically significant differences in the incidence of subsequent maltreatment between the control and treatment group – in either the overall comparison – or the comparisons within individual waiver counties.

No relationship was found between the "dose" of services received and the risk of subsequent maltreatment.

There were no statistically significant differences in time to subsequent maltreatment when comparing the control (36 days) and treatment (37 days) groups.

A primary objective of all child welfare interventions is to protect children from incidents of abuse and neglect. All of the families in the current waiver demonstration were associated with at least one prior allegation of maltreatment.

The following figures display the risk of subsequent reports of maltreatment. In the current report, we include any Category I, II or III allegation. These risks (i.e. relative percentages) are displayed for the overall waiver demonstration sample and by individual waiver counties (Kalamazoo, Macomb, and Muskegon). Overall, 23.3% of the families are associated with at least one subsequent allegation of maltreatment. There are no statistically significant differences between the control and treatment group – in either the overall comparison or the comparisons within individual waiver counties. There was no relationship between the "dose" of services received and the risk of subsequent maltreatment.

Figure III-10. Subsequent Maltreatment, OVERALL by Treatment and Control Groups

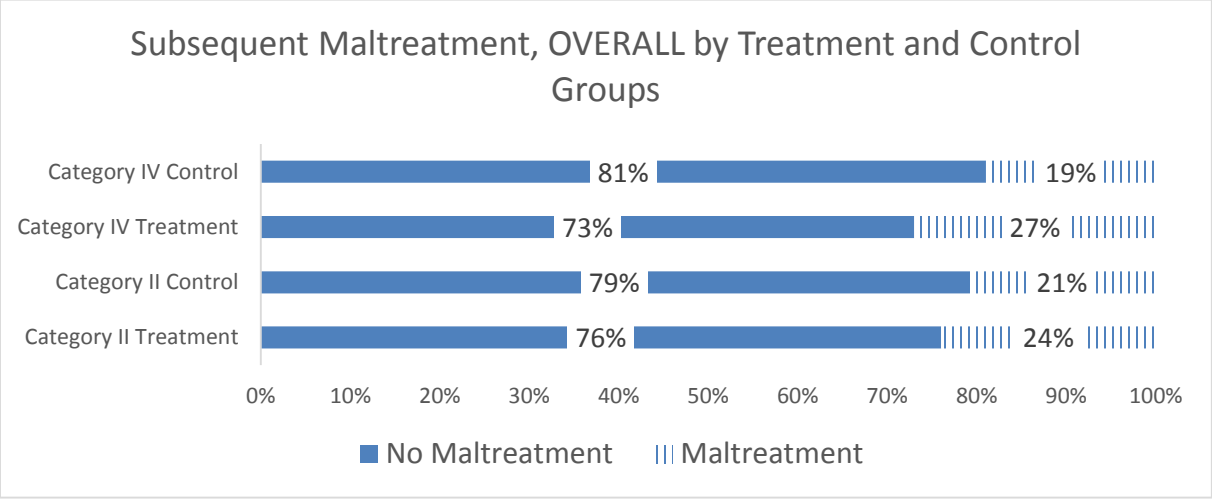


Figure III-11. Subsequent Maltreatment, KALAMAZOO by Treatment and Control Groups

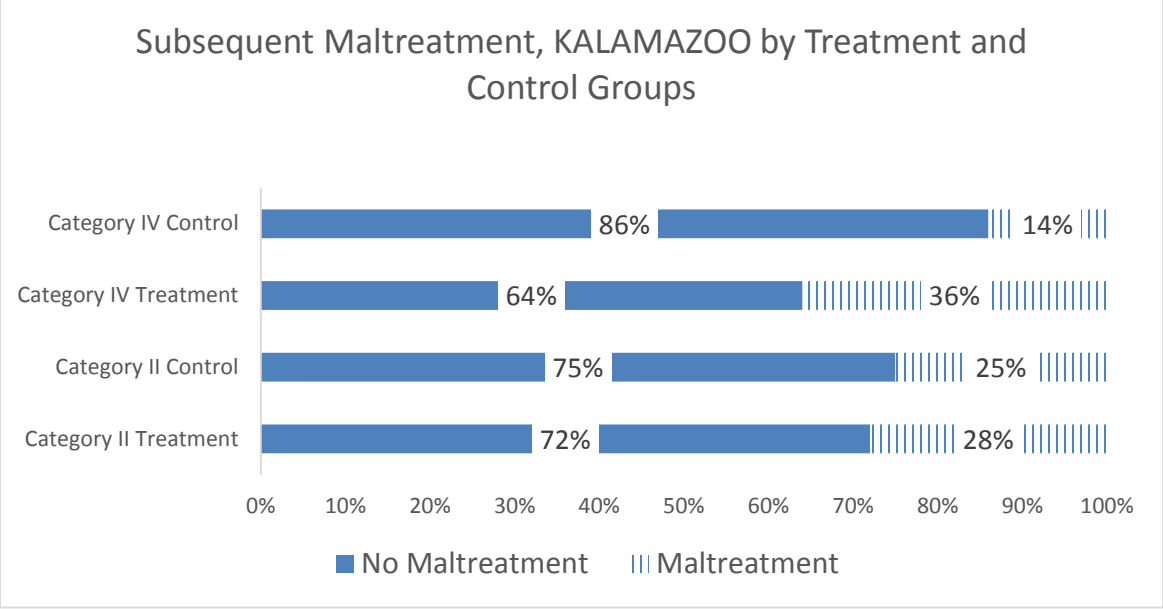


Figure III-12. Subsequent Maltreatment, MACOMB by Treatment and Control Groups

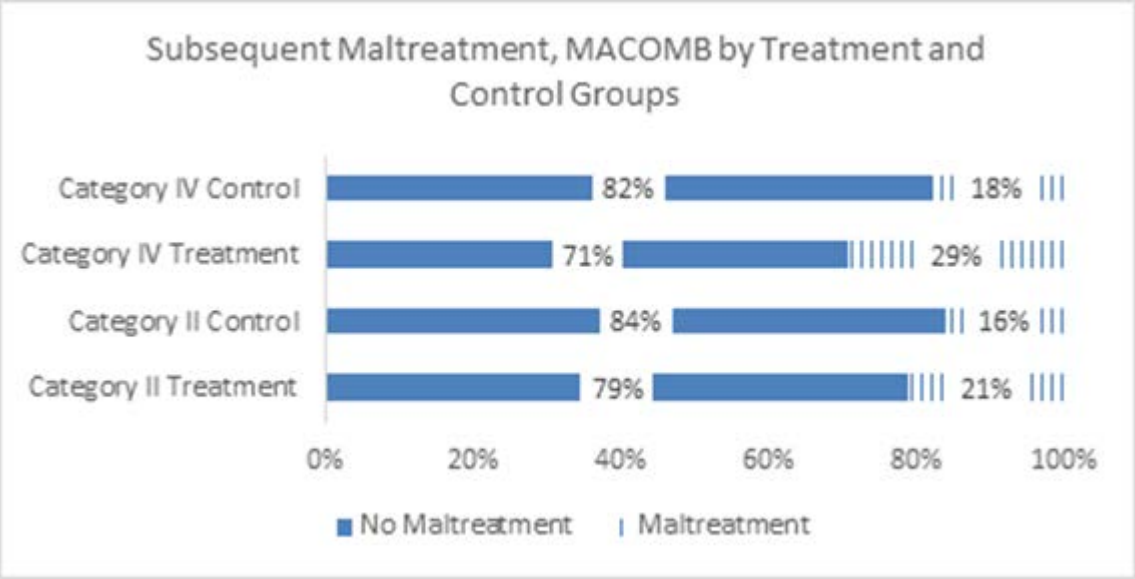
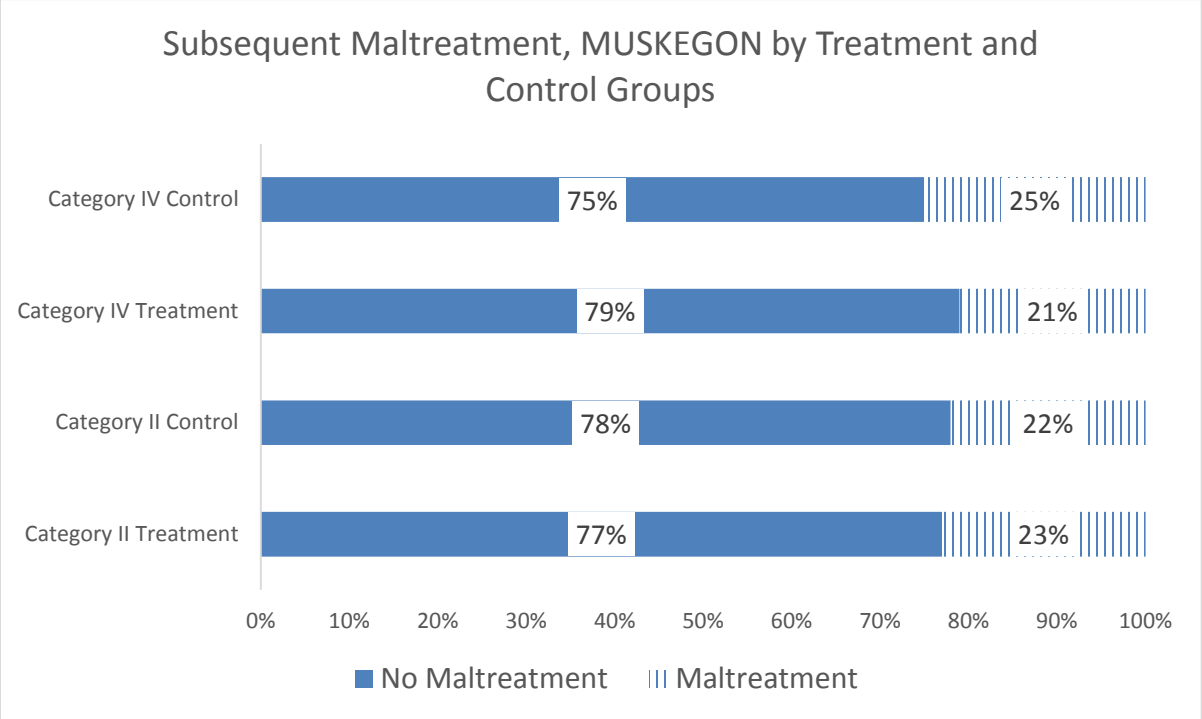


Figure III-13. Subsequent Maltreatment, MUSKEGON by Treatment and Control Groups



Time to Subsequent Maltreatment

The evaluation calculated the time between random assignment and the first subsequent episode of maltreatment (substantiated category I, II or III). On average, there were no statistically significant differences when comparing the control (36 days) and treatment (37 days) groups.

Risk Assessment

Research Question: Does family risk change over time?

Interim Findings:

There were no statistically significant differences when comparing changes in risk over time between the control and treatment groups.

However,

The risk of removal was significantly decreased when the family risk levels were improved.

The risk of maltreatment was significantly decreased when family risk level was improved.

The risk assessment data are only available for Category II cases. Table IV-9, below, captures the risk levels and the changes in risk over time. Each column represents the initial risk level, ranging from high to intensive. There were no cases initially classified as low or moderate risk. Adjacent to each initial risk level is the number of associated families (513 classified at high and 80 classified at intensive). The stacked columns represent the change over time. For example, of the cases that started out as "high risk" – at the time of risk re-assessment – 75% moved to "low risk" and 19% moved to "moderate risk." Similarly, of the cases that opened at "intensive risk" – at the time of re-assessment – 63% moved to low risk and 26% moved to moderate risk. There were no statistically significant differences when comparing changes in risk over time between the control and treatment groups.

Big effects were observed in the relationship between changes in risk assessment scores and subsequent removals. Specifically, the risk of removal was significantly decreased when the family risk level was improved (e.g. family moving from high risk to low risk). Fifty-four percent of families that experienced no change in risk scores had at least one child removed from the biological family home. In comparison, only 9% of families experienced a child removal when their risk score improved.

Big effects were also observed in the relationship between changes in risk assessment scores and subsequent maltreatment. Specifically, the risk of maltreatment was significantly decreased when family risk level was improved (e.g. family moving from high risk to low risk). Forty-three percent of families with no improvement in risk score were associated with subsequent maltreatment – as compared to only 22% of families that experienced at least some improvement in risk score.

Figure III-14. Overall Initial Risk Level by Re-Assessment Level

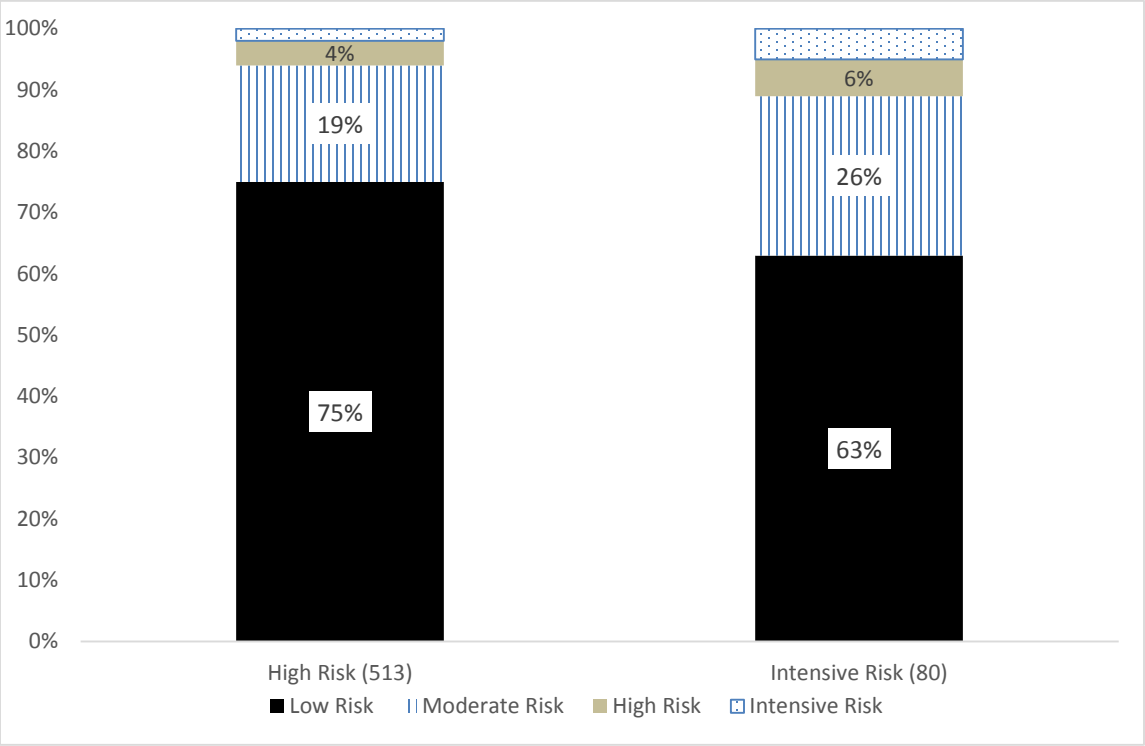


Figure III-15. KALAMAZOO Initial Risk Level by Re-Assessment Level

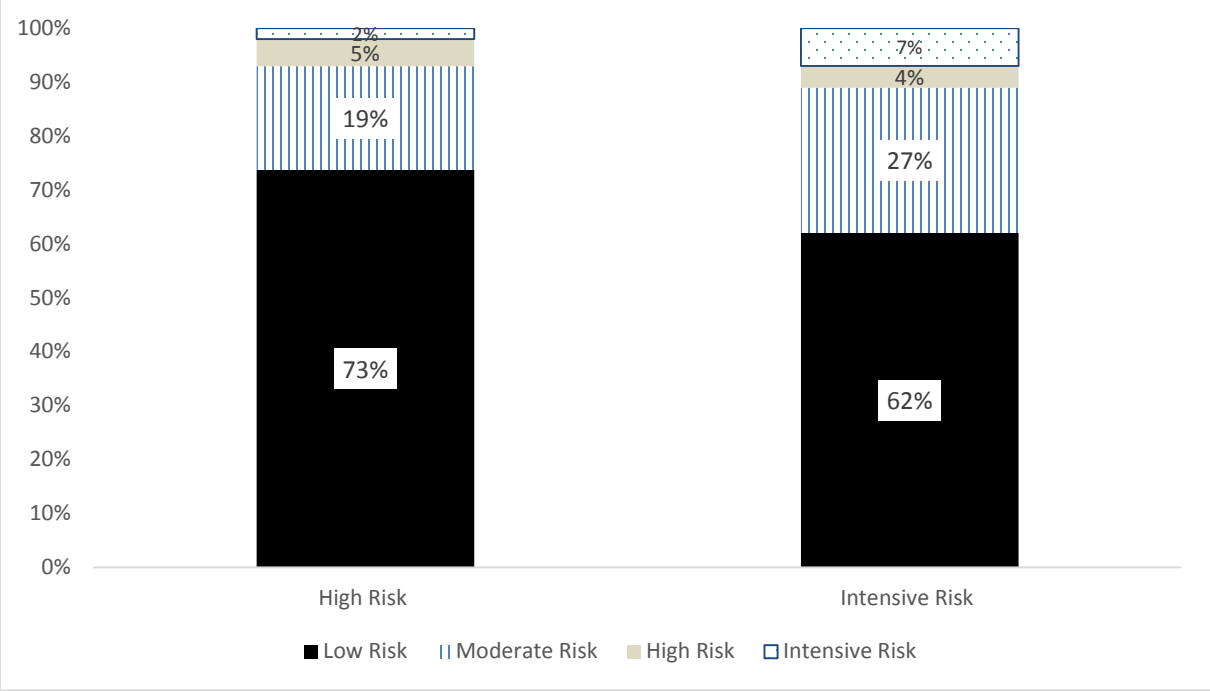


Figure III-16. MUSKEGON Initial Risk Level by Re-Assessment Level

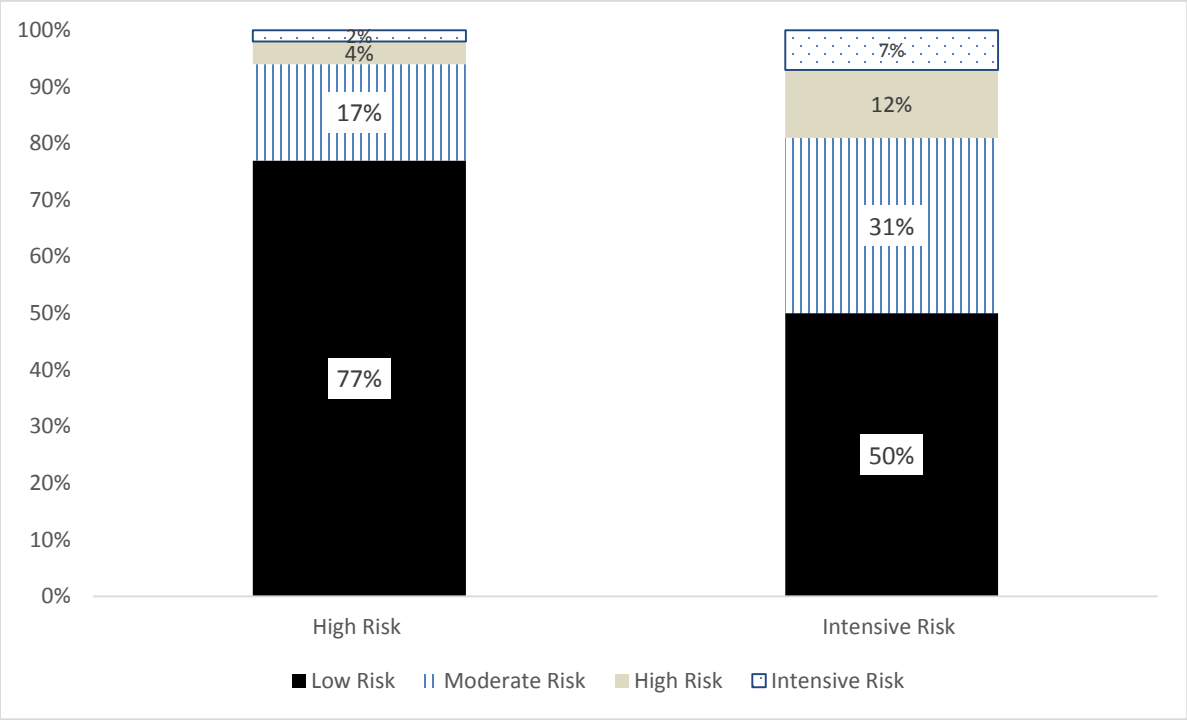
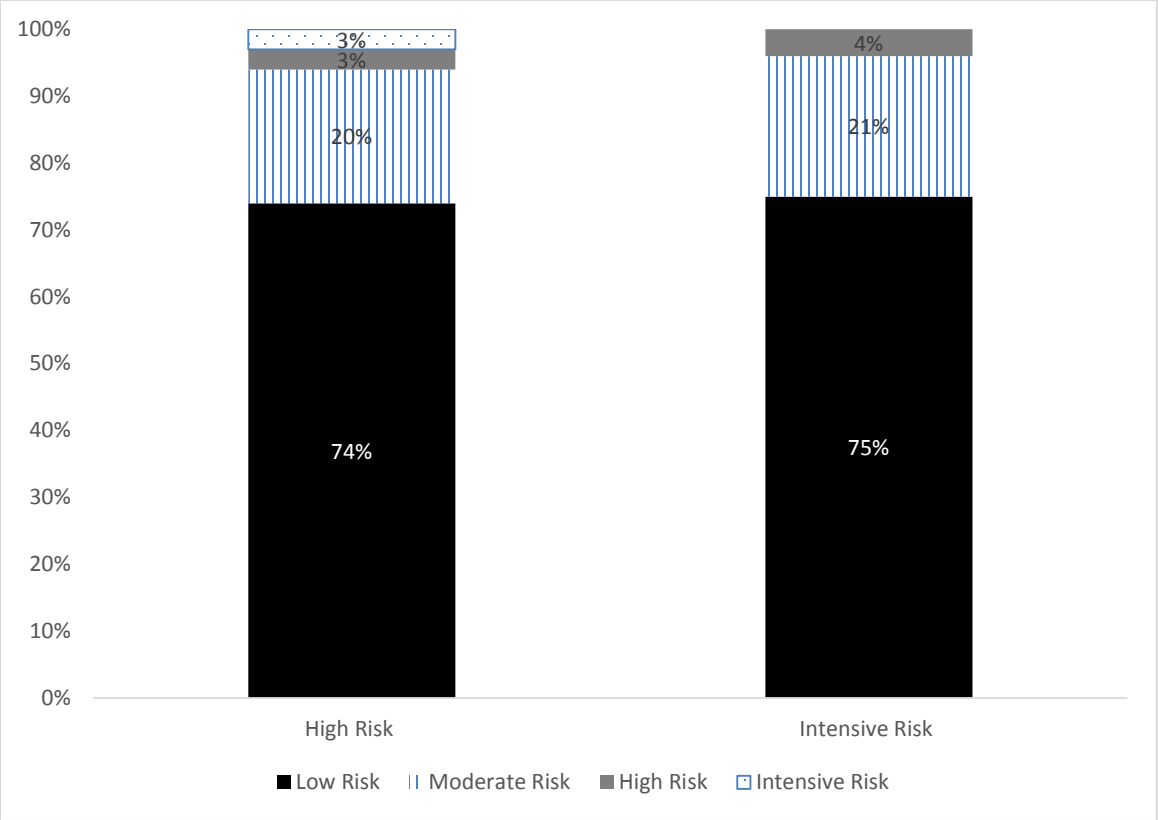


Figure III-17. MACOMB Initial Risk Level by Re-Assessment Level



IV. The Fiscal/Cost Study

Cost Study Data Collection and Analysis

The preliminary cost analysis portion of this project involves a comparative examination of the costs of services received by children and families assigned to the treatment group compared to the costs of services received by those in the control group (i.e. administrative direct, foster care placement, and subsequent investigation expenditures for the treatment group compared to those same expenditures for the control group). The analysis explores not only how the costs of services between the two groups are different, but also how they have changed over time, from January 2014 to November 2015. It includes an examination of average monthly costs by type of category for both the treatment and control groups. The preliminary cost analysis was performed utilizing data obtained from MDHHS; while these preliminary data are incomplete, future cost analyses will be more comprehensive.

For the treatment group, we reported on the following cost categories:

1) **Administrative Cost of Protect MiFamily Services:** Identifies cost of administering and implementing Protect MiFamily Services. A few components of this category are not included in the preliminary cost analysis.
    - **Direct services**: Includes counseling, parenting training, administration of tools, and so on. Included in the preliminary cost analysis.
    - **Indirect Services**: Overhead costs. *Not included in the preliminary cost analysis*.
    - **Mileage**: Cost of transportation to provide services to families. *Not included in the preliminary cost analysis.*
    - **Concrete Assistance:** Includes money or household provisions or supplies that help families meet basic daily necessities. **Not included in the preliminary cost analysis**.
2) **Cost of Foster Care Placement:** Identifies all costs associated with the removal of a child from a family's home and placement of the child into a foster home.
3) **CPS Treatment Costs:** Includes costs of services that contracted providers cannot pay for, such as psychiatric evaluation costs or urine analysis costs. *Not included in the preliminary cost analysis*.
4) **Cost of Subsequent CPS investigations:** Identifies costs associated with any CPS investigations made subsequent to assignment to the treatment group.

For the control group, we reported on the following cost categories:

1) **Administrative Cost of Ongoing CPS Services:** Includes administrative costs associated with a CPS case.
2) **Cost of Foster Care Placement:** Identifies all costs associated with the removal of a child from a family's home and placement of the child into a foster home.
3) **Cost of General Services:** Includes costs related to Families First, Families Together Building Solutions, wraparound services and other miscellaneous services or programs that are provided to cases.

4) **Cost of Subsequent CPS investigations:** Identifies costs associated with any CPS investigations made subsequent to assignment to the control group.

Table IV-1 describes the cost components for each group. Gathering the data for each cost component entailed detailed discussions with the MDHHS via calls and emails over the past months, which also served to clarify and resolve any misunderstandings or issues with the data. Discussions also involved determining the best format or structure to present the cost data, which was important for the project team to aggregate and perform the necessary calculations required for the cost analysis.

Table IV-1. Cost Categories for Treatment and Control Groups

Treatment Group	Notes
Administrative Costs of Protect MiFamily Services	Includes costs for direct services, indirect services, concrete assistance, and mileage. Only direct services costs are included in this cost analysis.
Cost of Foster Care Placement	Total cost of foster care placement across all days of placement per child per group was provided for the cost analysis.
CPS Treatment Costs	Includes what contracted providers cannot pay for, such as psychiatric evaluation costs or urine analysis costs.
Cost of Subsequent CPS Investigations	Average daily cost per CPS investigation (cost of supervisor included; payroll included; all fiscal years included; etc.) multiplied by the number of days of CPS investigations per family.
Control Group	
Administrative Costs of Ongoing CPS Services	Average daily administrative costs multiplied by the number of days a case was open.
Cost of Foster Care Placement	Total cost of foster care placement across all days of placement per child per group was provided for the cost analysis.
Cost of General Services	Includes expenses such as Families First, Families Together Building Solutions, wraparound services, and other miscellaneous services or programs.
Cost of Subsequent CPS Investigations	Average daily cost per CPS investigation (cost of supervisor included; payroll included; all fiscal years included; etc.) multiplied by the number of days of CPS investigations per family.

Cost Study Results

Research Question: Is spending for investigations and out-of-home care decreasing while spending for supportive evidence-based services to maintain children safely in their own home increasing?

Preliminary Interim Findings:

Between January 2014 and November 2015, the average monthly administrative cost per treatment family was around $1,100 as compared to the control families with an average monthly administrative cost of $734 per family.

The average monthly foster care placement cost per child in the treatment group was lower in most months studied as compared to the average monthly cost for a control group child.

The average monthly costs of subsequent investigations were similar in both groups, $57 for treatment families and $65 for control families.

Figure 1 shows the average monthly administrative costs per family for both treatment and control groups. Average administrative cost per family was around $1,100 between January 2014 and November 2015 in the treatment group. Direct costs account for 34% and indirect costs account for 61% of the average administrative costs. The remaining 5 percent of costs are due to mileage and concrete assistance. In the same period, the control group had an average administrative cost of $734 per family which is significantly below the treatment cost average. The average administrative cost for the control group includes the indirect costs.

Figure IV-1. Average Monthly Administrative Costs per Family, Treatment versus Control

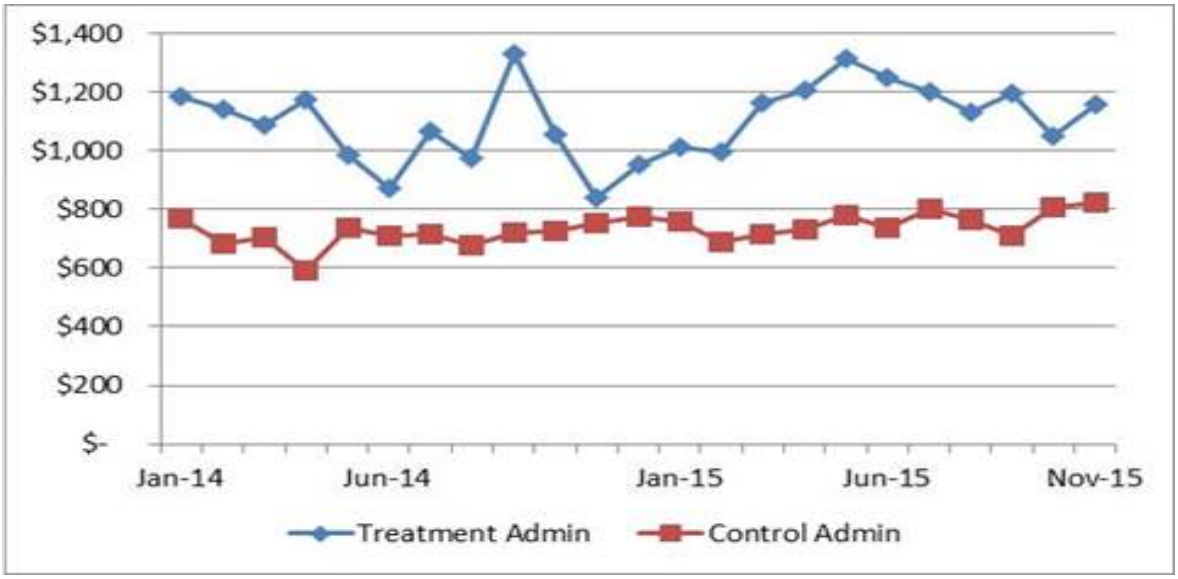


Figure 2 shows the average monthly costs for foster care placement per child. While both groups started to have upward trends starting from mid-year in 2014, the treatment group has been lower than control group in most months included in analysis.

Figure IV-2. Average Monthly Foster Care Placement Costs per Child, Treatment versus Control

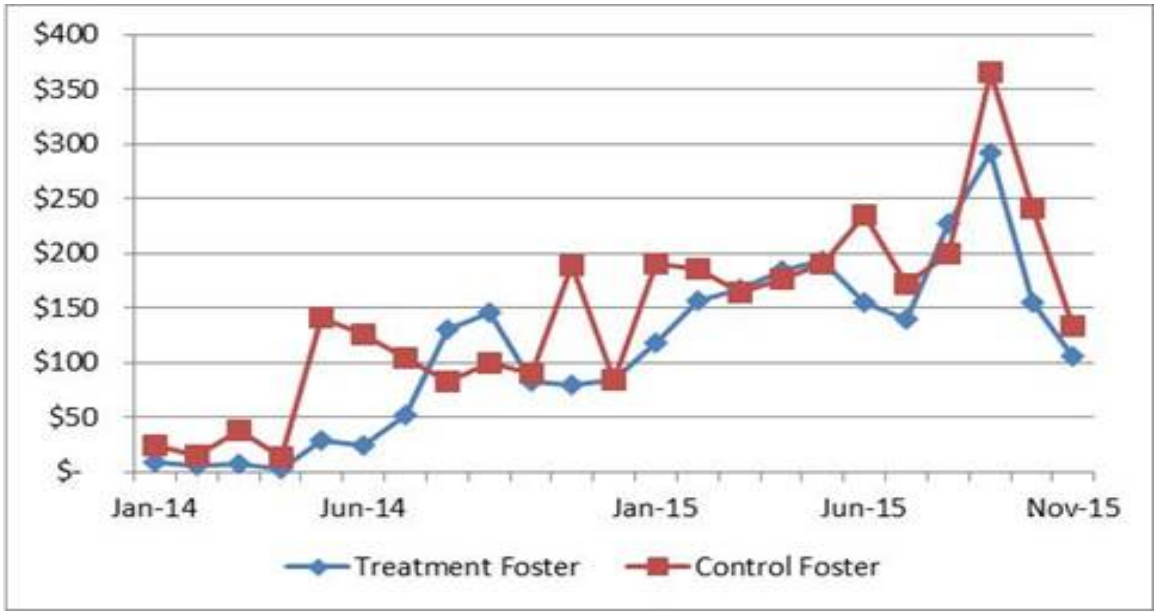
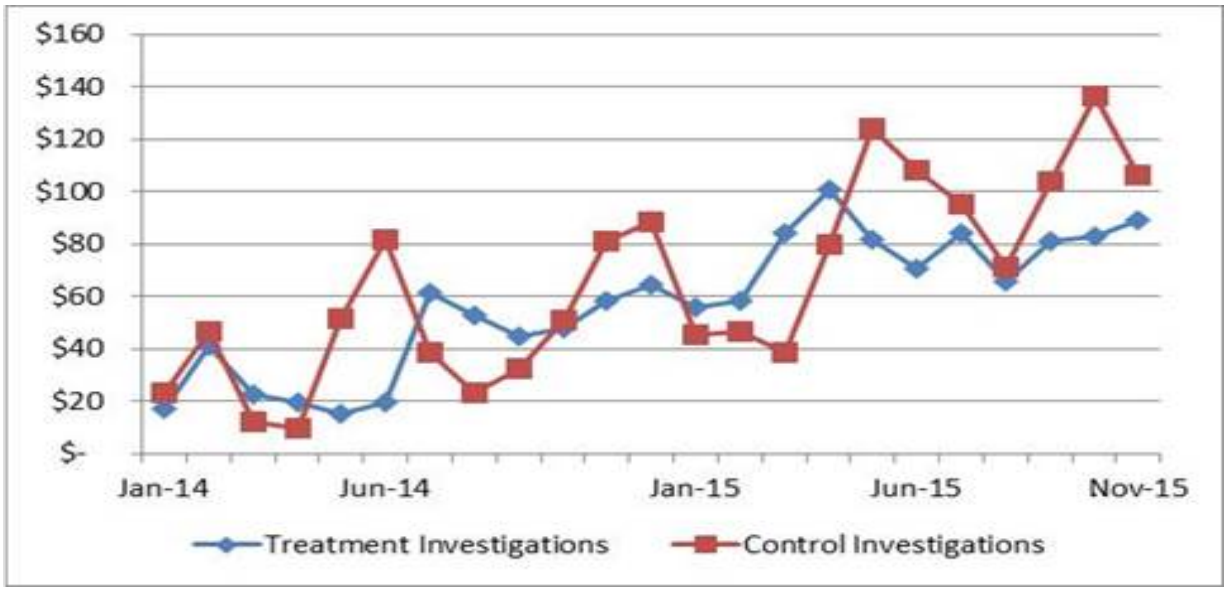


Figure 3 shows average monthly costs for subsequent investigations per family. The average costs of subsequent investigation per family were similar in both groups. The treatment group and the control group had overall monthly averages of $57 and $65 per family, respectively. In both groups, the average costs of subsequent investigations have been increasing over time.

Figure IV-3. Average Monthly Subsequent Investigations Cost per Family, Treatment versus Control



V. Summary, Lessons Learned, and Next Steps

Evaluation Summary

Michigan's Title IV-E Waiver Demonstration Project, Protect MiFamily, is an intensive in-home family preservation intervention consisting of prevention, preservation, and support services provided to families with young children determined by Children's Protective Services (CPS) to be at high or intensive risk for maltreatment. MDHHS established contracts with Lutheran Social Services of Michigan (now called Samaritas) and Catholic Charities of West Michigan to identify families' strengths and needs, coordinate timely referrals to community providers, provide clinical and evidence-based interventions and directly engage families in their own homes to build strengths and reduce risk. The Protect MiFamily project was designed to increase child safety, strengthen parental capacity and improve child wellbeing. It is expected that the demonstration will result in a reduction in child maltreatment and recidivism, a decrease in the number of young children placed in out of home care, and a measurable increase in social and emotional well-being of children.

This Interim Evaluation Report describes the implemented waiver intervention and the evaluation research methodologies, including the sampling plan, data collection methods, and data analyses performed to carry out a rigorous evaluation of Michigan's demonstration project. The evaluation includes random assignment, statistical measurements and outcome analysis methodologies designed to evaluate the demonstration's success on established outcomes. The evaluation data reporting period for the Interim Report covers is from August 1, 2013 through November 30, 2015.

Summary of Evaluation Activities and Major Findings

Random Assignment Summary

Random assignment is ongoing, and cases are randomized to three conditions: treatment, control, and unselected. The selection probabilities were set initially to (roughly) achieve the target number of cases. Among the treatment and control cases, the targets were designed to keep the number of treatment cases about twice the number of control cases and the number of Category IV cases at 10% of the number of cases assigned to treatment or control. The current proportion of cases in each assignment category is reasonably consistent with the target assignment probabilities; however, the proportion assigned to the treatment group is somewhat less than twice that assigned to the control group in Kalamazoo County. Cases are roughly evenly divided among the three counties, consistent with the project objectives.

Process Study Summary

The process evaluation examines implementation of the waiver demonstration. The process evaluation also includes a measure of program implementation fidelity. Throughout the course of the waiver demonstration, process data provides feedback to assess whether the demonstration is proceeding as intended and to identify barriers encountered and any changes needed for successful implementation.

Major Findings from the Process Evaluation

Interviews and Focus Groups

- A significantly lower rate of referral to community services than expected. The low rate of referral to community services presents challenges to the success of Protect MiFamily because a core element of the Protect MiFamily model is to connect families with community services and supports that can sustain their progress and well-being after they leave Protect MiFamily. The low rate of referral may be due to Protect MiFamily staff providing most services (mainly psycho-educational) themselves in the home. Referrals are primarily used for clinical services (substance abuse treatment, mental health) that require specialized professional or certified providers. The low rate of referral to community services is also influenced by client reluctance to go, transportation or scheduling barriers, service availability and the cost of outside services.
- Service availability remains a significant barrier, particularly mental health, temporary shelter, and affordable housing.
- Nearly one third of Protect MiFamily cases close before completing the full 15 months. Protect MiFamily staff reported the major factors as: CPS removed the child(ren) from the home; Change of custody; Family moved to a different county, often due to housing crises; Family declined further services; or, family became non-responsive to worker contact attempts for more than 30 days.
- Collaboration between CPS and Protect MiFamily faces significant challenges; however, successful CPS and Protect MiFamily staff teaming has occurred in several areas.
- Both MDHHS and the partner agencies have begun positive steps toward greater communication.
- Staff turnover is high in all three sites. Staff turnover in both Protect MiFamily and CPS causes breakdowns in collaboration.
- Hiring qualified candidates in a timely manner is a challenge stemming from competition from other programs as well as the entry level salary offered by Protect MiFamily.

Model Fidelity

- Though fidelity scores have fluctuated during the evaluation, item-level model fidelity data continues to document challenges with adherence to contact standards. These challenges are partly attributable to issues outside of the control of partner provider staff. For example, model fidelity data collectors frequently note that partner agency

staff only miss one contact (e.g. missed the required contact during one week), and the missed contact can be due to family cancellations or refusal to meet.
- Item-level model fidelity data also confirms strengths in service delivery, such as partner agency staff consistently addressing the Protect MiFamily Safety Assessment Plan during their contact with families, staff completing required progress reports on time in Phases 2 and 3, and staff convening family team meetings on time.

Family Satisfaction

- Data from the Family Satisfaction Survey has consistently shown high satisfaction with the program.
- Protect MiFamily Phase 1 survey results continue to suggest that overall satisfaction with program services is positive, with over 91% either agreeing or strongly agreeing that their family was getting the services they need and that they know how to contact other agencies to get their needs met.
- Protect MiFamily Phase 2 results also show high program satisfaction, with over 95% either agreeing or strongly agreeing that their family was getting needed services and nearly 98% indicating that they know how to contact other agencies to get their needs met.
- Protect MiFamily Phase 3 respondents also indicated high satisfaction, with over 97% either agreeing or strongly agreeing that their family was getting needed services and over 94% indicating that they know how to contact other agencies to get their needs met.

Lessons Learned for the Process Study

It was a goal of the evaluation to perform outcome analysis on whether the agencies are providing and managing services to effectively engage the families, coordinating meaningful and effective services and developing community relationships that ensure available and accessible services to meet the families' needs, throughout Protect MiFamily engagement and after Protect MiFamily closes the case. The evaluation also was to determine how the provision, accessibility, and availability of waiver intervention services to treatment families compared to the provision, accessibility and availability of services to control families. To this point in the evaluation, service data analysis has been limited to understanding the extent to which data captured represents services provided to control and treatment cases, identifying gaps in service documentation and understanding the underlying factors that prevent a full picture of the role of services in the demonstration. Protect MiFamily sites have made strides in the overall volume of service data collected and the number of families for whom service data exists; however, there is still insufficient service data for both the Protect MiFamily cases and control cases to conduct meaningful analysis.

Next Steps for the Process Study

At the time of this interim report, the process evaluation will focus on the following next steps:

- Continue to retrieve, record, and review agency documentation.
- Continue to participate in coaching calls, project steering committee meetings and other project meetings as appropriate.
- Continue to follow the progress of the action plans developed from the Casey Convening.
- Continue to receive and process Family Satisfaction Surveys and follow up with MDHHS on issues with Family Satisfaction Surveys received either in duplicate for a family and/or with dates that do not follow progression in phases.
- Continue to monitor both the Protective Factors Survey database and MiSACWIS data to determine if we are capturing all service data on both treatment and control cases.
- Continue to review the service data on the treatment and control cases, assess the quality of this data, and initiate the development of a detailed analysis plan.
- Work with MDHHS to continue the assessment of fidelity to the Protect MiFamily service model throughout the evaluation.
    - Continue to monitor data on family contact standards in Phases 1 and 2, particularly comments detailing the reasons for lack of adherence to standards.
- Plan for a final site visit in spring 2018.

Outcome Study Summary

The outcome evaluation address the research hypotheses outlined below.

When compared to families assigned to the control group:

- Parents and or caregivers in the treatment group will make positive changes in protective factors as determined by the Protective Factors Survey (Appendix B) completed before, during and after Protect MiFamily intervention. The Protective Factors Survey is a product of the Friends National Resource Center and the University of Kansas Institute for Educational Research and Public Science.
- Children in the treatment group will demonstrate improved well-being as determined by the Devereux Early Childhood Assessment (e-DECA).
- Children in the treatment group will experience fewer subsequent maltreatment episodes in the 15 months following acceptance into the demonstration, as determined by the absence of a confirmed CPS complaint investigation (Category I, II, or III).
- Children in the treatment group will remain safe in their homes 15 months following acceptance into the waiver, as determined by a “safe” or “safe with services” designation on the Safety Re-Assessment.
- The risk of future maltreatment for children in the treatment group will be reduced to low or moderate and will not elevate in the 15 months following acceptance into Protect MiFamily, as determined by the Structured Decision-Making (SDM) Risk Re-Assessment.

- Children in the treatment group will remain in their homes throughout waiver intervention and 15 months following acceptance into Protect MiFamily, as determined by the absence of a court-order authorizing the children to be taken into protective custody.

The PFS data is collected from experiment group caregiver/parent 3 times during the waiver period, at each phase of the waiver, by partner agency workers. Protective factors outcomes are measured by reviewing caretaker responses in five areas – family functioning/resilience, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development. Responses are provided at the family, caretaker, and child levels. Part III, a subpart in the Core Protective Factors questions, requires that the parent focus his/her responses on one child in the household that will benefit most from participation in the services. The survey results are designed to provide a snapshot of the family's protective factors (for evaluation purposes) at the time the survey is completed.

The Devereux Child Assessment requires a pre- and post- assessment administered by the Protect MiFamily worker and completed by the parent or caregiver for each child preschool age in the household and by the child's teacher for school-aged children, usually at the post-assessment. Items from the assessment of individual children are calculated into percentiles and t-scores. The differences in children's scores from pre-test and post-test (in pre-post tables) will be examined to determine improvement in social–emotional well-being.

With regard to the analysis of administrative outcomes, our evaluation tests the hypotheses as they relate to child safety and permanency. The key measure of safety is the subsequent report of maltreatment. The hypothesis to be tested is that children in the treatment group will experience significantly fewer subsequent maltreatment episodes following acceptance into the demonstration, as determined by the absence of a confirmed CPS complaint investigation (Category I, II, or III) as compared to children in the control group. We utilize the allegation data from MiSACWIS, comparing the treatment and control groups.

The evaluation team specifically looks at all allegations/reports of maltreatment that occur subsequent to random assignment (i.e. the date the parents enrolled in the waiver). The random assignment procedures were effective in creating equivalent groups. Thus we present the subsequent allegation (and removal) in a descriptive table that captures (1) the overall risk of subsequent maltreatment for the treatment and control groups and (2) the overall rates of subsequent maltreatment for the treatment and control groups.

The permanency hypothesis is that children in the treatment group will be more likely to remain safely in their homes following acceptance into Protect MiFamily. Similar to the analyses with the maltreatment data, we use the administrative data (e.g. substitute care records) from MiSACWIS to create figures that capture placement rates for both the treatment and control groups. We explore the overall risk of entry into substitute care settings and the timing of entry into substitute care.

The major outcome analyses focus on safety and permanency. It is critical to note that our analyses focus on the waiver demonstration as a whole and on individual counties. Significant county differences may emerge.

With regards to family risk, the evaluation team analyzes the risk assessment data to understand whether or not families are improving – with regard to reducing risk factors and strengthening protective factors. These analyses provide a general sense of whether the waiver is achieving the primary outcomes of interest. The SDM re-assessment of risk data is contained in the administrative data system, MiSACWIS, and we perform analysis of the SDM risk levels at time of referral for services, treatment services and control services as usual, compared to the risk level determined in subsequent SDM re-assessments. Risk levels are Intensive Risk, High Risk, Moderate Risk, and Low Risk.

Major Findings from the Outcome Study

Removal from the Biological Family Home

- For families that received the "full dose" of Protect MiFamily services (i.e. completed all 3 phases of PMF), children in the treatment group were significantly less likely (4.6%) to be removed from the biological family home as compared with children in the control group (10.8%). This finding suggests that families are more likely to remain intact when families are capable of completing Protect MiFamily services.

- Overall, 13.3% of families experienced the removal of at least one child from the biological family home. The risk of removal varies somewhat by county; however, there were no statistically significant differences when comparing the risk of removal between all control and treatment group families.

- On average, children were removed from the biological family home at 189 days from the date of random assignment. There was no difference when comparing the time to removal between the treatment (177 days) and control (220 days) groups.

Maltreatment Recurrence

- Overall, 23.3% of the families were associated with at least one subsequent allegation of maltreatment (category I, II or III). There were no statistically significant differences between the control and treatment group.

- On average, children were exposed to a subsequent and substantiated report of maltreatment at approximately 37 days. There was no difference when comparing the time to subsequent maltreatment between the treatment and control groups.

- When comparing the treatment families that completed all 3 phases –the Protect MiFamily full dose – with the families that were in the control group, there was no significant difference with regard to subsequent maltreatment.

Risk Assessment

- With regards to risk assessment, there were no cases initially classified as low or moderate risk. The vast majority of cases decreased in risk over time. For example, of the cases that started out as "high risk" – 75% moved to "low risk" and 19% moved to "moderate risk" by the time of re-assessment. Similarly, of the cases that opened at "intensive risk" – 63% moved to low risk and 26% moved to moderate risk. There were no statistically significant differences when comparing changes in risk over time between the control and treatment groups.

- Big effects were observed in the relationship between changes in risk assessment scores and subsequent removals and substantiated reports of maltreatment. Specifically, the risk of removal and maltreatment were significantly decreased when family risk levels were improved (e.g. family moving from high risk to low risk). Fifty-four percent of families that experienced no change in risk scores had at least one child removed from the biological family home. In comparison, only 9% of families experienced a child removal when their risk score improved. With regard to subsequent maltreatment, 43% families with no improvement in risk score were associated with subsequent maltreatment – as compared to only 22% of families that experienced at least some improvement in risk score.

Child Well-Being

- Overall, 30% of children who completed Protect MiFamily had statistically significant improvement in their well-being based on the Devereux Early Childhood Assessment Total Protective Factors score.

- The Devereux Early Childhood Assessment findings indicate that about 42% of children whose pre-test behavior indicated "Area of Need" or "Typical" showed improvement in behavior at the post-test.

- The Devereux Early Childhood Assessment findings did not support the MDHHS benchmarks of 70% of children showing statistically significant improvement in well-being at the post-assessment and 90% of children showing improvement in behavior at the post-test.

Protective Factors

- Families who completed Protect MiFamily showed improvement in protective factors between the pre-survey and post-survey, although the improvement did not meet the MDHHS benchmark of 95%.

- Overall, families who completed Protect MiFamily showed statistically significant improvement on 3 of the 4 Protective Factors Survey subscales and on 3 of the 5 Knowledge of Parenting/Child Development items.

Lessons Learned from the Outcome Study

- Deficient Continuous Quality Improvement or other process to catch and correct data quality issues, both for primary and administrative data, is an important challenge for the evaluation. The Protect MiFamily central office needs to develop and maintain a process to check the quality and improve data quality over time. Because there is no current process, data quality is a serious problem for the evaluation, requiring excessive and unbudgeted time and effort to try and correct data for the evaluation.
- There is a lack of organization and planning for providing the administrative data for the cost and outcomes evaluations.
- The Evaluation Team has difficulty drawing substantive conclusions from the interim primary data outcomes because so many families are dropping out of the Demonstration making post-survey data unavailable. If this trend doesn't change, the final evaluation will be meaningfully affected.

Next Steps for the Outcome Study

The Evaluation team will continue to work with MDHHS, partner agency staff and CPS staff on data quality issues. The teams are having a very difficult time in retrieving and accurately linking the necessary families' and children's services, assessments and financial data from the multiple data collection systems due to an inability to match case IDs and recipient IDs for each family member in each case. There appears to be problems with the assignment of multiple ID's for both individuals and cases in the MiSACWIS, along with a lot of duplication, data entry errors, and referrals made with incorrect IDs. There is now a clearer picture of the problems with recipient IDs provided to the evaluation team in the Protect MiFamily files. There are many different IDs in MiSACWIS that complicate selecting the correct ID. These issues are amplified by the association of many individuals to the case over time and multiple individuals associated with a specific case ID. Individuals associated with the case include any individual ever associated with the case ID in history, including individuals who had a periphery role in an investigation and victims who are now adults with victim children of their own. All of the staff are working together to accommodate these issues but will continue to require specific ID designations in order to match cases between systems throughout the project.

With regards to outcome evaluation data activities, the evaluation team will:

1) Continue the data receipt and tracking processes for primary and administrative data.
2) Produce the data discrepancy reports for the Protect MiFamily central office program staff and partner agency Protect MiFamily data entry staff; however, these reports will be sent quarterly rather than monthly and discrepancy corrections will be managed by Protect MiFamily central office program staff and partner agency data entry staff.
3) The evaluation team will continue to work with individual staff members to resolve data quality issues when they arise.

4) Hold periodic data quality meetings and training (via webinar) with Protect MiFamily central office program staff and partner agency data entry staff to discuss data issues and improved methods for obtaining quality and accuracy in the evaluation data.
5) Conduct outcome analysis for the required evaluation reports.

Cost Study Summary

The cost analysis portion of this project intends to analyze differences in costs of services between the participants in the treatment group and in the control group. In this preliminary report, the evaluation team reviewed cost data over time, from August 2013 to November 2015.

Major Findings from the Cost Study

The cost analysis is very preliminary in scope; therefore, there are no major findings to report.

Lessons Learned and Recommendations

Based on our preliminary findings, the intervention seems to have lower average costs. Average monthly costs for those receiving services under the State's waiver demonstration project are lower than for those receiving normal services under the Child Protective Services through the State. Note that this section or our cost analysis does not discuss or take into account the outcomes (e.g., improved well-being) of the children in families involved in the intervention.

Next Steps for Cost Analysis

Following this preliminary cost analysis, the next step for the project team involves obtaining the remaining administrative costs of Protect MiFamily Services for the treatment group – as mentioned previously, only costs associated with direct services across all three sites were utilized for the preliminary cost analysis. The project team will request from the Michigan DHHS any costs associated with indirect services, mileage, and concrete assistance across the three sites. Furthermore, certain clarifications are still needed from Michigan DHHS pertaining to the existing data we have received; for instance, mismatches of the Case ID—which links to a specific family in the control or treatment groups—between the administrative files for the waiver groups and the master sample file have not been fully resolved. Identifying why these mismatches occur and how to actively incorporate them into the cost analysis will be an important step in ensuring that our analysis is accurate, thorough, detailed, and nuanced.

Regarding the costs associated with the control group, the data we have received are more comprehensive and complete, and will therefore require relatively minimal follow-up with the MDHHS. The evaluation team will continue to receive monthly costs of general CPS services (e.g., Families First, Families Together Building Solutions, etc.), as well as any updates or status

changes to an ongoing CPS case for any particular family, which will help us successfully conduct and complete any future cost analysis.

Eventually, the project team plans on using any and all updated information or data for a more comprehensive and robust cost analysis, taking into account any new reporting periods. We expect that our future cost analysis will include notes on any implicit assumptions that were made or actions that were taken based upon these assumptions.

Lastly, the evaluation team expects that the next cost analysis will go beyond a comparative examination of costs of services between the treatment and control groups and we may be able to break down the costs and examine them by sub-groups or sub-populations. For instance, it would be interesting to look at how costs differ between those who drop out of Protect MiFamily before completion of services compared to those who complete services and to those in the control group. Other possibilities include examining how initial CPS investigation costs compare to any subsequent CPS investigation costs or how short-term service costs differ from long-term service costs across both groups.

APPENDIX A
PROTECT MIFAMILY PROGRAM LOGIC MODEL

Protect MiFamily Program Logic Model

Impetus, Inputs

1.1 Target Population

Families who reside in Kalamazoo, Macomb, and Muskegon counties with at least one child age 0-5 identified by CPS to be at high or intensive risk for maltreatment (either a Category II or Category IV disposition)

1.2 Service, Family Need

- To meet the service needs of families at high risk for child maltreatment (early intervention and long-term services) in order to prevent removal from homes
- To improve service planning and service delivery guided by timely comprehensive screening and assessment of family needs
- To increase flexibility of the array of services, intensity of intervention, and family contact

1.3 Local Partnership

- Michigan Department of Health and Human Services (MDHHS), Children's Services Administration
- Local County MDHHS (Kalamazoo, Macomb, and Muskegon)
- Partner agency contractors
- Local CMH and Medicaid Health Plan Providers
- The University of Michigan, School of Social Work

1.4 Project Resources

- Fiscal resources

Implementation

2.1 Family Services, Activities

- Administer Family Psychosocial Screen within 72 hours (Domestic violence supplemental questions if needed)
- Link families to substance abuse, domestic violence, and/or mental health services
- Administer Child Trauma Screening to each child age 0-5
- Provide evidence-based trauma intervention
- Conduct frequent child safety assessments and planning
- Provide intervention in coordination with evidence-based services
- Strengthen protective factors to build parenting capacity
- Develop case planning aligned with family needs and protective factors

2.2 Organizational Mechanisms, Supports

- Agency/organizational support for Waiver program
- Buy-in from key stakeholders
- Performance-based Contracting

2.3 Staffing

- Waiver staff training
- Waiver staff supervision

Outputs

3.1 Family Services, Activities

- The number of families that build protective factors
- The number of families who receive targeted screening for domestic violence, substance abuse, and/or mental illness
- The number of children who have trauma screenings completed
- The number of families who participate in an evidence-based intervention offered through the Waiver program
- The number of families identified as appropriate for receiving intervention
- The number of families who receive payment to assist them with immediate needs and short-term stressors

3.2 Organizational Mechanisms, Supports

- The number of agencies who receive payment for performance for achievement of identified outcomes related to child safety and wellbeing

3.3 Staffing

- The number of Protect MiFamily staff who demonstrate model fidelity
- The number of staff who complete training

Outcomes

During waiver intervention,

4.1 Safety:

- Children in the treatment group will experience a significant decrease in subsequent maltreatment episodes, determined by absence of confirmed CPS investigations.
- Children in the treatment group will experience increased safety and decreased risk of maltreatment.

4.2 Wellbeing:

- Parents in the treatment group will demonstrate increased knowledge of parenting and child development.
- Parents in the treatment group will make positive changes in protective factors and parenting ability.
- Children in the treatment group will demonstrate improved social and emotional wellbeing.

4.3 Family satisfaction:

- Families in the treatment group will demonstrate high rates of service utilization.
- Parents in the treatment group will demonstrate high satisfaction with the Waiver Project services provided.

At the end of 15 months,

5.1 Safety:

- Children will not experience maltreatment and recidivism.
- The future risk of child maltreatment will be reduced and not elevate.

5.2 Wellbeing:

- Parents will increase parenting capacity and parent functioning to safely care for their children.
- Children will experience improved social and emotional wellbeing.

5.3 Permanency:

- Children will not experience court-ordered removal and out-of-home placement.
- Children and families in the waiver group will demonstrate increased family preservation.

External Conditions

- Organizational or contextual factors that facilitate or hinder that hinder implementation or the provision, accessibility, availability, or quality of service
- Inter-agency-relationships as it relates to the quality of service provision and successful outcomes that include; courts, MDDHS-Child Welfare, Local MDHHS-Child Welfare, Waiver Services Providers, other community providers.
- Social, economic, and political factors affecting replicability or effectiveness of intervention services.

Appendix B

Protect MiFamily

Data Collection Forms

Pediatric Intake Form

The Pediatric Intake Form can be used with each family entering your care and readministered annually. Individuals with low literacy skills or whose first language is not English may require assistance to complete the form.

SCORING

Reading the Pediatric Intake Form, also known as the Family Psychosocial Screen, as a whole can help the primary care health professional develop a general understanding of the history, functioning, questions, and concerns of each family.

In addition, specific areas of the Pediatric Intake Form can be scored to provide further insight into specific areas of a family's functioning.

PARENTAL DEPRESSION

Under the heading "Family Activities" are three questions that screen for parental depression. A positive response to two or more questions is considered a positive screen. For parents with a positive screen, it may be helpful to explore other symptoms of depression such as changes in appetite, weight, sleep, activities, energy level, and ability to concentrate; feelings of hopelessness; and suicidal ideation (suicidal thoughts) or suicidal intent. Reassuring parents that depression is common is helpful, as is noting the availability of treatment options provided by mental health professionals and the positive prognosis for the treatment of depression. (See Bridge Topic: Parental Depression, p. 303.)

SUBSTANCE USE

Under the heading "Drinking and Drugs" are seven questions that screen for parental substance abuse. A positive response to any of the first six questions is considered a positive screen. Parents with a positive screen should be asked about frequency of substance use and how their substance use affects their family. A physician's advice to quit smoking is often highly effective, but a physician's advice to stop abusing substances may be less so. Refer for further assessment and treatment as indicated.

DOMESTIC VIOLENCE

Under the heading "Family Health Habits" are four questions that screen for domestic violence. A parent who responds positively to any of these questions should receive further assessment and counseling, including exploration of the extent and patterns of violence, and discussion of safety issues for children and adolescents in the home (including gun storage). A parent may need assistance with making an escape plan and should be referred to hotlines or shelters. Health professionals should affirm that domestic violence is wrong but not uncommon. Victims need follow-up visits and ongoing support even if they return to the abuser. Forming a therapeutic relationship centered around the child's safety and well-being is recommended because children and adolescents are at risk for physical abuse in homes where there is domestic violence. (See Bridge Topic: Domestic Violence, p. 227.)

PARENTAL HISTORY OF ABUSE

Under the heading "When You Were a Child" are eight questions that screen for parents' histories of abuse. A background of abuse predisposes parents to disciplinary practices that may be abusive or too permissive. A positive response to any of the first four questions is considered a positive screen. The last four questions help gather additional information about disciplinary techniques and parents' need for counseling or parenting classes. (See Bridge Topic: Child Maltreatment, p. 213.)

SOCIAL SUPPORTS

Under the heading "Help and Support" are questions that screen for social support, a strong factor in reducing life stresses and parenting stresses. Adequate social support helps ensure that parents have appropriate models for parenting practices and disciplinary techniques. If the parent's answers to the first three questions indicate that she has access to fewer than two support persons or that she is less than satisfied with the support she has, the screen is considered positive. Offer referrals to parenting groups, social work services,

(continued on next page)

home visitor programs, or community family support services.

The Pediatric Intake Form also assesses a number of other risk factors for developmental and behavior problems. Risk factors include frequent household moves, being a single parent, having three or more children in the home, having less than a high school education, and being unemployed. Scoring four or more risk factors, including having mental health problems and an authoritarian parenting style (observed when parents use commands excessively or are negative and less than responsive to child-initiated interests), is associated with a substantial drop in children's I.Q. and school achievement. In such cases, children should be referred for early stimulation programs such as Head Start or a quality child care or preschool program.

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Pediatric Intake Form

Our practice is dedicated to providing the best possible care for your child. In order for us to serve you better, please take a few minutes to answer the following questions. Your answers will be kept strictly confidential as part of your child's medical record. Ongoing evaluations of our care may involve chart reviews by qualified persons, but neither your name nor your child's name will ever appear in any reports.

Circle either the word or the letter for your answer where appropriate. Fill in answers where space is provided.

Child's Name _____ Today's Date _____

Are you the child's
A. Mother
B. Father
C. Grandparent
D. Foster parent
E. Other relative
F. Other
G. Self (Are you the patient?)

How many times have you moved in the last year?
_____ times

Where is the child living now?
A. House or apartment with family
B. House or apartment with relatives or friends
C. Shelter
D. Other

Besides you, does anyone else take care of the child? If yes, who? _____ Yes No

Has child received health care elsewhere? If yes, what? _____ Yes No

Does the child have any allergies to any medications? If yes, what? _____ Yes No

Has the child received any immunizations? Yes No
Which ones? _____
Where? _____

Has the child ever been hospitalized? Yes No
When? _____
Where? _____
Why? _____

How would you rate this child's health in general?
A. Excellent B. Good C. Fair D. Poor

Do you have any concerns about your child's behavior or development? Yes No
If yes, what? _____

What are your main concerns about your child?

How old are you?
_____ years old

Are you
A. Single
B. Married
C. Separated
D. Divorced
E. Other

What is the highest grade you have completed?
1 2 3 4 5 6 7 8 9 10 11 12 (High School/GED) 13 14 15 16 17 18 19
Some college or vocational school | College graduate | Postgraduate

FAMILY MEDICAL HISTORY

Do the child's mother, father, or grandparents have any of the following? If yes, who?

Yes No High blood pressure _____
Yes No Diabetes _____
Yes No Lung problems (asthma) _____
Yes No Heart problems _____
Yes No Miscarriages _____
Yes No Learning problems _____
Yes No Nerve problems _____
Yes No Mental illness (depression) _____
Yes No Drinking problems _____
Yes No Drug problems _____
Yes No Other _____

FAMILY HEALTH HABITS

How often does your child use a seatbelt (carseat)?
A. Never B. Rarely C. Sometimes D. Often E. Always

Does your child ride a bicycle? Yes No
If yes, how often does he/she use a helmet?
A. Never B. Rarely C. Sometimes D. Often E. Always

Do you feel that you live in a safe place? Yes No

In the past year, have you ever felt threatened in your home? Yes No

In the past year, has your partner or other family member pushed you, punched you, kicked you, hit you, or threatened to hurt you? Yes No

What kind of guns are in your home?
A. Handgun B. Shotgun C. Rifle D. Other_____ E. None

If you have a gun at home, is it locked up? N/A Yes No

Does anyone in your household smoke? Yes No

Do you currently smoke cigarettes? If yes, how many cigarettes do you smoke per day? Yes No

_____ cigarettes/day

(continued on next page)

DRINKING AND DRUGS

In the past year have you ever had a drinking problem? Yes No

Have you tried to cut down on alcohol in the past year? Yes No

How many drinks does it take for you to get high or get a buzz? 1 2 3 4 5 6 7 or more

Do you ever have five or more drinks at one time? Yes No

Have you ever had a drug problem? Yes No

Have you used any drugs in the last 24 hours? Yes No
If yes, which one(s)
Cocaine Heroin Methadone Speed Marijuana Other:

Are you in a drug or alcohol recovery program now? If yes, which one(s) Yes No

Would you like to talk with other parents who are dealing with alcohol or drug problems? Yes No

WHEN YOU WERE A CHILD

Did either parent have a drug or alcohol problem? Yes No

Were you raised part or all of the time by foster parents or relatives (other than your parents)? Yes No

How often did your parents ground you or put you in time out?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often did your parents ridicule you in front of friends or family?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often were you hit with an object such as a belt, board, hairbrush, stick, or cord?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often were you thrown against walls or down stairs?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

Do you feel you were physically abused? Yes No

Do you feel you were neglected? Yes No

Do you feel you were hurt in a sexual way? Yes No

Did your parents ever hurt you when they were out of control? Yes No

Are you ever afraid you might lose control and hurt your child? Yes No

Would you like more information about free parenting programs, parent hotlines, or respite care? Yes No

Would you like information about birth control or family planning? Yes No

FAMILY ACTIVITIES

How strong are your family's religious beliefs or practices?
A. Very strong B. Moderately strong C. Not strong D. N/A

Do you have a religious affiliation? If so, what is your religion?

How often do you read bedtime stories to your child?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

How often does your family eat meals together?
A. Frequently B. Often C. Occasionally D. Rarely E. Never

What does your family do together for fun?

How often in the last week have you felt depressed?
0 1–2 3–4 5–7 days

In the past year, have you had two weeks or more during which you felt sad, blue, or depressed, or lost pleasure in things that you usually cared about or enjoyed? Yes No

Have you had two or more years in your life when you felt depressed or sad most days, even if you felt OK sometimes? Yes No

HELP AND SUPPORT

Whom can you count on to be dependable when you need help (just write their initials and their relationship to you):
A. No one D. _____ G. _____
B. _____ E. _____ H. _____
C. _____ F. _____ I. _____

How satisfied are you with their support?
A. Very satisfied C. A little satisfied E. Fairly dissatisfied
B. Fairly satisfied D. A little dissatisfied F. Very dissatisfied

Who accepts you totally, including both your best and worst points?
A. No one D. _____ G. _____
B. _____ E. _____ H. _____
C. _____ F. _____ I. _____

How satisfied are you with their support?
A. Very satisfied C. A little satisfied E. Fairly dissatisfied
B. Fairly satisfied D. A little dissatisfied F. Very dissatisfied

Whom do you feel truly loves you deeply?
A. No one D. _____ G. _____
B. _____ E. _____ H. _____
C. _____ F. _____ I. _____

How satisfied are you with their support?
A. Very satisfied C. A little satisfied E. Fairly dissatisfied
B. Fairly satisfied D. A little dissatisfied F. Very dissatisfied

Source: Adapted, with permission, from Kemper KJ, Kelleher KJ. 1996. Family psychosocial screening: Instruments and techniques. *Ambulatory Child Health* 1:325–339. (*Ambulatory Child Health* published by Blackwell Science, http://www.blacksci.co.uk.)

Psychosocial Evaluation
Waiver Project
Michigan Department of Health & Human Services

Family I.D. Number	Telephone number	Referral date to waiver program

1. Have you ever experienced domestic violence? Can you tell me who the perpetrator was?
2. Are you ever afraid of your current or former partner? Please explain.
3. Does your partner prevent you from visiting friends and family?
4. Does your partner prevent you from going to school or work?
5. Does your partner tell you what to wear, what to do, where you can go, or whom you can talk to?
6. Does your partner control the household income?
7. Does your partner follow you to "check-up" on you or check the mileage on your car?
8. Does your partner telephone you constantly while you are at work or home?
9. Does your partner give you threatening looks or stares when he/she does not agree with something you said or did?
10. Does your partner call you degrading names, put you down or humiliate you?
11. Does your partner blame you or tell you that you are at fault for the abuse or any problems you are having?
12. Does your partner deny or minimize their abusive behavior toward you?
13. Has your partner ever destroyed your personal possessions or household items?
14. Has your partner ever pushed, kicked, slapped, punched or choked you?
15. Has your partner ever threatened to kill or harm themselves, you, the children, or a pet?
16. How many times have you experienced abusive behavior from this person in the last 3 months? Can you describe the abuse?
17. Have you had to seek medical assistance for injuries or health problems resulting from your partners' violence?
18. Has your partner ever physically abused your children?
19. Has your partner ever asked your children to report your daily activities or "spy" on you?
20. Has your partner ever hurt you in front of your children?
21. How do you think the violence at home affects your children?
22. Have your children ever intervened in a physical or verbal assault to protect you or to stop the violence?
23. Has your partner ever threatened you with a weapon or gun?
24. Are there weapons in your home or does your partner have access to a dangerous weapon or a gun?
25. Do you believe your family is safe tonight?
26. Do you have a safety plan if you do not feel safe? If no: Can we create a safety plan together and include the children?

Trauma Informed System Initiative

Screening Checklist: Identifying Children at Risk Ages 0-5

Please check each area where the item is known or suspected.

If history is positive for exposure and concerns are present in one or more areas, a comprehensive assessment may be helpful in understanding the child's functioning and needs.

1. Are you aware of or do you suspect the child has experienced any of the following:
   - _____Physical abuse
   - _____Suspected neglectful home environment
   - _____Emotional abuse
   - _____Exposure to domestic violence
   - _____Known or suspected exposure to drug activity *aside from parental use*
   - _____Known or suspected exposure to any other violence *not already identified*
   - _____Parental drug use/substance abuse
   - _____Multiple separations from parent or caregiver
   - _____Frequent and multiple moves or homelessness
   - _____Sexual abuse or exposure
   - _____Other _____

If you are not aware of a trauma history, but multiple concerns are present in questions 2, 3, and 4, then there may be a trauma history that has not come to your attention.

Note: Concerns in the following areas do not necessarily indicate trauma; however, there is a strong relationship.

2. Does the child show any of these behaviors:
   - _____Excessive aggression or violence towards self or others
   - _____Repetitive violent and/or sexual play (or maltreatment themes)
   - _____Explosive behavior (excessive and prolonged tantruming)
   - _____Disorganized behavioral states (i.e. attention, play)
   - _____Very withdrawn or excessively shy
   - _____Bossy and demanding behavior with adults and peers
   - _____Sexual behaviors not typical for child's age
   - _____Difficulty with sleeping or eating
   - _____Regressed behaviors (i.e. toileting, play)
   - _____Other _____
3. Does the child exhibit any of the following emotions or moods:
   - _____Chronic sadness, doesn't seem to enjoy any activities.
   - _____Very flat affect or withdrawn behavior
   - _____Quick, explosive anger
   - _____Other _____
4. Is the child having relational and/or attachment difficulties?
   - _____Lack of eye contact
   - _____Sad or empty eyed appearance
   - _____Overly friendly with strangers (lack of appropriate stranger anxiety)
   - _____Vacillation between clinginess and disengagement and/or aggression
   - _____Failure to reciprocate (i.e. hugs, smiles, vocalizations, play)
   - _____Failure to seek comfort when hurt or frightened
   - _____Other _____

When checklist is completed, please fax to:

Child's First Name:_____ Age:_____ Gender:_____

County: _____ Date: _____

Henry, Black-Pond, & Richardson (2010)
Western Michigan University

FAMILY SATISFACTION SURVEY
WAIVER PROJECT

Michigan Department of Human Services

MiSACWIS Case ID: | | | | | | | | | | **FTM Phase:** | | | | **Date:** | | / | | / | | | | |

Please fill out this survey so we can learn how to give your family and other families in your community better services. Your answers are very important to us. They will help us find out how satisfied you are with the services your family receives from your Project Worker or other service providers. They will also find out how well the services meet your family's needs. The survey should take you about 5 to 10 minutes to do. You can seal your survey in the provided envelope so it will be private. We will not use information that names you or your family members in any reports. We will report information only for the entire group of families studied. Your Project Worker will not see your answers.

Please check the number that best says how much you agree or disagree with each statement below. Answer for yourself and your family. (Check "0" if the statement does not apply to your family.) Please use blue or black ink.

1. My family is getting the services we need.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

2. My family is taught new ways to talk and work with each other.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

3. My family is taught new and better ways to deal with our child(ren)'s behavior.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

4. My family and I know how to contact other agencies to get our needs met.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

5. My family is taught how to manage money better.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

6. My family is taught to manage our time better.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

7. My family is better able to understand and deal with our feelings.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

8. My family gets help getting mental health services we need.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

9. My family gets help getting substance abuse treatment services we need.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

10. My family gets help in finding a place to live.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

11. My family is taught ways to keep our family safe.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

12. My family gets help in learning how to keep our home clean and safe (e.g. household chores and repairs, etc.).

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	0 ☐

13. The appointments with my Project Worker are at convenient places for my family.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

14. My Project Worker schedules our appointments at times that work best for me and my family.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

15. My Project Worker asks for my family's opinions.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

16. My Project Worker welcomes my family's and my comments, ideas, and opinions and includes them in the plans for service.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

17. The Project has helped me and my family reach our goals.

Strongly Agree	Agree	Neutral or Undecided	Disagree	Strongly Disagree	Does Not Apply
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

18. What do you like most about the Project?

19. Is there anything about the Project or your Project Worker that you do not like? If YES, what do you not like?

20. Is there anything that the Project Worker or Project could do to be more helpful? If YES, what would be more helpful?

Thank you for your help!

Authority: P.A. 280 of 1939 Response: Voluntary Penalty: None	Department of Human Services (DHS) will not discriminate against any person or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, please make your needs known to a DHS office in your area.

43005

ENCUESTA ACERCA DE LA SATISFACCIÓN DE FAMILIAS
PROYECTO DE EXENCIÓN

Departamento de servicios humanos de Michigan

Número de identificación de MiSACWIS ☐☐☐☐☐☐☐☐☐ **Fase FTM:** ☐☐☐ **Fecha:** ☐☐ / ☐☐ / ☐☐☐☐

Sírvase llenar esta encuesta para que podamos aprender cómo proporcionar mejores servicios a su familia y a otras familias de su comunidad. Sus respuestas son muy importantes para nosotros, ya que nos ayudarán a conocer su nivel de satisfacción con los servicios que su familia recibe del trabajador del proyecto que le fue asignado o de otros proveedores de servicio. Además, por medio de sus respuestas podremos saber en qué medida satisfacen los servicios las necesidades de su familia. Contestar la encuesta le tomará unos 5 a 10 minutos. Puede mantener su encuesta en privado al sellarla en el sobre adjunto. No utilizaremos ninguna información que lo identifique a usted ni a su familia en ninguno de nuestros informes. Únicamente haremos nuestros informes basándonos en todo el conjunto de familias que participaron en el estudio. Su trabajador del proyecto no verá sus respuestas.

Marque el casillero que representa mejor en qué medida está de acuerdo o en desacuerdo con cada una de las siguientes afirmaciones. Responda por usted y su familia. (Marque el casillero que lleva el "0" si la afirmación no aplica a su familia). Por favor use tinta azul o negra solamente.

1. Mi familia y yo estamos recibiendo los servicios que necesitamos.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

2. Se le ha enseñado a mi familia nuevas maneras de comunicación y de trabajo en equipo.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

3. Se le ha enseñado a mi familia nuevas y mejores maneras para tratar el comportamiento de nuestro(s) niño(s).

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

4. Mi familia y yo sabemos cómo comunicarnos con otros organismos para satisfacer nuestras necesidades.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

5. Se le ha enseñado a mi familia una mejor manera para manejar el dinero.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

6. Se le ha enseñado a mi familia a organizar mejor el tiempo.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5	**4**	**3**	**2**	**1**	**0**
☐	☐	☐	☐	☐	☐

7. Mi familia puede comprender y lidiar de una mejor manera con nuestros sentimientos.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5	**4**	**3**	**2**	**1**	**0**
☐	☐	☐	☐	☐	☐

8. Mi familia y yo recibimos apoyo para obtener los servicios de salud mental que necesitamos.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5	**4**	**3**	**2**	**1**	**0**
☐	☐	☐	☐	☐	☐

9. Mi familia y yo recibimos apoyo para obtener los servicios para el tratamiento de abuso de drogas que necesitamos.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5	**4**	**3**	**2**	**1**	**0**
☐	☐	☐	☐	☐	☐

10. Mi familia recibe apoyo para encontrar un lugar donde vivir.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5	**4**	**3**	**2**	**1**	**0**
☐	☐	☐	☐	☐	☐

11. Se le ha enseñado a mi familia las maneras para mantener a nuestra familia a salvo.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5	**4**	**3**	**2**	**1**	**0**
☐	☐	☐	☐	☐	☐

12. Mi familia recibe apoyo para aprender a mantener nuestra casa limpia y segura (por ej. hacer la tareas del hogar y reparaciones, etc.).

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5	**4**	**3**	**2**	**1**	**0**
☐	☐	☐	☐	☐	☐

13. Las citas con el trabajador del proyecto que me fue asignado se hicieron en un lugar accesible para mi familia.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

14. El trabajador del proyecto que me fue asignado programa nuestras citas cuando es más conveniente para mí y mi familia.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

15. El trabajador del proyecto que me fue asignado le pregunta a mi familia su opinión.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

16. Al trabajador del proyecto que me fue asignado le gusta recibir comentarios, ideas y opiniones de mí y mi familia y los incluye en el plan de servicio.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

17. El proyecto nos ha ayudado a mí y a mi familia a lograr nuestros objetivos.

Completamente de acuerdo	De acuerdo	Neutro o indeciso	En desacuerdo	Completamente en desacuerdo	No aplica
5 ☐	**4** ☐	**3** ☐	**2** ☐	**1** ☐	**0** ☐

18. ¿Qué es lo que más le gusta del proyecto?

19. ¿Hay algo que no le guste del proyecto o del trabajador del proyecto? Si la respuesta es sí, ¿qué no le gusta?

20. ¿Hay algo que podría hacer el proyecto o el trabajador del proyecto que sería más útil? Si la respuesta es sí, ¿qué podría ser más útil?

Muchísimas gracias por su colaboración.

Autoridad: P.A. 280 de 1939 Respuesta: Voluntaria Sanción: Ninguna	El Departamento de servicios humanos (DHS, por sus siglas en inglés) no discrimina a ninguna persona por su raza, sexo, religión, edad, nacionalidad, color, altura, peso, estado civil, convicciones políticas o discapacidad. Si necesita ayuda para leer, escribir, escuchar, etc., bajo la Ley para personas con discapacidades (ADA, por sus siglas en inglés), dé a conocer sus necesidades al Departamento de servicios humanos (DHS) de su localidad.

Michigan Department of Human Services
Protect MiFamily - Michigan's Title IV-E Waiver Demonstration Model Fidelity Checklist

Date Completed (1)	Rater Initials (2)	Agency Being Rated (3)	Agency County (4)	Waiver Service Phase (5)	Case ID# (6)	CPS Category (7)	Referral Date (8)
☐☐/☐☐/☐☐☐☐ mm dd yyyy	☐☐	Lutheran Social Services Kalamazoo ☐ Lutheran Social Services Macomb ☐ Catholic Charities Muskegon ☐	Kalamazoo ☐ Macomb ☐ Muskegon ☐	1 ☐ 2 ☐ 3 ☐ Closed in Phase 1 ☐ Closed in Phase 2 ☐ Closed in Phase 3 ☐	☐☐☐☐☐☐☐☐☐	2 ☐ 4 ☐	☐☐/☐☐/☐☐☐☐ mm dd yyyy

Rating Instructions: If the item was completed as required for the phase being rated, enter an X in the Yes column. If the item was not completed as required for the phase being rated, enter an X in the No column. If the item was not completed because it was not required for the phase, or because the deadline for the item has not occurred within the phase being rated, enter an X in the N/A (Not Applicable) column. Only one column can be used per item.

A. Contacts and Assessments	Y	N	N/A	Notes	Data Source
1a Did the waiver worker maintain contact standards with the family as required for this phase? (Twice every 7 days in Phase 1; once every 7 days in Phase 2; once a month in Phase 3) **ALL PHASES**	☐	☐			Date Face to Face Visit (Protect MiFamily Database Face to Face Contact Field) & Referral Date (Protect MiFamily Database/Form 892)
1b If the waiver worker did not maintain contact standards with the family as required for this phase was the family contacted twice every 8-10 days in Phase 1, or once every 8-10 days in Phase 2? **PHASES ONE & TWO ONLY**	☐	☐	☐		Date Face to Face Visit (Protect MiFamily Database Face to Face Contact Field) & Referral Date (Protect MiFamily Database/Form 892)
2 Was the Family Psychosocial Screen administered within 7 days of referral? **PHASE ONE ONLY**	☐	☐	☐	referral date + 7 days	Date (Protect MiFamily Database Family Psychosocial Screen Field) & Referral Date (Protect MiFamily Database/Form 892)
3 Did the waiver worker develop an initial written safety plan within 7 days of the family's referral to the waiver project? **PHASE ONE ONLY**	☐	☐	☐	referral date + 7 days	Safety Assessment Plan (Form 1232) & Referral Date (Protect MiFamily Database/Form 892)
4 Did the waiver worker administer the Protective Factors Survey as required for this phase? **ALL PHASES**	☐	☐	☐	**N/A if not within PFS administration window**	PFS Database & Referral Date (Protect MiFamily Database/Form 892)
5 Did the waiver worker administer the Devereux Early Childhood Assessment to each child in the household ages 0-5 as required for this phase? **PHASES ONE & THREE**	☐	☐	☐		DECA Pre & Post Test Score Sheet & Referral Date (Protect MiFamily Database/Form 892)

Rating Instructions: If the item was completed as required for the phase being rated, enter an X in the Yes column. If the item was not completed as required for the phase being rated, enter an X in the No column. If the item was not completed because it was not required for the phase, or because the deadline for the item has not occurred within the phase being rated, enter an X in the N/A (Not Applicable) column. Only one column can be used per item.

	A. Contacts and Assessments	Y	N	N/A	Notes	Data Source
6	Did the waiver worker administer the Trauma Screening Checklist to each child in the home ages 0-5 within 30 days of the family's referral to the waiver project? **PHASE ONE ONLY**	☐	☐	☐	referral date + 30 days	Date Administered (Protect MiFamily Database Trauma Screening Checklist Field) & Referral Date (Protect MiFamily Database/Form 892)
7	If appropriate for case status (open/closed) or case category, did the waiver worker complete the Risk Re-Assessment as required for this phase? **PHASES TWO & THREE**	☐	☐	☐	N/A if open CPS Category 2 or 4	Risk Re-Assessment Date (Protect MiFamily Database Case Phase Information Field) & Referral Date (Protect MiFamily Database/Form 892)
8	Did the waiver worker provide the designated family member with the waiver family satisfaction survey as required for this phase? **ALL PHASES**	☐	☐	☐		Survey Provided (Protect MiFamily Database FTM Field) & Referral Date (Protect MiFamily Database/Form 892)
9	Is there evidence that the waiver worker addressed the Waiver Safety Assessment Plan as required for this phase? **PHASES TWO & THREE**	☐	☐	☐		Safety Assessment Plan (Form 1232) & Referral Date (Protect MiFamily Database/Form 892)
10	Did the waiver worker complete the Safety Re-Assessment at 15 months? **PHASE THREE ONLY**	☐	☐	☐		Date of Re-Assessment (Protect MiFamily Database Final Safety Assessment Field) & Referral Date (Protect MiFamily Database/Form 892)
11	Did the waiver worker complete a written case plan with the family no later than 45 days after the family was referred to the waiver project? **PHASE ONE ONLY**	☐	☐	☐		Case Plan (Form 1091) & Referral Date (Protect MiFamily Database/Form 892)
12	Did the waiver worker complete the progress report as required for this phase? **PHASES TWO & THREE**	☐	☐	☐		Progress Report (Form 1239) & Referral Date (Protect MiFamily Database/Form 892)
13	Did the waiver worker complete the Final Progress Report? **PHASE THREE ONLY**	☐	☐	☐		Final Progress Report (DHS-839-FEW)
14	Did the waiver worker complete the Case Close Notification? **ALL PHASES**	☐	☐	☐		Case Close Notification (DHS-1240-FEW)
	B. Family Team Meetings	Y	N	N/A	Notes	Data Source
1	Did the waiver worker convene a family team meeting as required for this phase? **ALL PHASES**	☐	☐	☐	**N/A if not within FTM administration window**	Date (Protect MiFamily Database Field for FTM) & Referral Date (Protect MiFamily Database/Form 892)

Rating Instructions: If the item was completed as required for the phase being rated, enter an X in the Yes column. If the item was not completed as required for the phase being rated, enter an X in the No column. If the item was not completed because it was not required for the phase, or because the deadline for the item has not occurred within the phase being rated, enter an X in the N/A (Not Applicable) column. Only one column can be used per item.

	C. Worker Service Delivery	Y	N	N/A	Notes	Data Source
1	Were the provided community service referrals related to family's identified risks and needs? **ALL PHASES**	☐	☐	☐	Completed as needed	Waiver Community Service Referral (Form 1233) - Reasons for Referral
2	Did the waiver worker advance the family through this phase in accordance with the time allotted for this waiver phase? **PHASES TWO & THREE**	☐	☐	☐		Date Advanced (Protect MiFamily Database Case Phase Information Field) & Referral Date (Protect MiFamily Database/Form 892)
3	Did the waiver worker refer and link the family to concrete services that addressed either child safety, risk, or well-being? **ALL PHASES**	☐	☐	☐	Completed as needed	Concrete Assistance (Form 1235) - Amount Requested/Related Goal
4	Did the waiver worker send the letter summarizing progress to the family no later than 7 days after case closure? **ALL PHASES**	☐	☐	☐		Copy of Letter in Case File & Date of Case Closure (Protect MiFamily Database Case Phase Information Field)

*As needed documentation can also be retrieved from the physical case file

PROTECTIVE FACTORS SURVEY

(Program Information-- For Staff Use Only)

Agency ID _____ **Family ID #** _____

1. Date survey completed: ____/____/____

☐ Pretest **(PHASE 1)**
☐ **PHASE 2 (WILL NOT BE ENTERED IN PFS DATABASE)**
☐ Post test **(PHASE 3)**

2. How was the survey completed?

☐ Completed in face to face interview
☐ Completed by participant with program staff available to explain items as needed
☐ Completed by participant without program staff present

3. Has the participant had any involvement with Child Protective Services?

☐ NO ☐ YES ☐ NOT SURE

4.a. Date participant began program (complete for pretest) ____/____/____

4.b. Date participant completed program (complete at post-test) ____/____/____

5. OMMITTED.

6. Participant's Attendance: (Estimate if necessary)

A) **Answer at Pretest:** Number of hours of service offered to the consumer: _____

B) **Answer at Post-test:** Number of hours of service received by the consumer: _____

This survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.

PROTECTIVE FACTORS SURVEY

Agency ID _____ **Family ID #** _____

1. Date Survey Completed: _/____/____ **2. Sex:** ☐ Male ☐ Female **3. Age (in years):** _____

4. Race/Ethnicity: (Please choose the ONE that best describes what you consider yourself to be)

☐A Native American or Alaskan Native
☐B Asian
☐C African American
☐D African Nationals/Caribbean Islanders
☐E Hispanic or Latino
☐F Middle Eastern
☐G Native Hawaiian/Pacific Islanders
☐H White (Non Hispanic/European American)
☐I. Multi-racial
☐J Other _____

5. Marital Status:

☐A Married ☐B Partnered ☐C Single ☐D Divorced ☐E Widowed ☐F Separated

6. Family Housing:

☐A Own ☐B Rent ☐C Shared housing with relatives/friends
☐D Temporary (shelter, temporary with friends/relatives) ☐E Homeless

7. Family Income:

☐A $0-$10,000 ☐B $10,001-$20,000 ☐C $20,001-$30,000
☐D $30,001-$40,000 ☐E $40,001-$50,000 ☐F more than 50,001

8. Highest Level of Education:

☐A Elementary or junior high school ☐B Some high school ☐C High school diploma or GED
☐D Trade/Vocational Training ☐E Some college ☐F 2-year college degree (Associate's)
☐G 4-year college degree (Bachelor's) ☐H Master's degree ☐I PhD or other advanced degree

9. Which, if any, of the following do you currently receive? (Check all that apply)

☐A Food Stamps ☐B Medicaid (State Health Insurance) ☐C Earned Income Tax Credit
☐D TANF ☐E Head Start/Early Head Start Services ☐F None of the above

10. Please tell us about the children living in your household.

	Gender		Birth Date (mm/dd/yy)	Your Relationship To Child (check one)						
	Male	Female		A Birth parent	B Adoptive parent	C Grand-parent	D-Sibling	E-Other relative	F-Foster Parent	Other
Child 1										
Child 2										
Child 3										
Child 4										

If more than 4 children, please use space provided on the back of this sheet.

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PROTECTIVE FACTORS SURVEY

Part I. Please *circle* the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time. The number 4 means that the statement is true about half the time.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
1. In my family, we talk about problems.	1	2	3	4	5	6	7
2. When we argue, my family listens to "both sides of the story."	1	2	3	4	5	6	7
3. In my family, we take time to listen to each other.	1	2	3	4	5	6	7
4. My family pulls together when things are stressful.	1	2	3	4	5	6	7
5. My family is able to solve our problems.	1	2	3	4	5	6	7

Part II. Please *circle* the number that best describes how much you agree or disagree with the statement.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
6. I have others who will listen when I need to talk about my problems.	1	2	3	4	5	6	7
7. When I am lonely, there are several people I can talk to.	1	2	3	4	5	6	7
8. I would have no idea where to turn if my family needed food or housing.	1	2	3	4	5	6	7
9. I wouldn't know where to go for help if I had trouble making ends meet.	1	2	3	4	5	6	7
10. If there is a crisis, I have others I can talk to.	1	2	3	4	5	6	7
11. If I needed help finding a job, I wouldn't know where to go for help.	1	2	3	4	5	6	7

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PROTECTIVE FACTORS SURVEY

Part III. This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services. Please write the child's age or date of birth and then answer questions with this child in mind.

Child's Age _____ **or** **DOB** ____/____/____

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
12. There are many times when I don't know what to do as a parent.	1	2	3	4	5	6	7
13. I know how to help my child learn.	1	2	3	4	5	6	7
14. My child misbehaves just to upset me.	1	2	3	4	5	6	7

Part IV. Please tell us how often each of the following happens in your family.

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
15. I praise my child when he/she behaves well.	1	2	3	4	5	6	7
16. When I discipline my child, I lose control.	1	2	3	4	5	6	7
17. I am happy being with my child.	1	2	3	4	5	6	7
18. My child and I are very close to each other.	1	2	3	4	5	6	7
19. I am able to soothe my child when he/she is upset.	1	2	3	4	5	6	7
20. I spend time with my child doing what he/she likes to do.	1	2	3	4	5	6	7

This survey was developed by the FRIENDS National Resource Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.

Devereux Early Childhood Assessment for Infants
Record Form
(1 month up to 18 months)

Mary Mackrain, Paul LeBuffe and Gregg Powell

Infant's Name _____ Gender _____ DOB _____ Age _____ (In Months)

Person Completing this Form _____ Relationship to Infant _____

Date of Rating _____ Site/Program _____ Room _____

This form describes a number of behaviors seen in some infants. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the infant…*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Answer each question carefully. There are no right or wrong answers. Please answer every item. If you wish to change your answer, put an X through it and fill in your new choice as shown to the right.

Never	Rarely	Occasionally	Frequently	Very Frequently
☒	☑	☐	☐	☐

Item #	*During the past 4 weeks, how often did the infant…*	Never	Rarely	Occasionally	Frequently	Very Frequently
1	try to do new things?	☐	☐	☐	☐	☐
2	respond when spoken to?	☐	☐	☐	☐	☐
3	imitate actions of others?	☐	☐	☐	☐	☐
4	enjoy interacting with others?	☐	☐	☐	☐	☐
5	keep trying when unsuccessful?	☐	☐	☐	☐	☐
6	enjoy being cuddled?	☐	☐	☐	☐	☐
7	show interest in what others were doing?	☐	☐	☐	☐	☐
8	show affection for a familiar adult?	☐	☐	☐	☐	☐
9	notice changes in surroundings?	☐	☐	☐	☐	☐
10	seek comfort from familiar adults?	☐	☐	☐	☐	☐
11	adjust her/his energy level to the type of play?	☐	☐	☐	☐	☐
12	act in a good mood?	☐	☐	☐	☐	☐
13	act happy when praised?	☐	☐	☐	☐	☐
14	make eye contact with others?	☐	☐	☐	☐	☐
15	explore surroundings?	☐	☐	☐	☐	☐
16	calm down with help from a familiar adult?	☐	☐	☐	☐	☐
17	express her/his dislikes?	☐	☐	☐	☐	☐
18	smile back at a familiar adult?	☐	☐	☐	☐	☐
19	reach for a familiar adult?	☐	☐	☐	☐	☐
20	respond to her/his name?	☐	☐	☐	☐	☐
21	keep trying to obtain a toy?	☐	☐	☐	☐	☐
22	react to another child's cry?	☐	☐	☐	☐	☐
23	smile at familiar adults?	☐	☐	☐	☐	☐
24	respond positively to adult attention?	☐	☐	☐	☐	☐
25	act happy?	☐	☐	☐	☐	☐
26	act in a way that make others smile or show interest?	☐	☐	☐	☐	☐
27	easily go from one activity to another?	☐	☐	☐	☐	☐
28	seek attention when a familiar adult was with another child?	☐	☐	☐	☐	☐
29	look to a familiar adult when exploring her/his surroundings?	☐	☐	☐	☐	☐
30	enjoy being around other children?	☐	☐	☐	☐	☐
31	show pleasure when interacting with adults?	☐	☐	☐	☐	☐
32	act happy with familiar adults?	☐	☐	☐	☐	☐
33	accept comfort from a familiar adult?	☐	☐	☐	☐	☐

Devereux Early Childhood Assessment for Toddlers
Record Form
(18 months up to 36 months)

Mary Mackrain, Paul LeBuffe and Gregg Powell

Toddler's Name _____ Gender _____ DOB _____ Age _____ (In Months)

Person Completing this Form _____ Relationship to Toddler _____

Date of Rating _____ Site/Program _____ Room _____

This form describes a number of behaviors seen in some toddlers. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the toddler…*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Answer each question carefully. There are no right or wrong answers. Please answer every item. If you wish to change your answer, put an X through it and fill in your new choice as shown to the right.

Never	Rarely	Occasionally	Frequently	Very Frequently
☒	☑	☐	☐	☐

Item #	*During the past 4 weeks, how often did the toddler…*	Never	Rarely	Occasionally	Frequently	Very Frequently
1	enjoy interacting with others?	☐	☐	☐	☐	☐
2	show affection for a familiar adult?	☐	☐	☐	☐	☐
3	adjust to changes in routine?	☐	☐	☐	☐	☐
4	seek comfort from familiar adults?	☐	☐	☐	☐	☐
5	makes needs known to a familiar adult?	☐	☐	☐	☐	☐
6	act happy with familiar adults?	☐	☐	☐	☐	☐
7	show interest in her/his surroundings?	☐	☐	☐	☐	☐
8	respond when spoken to?	☐	☐	☐	☐	☐
9	show concern for other children?	☐	☐	☐	☐	☐
10	try to comfort others?	☐	☐	☐	☐	☐
11	act happy when praised?	☐	☐	☐	☐	☐
12	participate in group activities?	☐	☐	☐	☐	☐
13	make eye contact with others?	☐	☐	☐	☐	☐
14	enjoy being cuddled?	☐	☐	☐	☐	☐
15	smile back at a familiar adult?	☐	☐	☐	☐	☐
16	ask to do new things?	☐	☐	☐	☐	☐
17	reach for a familiar adult?	☐	☐	☐	☐	☐
18	respond to her/his name?	☐	☐	☐	☐	☐
19	react to another child's cry?	☐	☐	☐	☐	☐
20	smile at familiar adults?	☐	☐	☐	☐	☐
21	easily go from one activity to another?	☐	☐	☐	☐	☐
22	show pleasure when interacting with adults?	☐	☐	☐	☐	☐
23	handle frustration well?	☐	☐	☐	☐	☐
24	makes others aware of her/his needs?	☐	☐	☐	☐	☐
25	accept comfort from a familiar adult?	☐	☐	☐	☐	☐
26	play make-believe?	☐	☐	☐	☐	☐
27	follow simple directions?	☐	☐	☐	☐	☐
28	show preference for a particular playmate?	☐	☐	☐	☐	☐
29	try to clean up after herself/himself?	☐	☐	☐	☐	☐
30	easily follow a daily routine?	☐	☐	☐	☐	☐
31	play with other children?	☐	☐	☐	☐	☐
32	try to do things for herself/himself?	☐	☐	☐	☐	☐
33	calm herself/himself?	☐	☐	☐	☐	☐
34	accept another choice when the first choice was not available?	☐	☐	☐	☐	☐
35	have regular sleeping patterns?	☐	☐	☐	☐	☐
36	express a variety of emotions (e.g. happy, sad, mad)?	☐	☐	☐	☐	☐

Devereux Early Childhood Assessment for Preschoolers
Second Edition (DECA-P2)

(for children ages 3 through 5 years)

Paul A. LeBuffe ■ Jack A. Naglieri

Child's Name: _____ Gender: _____ Date of Birth: _____

Program/Site: _____ Classroom/Group: _____ Age: _____

Person Completing this Form: _____ Relationship to Child: _____ Date of Rating: _____

This form describes a number of behaviors seen in some young children. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the child...*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Please answer each question carefully. There are no right or wrong answers. If you wish to change your answer, put an ✗ through it and fill in your new choice as shown to the right. Please do not skip any items.

Never	Rarely	Occasionally	Frequently	Very Frequently
✗	✓	☐	☐	☐

Item #	*During the past 4 weeks, how often did the child...*	Never ✓	Rarely ✓	Occasionally ✓	Frequently ✓	Very Frequently ✓
1.	act in a way that made adults smile or show interest in him/her?	☐	☐	☐	☐	☐
2.	listen to or respect others?	☐	☐	☐	☐	☐
3.	control his/her anger?	☐	☐	☐	☐	☐
4.	seem sad or unemotional at a happy occasion?	☐	☐	☐	☐	☐
5.	show confidence in his/her abilities (for instance, say "I can do it!")?	☐	☐	☐	☐	☐
6.	have a temper tantrum?	☐	☐	☐	☐	☐
7.	keep trying when unsuccessful (show persistence)?	☐	☐	☐	☐	☐
8.	seem uninterested in other children or adults?	☐	☐	☐	☐	☐
9.	use obscene gestures or offensive language?	☐	☐	☐	☐	☐
10.	try different ways to solve a problem?	☐	☐	☐	☐	☐
11.	seem happy or excited to see his/her parent or guardian?	☐	☐	☐	☐	☐
12.	destroy or damage property?	☐	☐	☐	☐	☐
13.	try or ask to try new things or activities?	☐	☐	☐	☐	☐
14.	show affection for familiar adults?	☐	☐	☐	☐	☐
15.	start or organize play with other children?	☐	☐	☐	☐	☐
16.	show patience?	☐	☐	☐	☐	☐
17.	ask adults to play with or read to him/her?	☐	☐	☐	☐	☐
18.	have a short attention span (difficulty concentrating)?	☐	☐	☐	☐	☐
19.	share with other children?	☐	☐	☐	☐	☐
20.	handle frustration well?	☐	☐	☐	☐	☐
21.	fight with other children?	☐	☐	☐	☐	☐
22.	become upset or cry easily?	☐	☐	☐	☐	☐
23.	show an interest in learning new things?	☐	☐	☐	☐	☐
24.	trust familiar adults and believe what they say?	☐	☐	☐	☐	☐
25.	accept another choice when his/her first choice was not available?	☐	☐	☐	☐	☐
26.	seek help from children/adults when necessary?	☐	☐	☐	☐	☐
27.	hurt others with actions or words?	☐	☐	☐	☐	☐
28.	cooperate with others?	☐	☐	☐	☐	☐
29.	calm himself/herself down?	☐	☐	☐	☐	☐
30.	get easily distracted?	☐	☐	☐	☐	☐
31.	make decisions for himself/herself?	☐	☐	☐	☐	☐
32.	appear happy when playing with others?	☐	☐	☐	☐	☐
33.	choose to do a task that was hard for him/her?	☐	☐	☐	☐	☐
34.	look forward to activities at home or school (for instance, birthdays or trips)?	☐	☐	☐	☐	☐
35.	touch children or adults in a way that you thought was inappropriate?	☐	☐	☐	☐	☐
36.	show a preference for a certain adult, teacher, or parent?	☐	☐	☐	☐	☐
37.	play well with others?	☐	☐	☐	☐	☐
38.	remember important information?	☐	☐	☐	☐	☐

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DESSA-MINI
DEVEREUX STUDENT STRENGTHS ASSESSMENT
K-8TH GRADE

DEVEREUX STUDENT STRENGTHS ASSESSMENT - MINI (DESSA-MINI)

FORM 1

JACK A. NAGLIERI, PAUL A. LEBUFFE, AND VALERIE B. SHAPIRO

Child's Name _____ Gender _____ DOB _____ Grade _____

Person Completing this Form _____ Relationship to Child _____

Date of Rating _____ School/Organization _____ Classroom/Program _____

This form describes a number of behaviors seen in some children. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the child...*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Answer each question carefully. There are no right or wrong answers. Please answer every item. If you wish to change your answer, put an X through it and fill in your new choice as shown to the right.

Never	Rarely	Occasionally	Frequently	Very Frequently
X	✓	2	3	4

Item #	*During the past 4 weeks, how often did the child...*	Never	Rarely	Occasionally	Frequently	Very Frequently	Score
1.	accept responsibility for what she/he did?	0	1	2	3	4	_____
2.	do something nice for somebody?	0	1	2	3	4	_____
3.	speak about positive things?	0	1	2	3	4	_____
4.	pay attention?	0	1	2	3	4	_____
5.	contribute to group efforts?	0	1	2	3	4	_____
6.	perform the steps of a task in order?	0	1	2	3	4	_____
7.	show care when doing a project or school work?	0	1	2	3	4	_____
8.	follow the advice of a trusted adult?	0	1	2	3	4	_____

Raw Score Sum _____

Turn over to finish scoring →

Recommendations: _____

_____

_____

_____

KAPLAN

DESSA-MINI
DEVEREUX STUDENT STRENGTHS ASSESSMENT
K-8TH GRADE

DEVEREUX STUDENT STRENGTHS ASSESSMENT - MINI (DESSA-MINI)

FORM 2

JACK A. NAGLIERI, PAUL A. LEBUFFE, AND VALERIE B. SHAPIRO

Child's Name _____ Gender _____ DOB _____ Grade _____

Person Completing this Form _____ Relationship to Child _____

Date of Rating _____ School/Organization _____ Classroom/Program _____

This form describes a number of behaviors seen in some children. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the child...*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Answer each question carefully. There are no right or wrong answers. Please answer every item. If you wish to change your answer, put an X through it and fill in your new choice as shown to the right.

Never	Rarely	Occasionally	Frequently	Very Frequently
☒	☑	2	3	4

Item #	*During the past 4 weeks, how often did the child...*	Never	Rarely	Occasionally	Frequently	Very Frequently	Score
1.	follow the example of a positive role model?	0	1	2	3	4	_____
2.	keep trying when unsuccessful?	0	1	2	3	4	_____
3.	take an active role in learning?	0	1	2	3	4	_____
4.	attract positive attention from peers?	0	1	2	3	4	_____
5.	respect another person's opinion?	0	1	2	3	4	_____
6.	attract positive attention from adults?	0	1	2	3	4	_____
7.	work hard on projects?	0	1	2	3	4	_____
8.	offer to help somebody?	0	1	2	3	4	_____

Raw Score Sum _____

Turn over to finish scoring →

Recommendations: _____

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Product Code #19308

DESSA-MINI
DEVEREUX STUDENT STRENGTHS ASSESSMENT
K-8TH GRADE

DEVEREUX STUDENT STRENGTHS ASSESSMENT - MINI (DESSA-MINI)

FORM 3

JACK A. NAGLIERI, PAUL A. LEBUFFE, AND VALERIE B. SHAPIRO

Child's Name _____ Gender _____ DOB _____ Grade _____

Person Completing this Form _____ Relationship to Child _____

Date of Rating _____ School/Organization _____ Classroom/Program _____

This form describes a number of behaviors seen in some children. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the child...*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Answer each question carefully. There are no right or wrong answers. Please answer every item. If you wish to change your answer, put an X through it and fill in your new choice as shown to the right.

Never	Rarely	Occasionally	Frequently	Very Frequently
☒	☑	2	3	4

Item #	*During the past 4 weeks, how often did the child...*	Never	Rarely	Occasionally	Frequently	Very Frequently	Score
1.	show good judgment?	0	1	2	3	4	_____
2.	take steps to achieve goals?	0	1	2	3	4	_____
3.	try to do her/his best?	0	1	2	3	4	_____
4.	focus on a task despite a problem or distraction?	0	1	2	3	4	_____
5.	prepare for school, activities, or upcoming events?	0	1	2	3	4	_____
6.	do routine tasks or chores without being reminded?	0	1	2	3	4	_____
7.	learn from experience?	0	1	2	3	4	_____
8.	express high expectations for himself/herself?	0	1	2	3	4	_____

Raw Score Sum _____

Turn over to finish scoring →

Recommendations: _____

_____

_____

_____

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Product Code #19309

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DESSA-MINI
DEVEREUX STUDENT STRENGTHS ASSESSMENT
K-8TH GRADE

DEVEREUX STUDENT STRENGTHS ASSESSMENT - MINI (DESSA-MINI)

FORM 4

JACK A. NAGLIERI, PAUL A. LEBUFFE, AND VALERIE B. SHAPIRO

Child's Name _____ Gender _____ DOB _____ Grade _____

Person Completing this Form _____ Relationship to Child _____

Date of Rating _____ School/Organization _____ Classroom/Program _____

This form describes a number of behaviors seen in some children. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the child...*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Answer each question carefully. There are no right or wrong answers. Please answer every item. If you wish to change your answer, put an X through it and fill in your new choice as shown to the right.

Never	Rarely	Occasionally	Frequently	Very Frequently
☒	☑	2	3	4

Item #	*During the past 4 weeks, how often did the child...*	Never	Rarely	Occasionally	Frequently	Very Frequently	Score
1.	look forward to classes or activities at school?	0	1	2	3	4	_____
2.	show appreciation of others?	0	1	2	3	4	_____
3.	encourage positive behavior in others?	0	1	2	3	4	_____
4.	teach another person to do something?	0	1	2	3	4	_____
5.	show an awareness of her/his personal strengths?	0	1	2	3	4	_____
6.	make a suggestion or request in a polite way?	0	1	2	3	4	_____
7.	use available resources (people or objects) to solve a problem?	0	1	2	3	4	_____
8.	seek out additional knowledge or information?	0	1	2	3	4	_____

Raw Score Sum _____

Turn over to finish scoring →

Recommendations: _____

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Product Code #19311

CONTROL GROUP EXPENDITURE DATA COLLECTION
Title IV-E Waiver Project
Michigan Department of Health and Human Services

Control Family Intake #: _____
Control Family Case ID#: _____
Control Family Name: _____
County: _____

Only enter information on Services where payment has been requested or In-kind services have been received.

CPS Open Date: _____ **CPS Closure Date:** _____

1 Service	2 Individual (I) or Family (F)	3 Service Start Date	4 Service End Date	5 # of Units of Service	6 Provider Name and ID	7 Service Costs	8 Fund Source Code Complete only if known

Code #	Fund Source	Code #	Fund Source
02	CPCP	07	CTF Grant – (CBCAP)
03	IV-B2	08	SSBG
04	TANF	09	Great Start Collab.
05	CS/PP	10	Medicaid
06	Emergency Relief	11	Other Funds
		12	In Kind or No Cost to MDHHS

Codes For Waiver Control Group – Expenditure Data Collection

Service Category	Service Name
Clinical Services	Individual counseling
	Family counseling
	Group counseling
	Domestic violence assessment
	Substance abuse assessment
	Trauma assessment
	Trauma focused interventions
	Inpatient treatment (psychiatric/mental health)
	Inpatient treatment (substance abuse)
	Outpatient treatment (substance abuse)
	Substance abuse testing
	Home based outreach counseling
	Clinical assessment (psychological/psychiatric)
	Mental health service referrals/psychiatric consultation
Educational Services	School social worker or psychologist
	Headstart or other pre-school
	Before/After school care program
	Home based instruction from school district
	Special education services
	Tutoring
	Early-on (assessment and/or intervention)
	Adult education/literacy services
Parent/Family Support	CPS case management
	Custody and/or visitation services
	Parenting education (in-home, group or class)
	Self-help support group (parent café, etc.)
	Mentoring for parents
	Mentoring for youth
	Child care, respite care
	Household management/homemaker services
	Family resource center
	Home visitation program
	Domestic violence support, intervention, counseling
	Housing/shelter
	Utility assistance
	Food assistance
	Appliances or furniture assistance
	Household repair
	Clothing
	Legal help/drug court/probation services
	Employment services
	Recreational activities/clubs
	Faith-based interventions or information
	Wraparound
	Families First

	Families Together Building Solutions
	Family Reunification Programs
	Pathways to Potential
	Transportation services (bus tokens, etc.)
	WIC information
	Strong Families/Safe Child
	Budgeting information
Health Related Services	Well-child examinations
	Physical health/medical information and referrals
	Medication reviews
	Dental services (adult or child)
	Family planning/pre-natal services
	Maternal infant health

APPENDIX C
FAMILY SATISFACTION RESULTS

Family Satisfaction Survey Results, Overall (as of 11/30/15)												
Questions	**Strongly Agree**		**Agree**		**Neutral**		**Disagree**		**Strongly Disagree**		**Does Not Apply**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
1. My family is getting the services we need.	296	68.2%	112	25.8%	19	4.4%	2	0.5%	2	0.5%	3	0.7%
2. My family is taught new ways to talk and work with each other.	192	44.2%	177	40.8%	46	10.6%	5	1.2%	1	0.2%	13	3.0%
3. My family is taught new and better ways to deal with our child(ren)'s behavior.	187	43.1%	175	40.3%	44	10.1%	6	1.4%	3	0.7%	19	4.4%
4. My family and I know how to contact other agencies to get our needs met.	252	58.1%	155	35.7%	17	3.9%	5	1.2%	1	0.2%	4	0.9%
5. My family is taught how to manage money better.	135	31.2%	156	36.0%	92	21.3%	9	2.1%	2	0.5%	39	9.0%
6. My family is taught to manage our time better.	156	31.2%	176	40.8%	59	13.7%	4	0.9%	1	0.2%	35	8.1%
7. My family is better able to understand and deal with our feelings.	189	43.6%	186	42.9%	43	9.9%	4	0.9%	1	0.2%	11	2.5%
8. My family gets help getting mental health services we need.	178	41.7%	151	35.4%	28	6.6%	6	1.4%	1	0.2%	63	14.8%
9. My family gets help getting substance abuse treatment services we need.	113	26.5%	90	21.1%	36	8.4%	7	1.6%	2	0.5%	179	41.9%
10. My family gets help in finding a place to live.	120	28.0%	83	19.4%	59	13.8%	11	2.6%	5	1.2%	150	35.1%
11. My family is taught ways to keep our family safe.	247	56.8%	149	34.3%	13	3.0%	3	0.7%	1	0.2%	22	5.1%
12. My family gets help in learning how to keep our home clean and safe (e.g. household chores and repairs, etc.).	165	38.0%	129	29.7%	31	7.1%	9	2.1%	1	0.2%	99	22.8%
13. The appointments with my Project Worker are at convenient places for my family.	319	74.0%	99	23.0%	8	1.9%	1	0.2%	0	0.0%	4	0.9%
14. My Project Worker schedules our appointments at times that work best for me and my family.	344	79.5%	83	19.2%	2	0.5%	1	0.2%	1	0.2%	2	0.5%
15. My Project Worker asks for my family's opinions.	324	75.0%	98	22.7%	6	1.4%	1	0.2%	3	0.7%	0	0.0%
16. My Project Worker welcomes my family's and my comments, ideas, and opinions and includes them in the plans for service.	334	77.0%	91	21.0%	3	0.7%	2	0.5%	2	0.5%	2	0.5%
17. The Project has helped me and my family reach our goals.	270	62.4%	125	28.9%	27	6.2%	2	0.5%	2	0.5%	7	1.6%

Family Satisfaction Survey Results , Phase 1 (as of 11/30/15)												
Questions	**Strongly Agree**		**Agree**		**Neutral**		**Disagree**		**Strongly Disagree**		**Does Not Apply**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
1. My family is getting the services we need.	123	57.2%	74	34.4%	13	6.1%	2	0.9%	1	0.5%	2	0.9%
2. My family is taught new ways to talk and work with each other.	75	35.1%	91	42.5%	15.42	4.0%	2	1.0%	1	0.5%	10	4.7%
3. My family is taught new and better ways to deal with our child(ren)'s behavior.	80	37.2%	85	39.5%	29	13.5%	6	2.8%	2	0.9%	13	6.1%
4. My family and I know how to contact other agencies to get our needs met.	107	49.8%	89	41.4%	11	5.1%	5	2.3%	0	0.0%	3	1.4%
5. My family is taught how to manage money better.	49	22.9%	75	35.1%	55	25.7%	8	3.7%	2	0.9%	25	11.7%
6. My family is taught to manage our time better.	62	29.3%	89	42.0%	39	18.4%	3	1.4%	1	0.5%	18	8.5%
7. My family is better able to understand and deal with our feelings.	78	36.3%	97	45.1%	28	13.0%	3	1.4%	1	0.5%	8	3.7%
8. My family gets help getting mental health services we need.	80	37.6%	84	39.4%	12	5.6%	5	2.4%	0	0.0%	32	15.0%
9. My family gets help getting substance abuse treatment services we need.	46	21.7%	50	23.6%	23	10.9%	5	2.4%	1	0.5%	87	41.0%
10. My family gets help in finding a place to live.	50	23.7%	47	22.3%	33	15.6%	8	3.8%	4	1.9%	69	32.7%
11. My family is taught ways to keep our family safe.	106	49.3%	82	38.1%	8	3.7%	2	0.9%	1	0.5%	16	7.4%
12. My family gets help in learning how to keep our home clean and safe (e.g. household chores and repairs, etc.).	70	32.7%	65	30.4%	18	8.4%	7	3.3%	1	0.5%	53	24.8%
13. The appointments with my Project Worker are at convenient places for my family.	144	67.9%	58	27.4%	7	3.3%	1	0.5%	0	0.0%	2	0.9%
14. My Project Worker schedules our appointments at times that work best for me and my family.	162	75.7%	49	22.9%	1	0.5%	1	0.5%	1	0.5%	0	0.0%
15. My Project Worker asks for my family's opinions.	151	70.6%	56	26.2%	4	1.9%	0	0.0%	3	1.4%	0	0.0%
16. My Project Worker welcomes my family's and my comments, ideas, and opinions and includes them in the plans for service.	155	72.1%	55	25.6%	1	0.5%	2	0.9%	2	0.9%	0	0.0%
17. The Project has helped me and my family reach our goals.	110	51.2%	71	33.0%	25	11.6%	2	0.9%	2	0.9%	5	2.3%

Family Satisfaction Survey Results , Phase 2 (as of 11/30/15)												
Questions	**Strongly Agree**		**Agree**		**Neutral**		**Disagree**		**Strongly Disagree**		**Does Not Apply**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
1. My family is getting the services we need.	106	79.1%	22	16.4%	4	3.0%	1	0.8%	0	0.0%	1	0.8%
2. My family is taught new ways to talk and work with each other.	71	53.0%	52	38.8%	8	6.0%	1	0.8%	0	0.0%	2	1.5%
3. My family is taught new and better ways to deal with our child(ren)'s behavior.	64	48.1%	56	42.1%	7	5.3%	0	0.0%	1	0.8%	5	3.8%
4. My family and I know how to contact other agencies to get our needs met.	88	66.2%	42	31.6%	2	1.5%	0	0.0%	1	0.8%	0	0.0%
5. My family is taught how to manage money better.	53	39.9%	48	36.1%	20	15.0%	1	0.8%	0	0.0%	11	8.3%
6. My family is taught to manage our time better.	55	41.4%	52	39.1%	12	9.0%	1	0.8%	0	0.0%	13	9.8%
7. My family is better able to understand and deal with our feelings.	68	50.8%	53	39.6%	10	7.5%	1	0.8%	0	0.0%	2	1.5%
8. My family gets help getting mental health services we need.	60	46.5%	38	29.5%	11	8.5%	1	0.8%	1	0.8%	18	14.0%
9. My family gets help getting substance abuse treatment services we need.	44	24.0%	24	18.3%	7	5.3%	2	1.5%	0	0.0%	54	41.2%
10. My family gets help in finding a place to live.	40	30.3%	24	18.2%	16	12.1%	2	1.5%	1	0.8%	49	37.1%
11. My family is taught ways to keep our family safe.	88	65.7%	39	29.1%	1	0.8%	1	0.8%	0	0.0%	5	3.7%
12. My family gets help in learning how to keep our home clean and safe (e.g. household chores and repairs, etc.).	53	39.6%	40	29.9%	8	6.0%	1	0.8%	0	0.0%	32	23.9%
13. The appointments with my Project Worker are at convenient places for my family.	108	81.2%	24	18.1%	0	0.0%	0	0.0%	0	0.0%	1	0.8%
14. My Project Worker schedules our appointments at times that work best for me and my family.	112	84.2%	20	15.0%	1	0.8%	0	0.0%	0	0.0%	0	0.0%
15. My Project Worker asks for my family's opinions.	106	80.3%	23	17.4%	2	1.5%	1	0.8%	0	0.0%	0	0.0%
16. My Project Worker welcomes my family's and my comments, ideas, and opinions and includes them in the plans for service.	110	82.7%	21	15.8%	1	0.8%	0	0.0%	0	0.0%	1	0.8%
17. The Project has helped me and my family reach our goals.	92	69.2%	39	29.3%	1	0.8%	0	0.0%	0	0.0%	1	0.8%

Family Satisfaction Survey Results , Phase 3 (as of 11/30/15)												
Questions	**Strongly Agree**		**Agree**		**Neutral**		**Disagree**		**Strongly Disagree**		**Does Not Apply**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
1. My family is getting the services we need.	67	78.8%	16	18.8%	2	2.4%	0	0.0%	0	0.0%	0	0.0%
2. My family is taught new ways to talk and work with each other.	46	53.5%	34	39.5%	5	5.8%	0	0.0%	0	0.0%	1	1.2%
3. My family is taught new and better ways to deal with our child(ren)'s behavior.	43	50.0%	34	39.5%	8	9.3%	0	0.0%	0	0.0%	1	1.2%
4. My family and I know how to contact other agencies to get our needs met.	57	66.3%	24	27.9%	4	4.7%	0	0.0%	0	0.0%	1	1.2%
5. My family is taught how to manage money better.	33	38.4%	33	38.4%	17	19.8%	0	0.0%	0	0.0%	3	3.5%
6. My family is taught to manage our time better.	39	45.4%	35	40.7%	8	9.3%	0	0.0%	0	0.0%	4	4.7%
7. My family is better able to understand and deal with our feelings.	43	50.6%	36	42.4%	5	5.9%	0	0.0%	0	0.0%	1	1.2%
8. My family gets help getting mental health services we need.	38	44.7%	29	34.1%	5	5.9%	0	0.0%	0	0.0%	13	15.3%
9. My family gets help getting substance abuse treatment services we need.	23	27.4%	16	19.1%	6	7.1%	0	0.0%	1	1.2%	38	45.2%
10. My family gets help in finding a place to live.	30	35.3%	12	14.1%	10	11.8%	1	1.2%	0	0.0%	32	37.7%
11. My family is taught ways to keep our family safe.	53	61.6%	28	32.6%	4	4.7%	0	0.0%	0	0.0%	1	1.2%
12. My family gets help in learning how to keep our home clean and safe (e.g. household chores and repairs, etc.).	42	48.8%	24	27.9%	5	5.8%	1	1.2%	0	0.0%	14	16.3%
13. The appointments with my Project Worker are at convenient places for my family.	67	77.9%	17	19.8%	1	1.2%	0	0.0%	0	0.0%	1	1.2%
14. My Project Worker schedules our appointments at times that work best for me and my family.	70	81.4%	14	16.3%	0	0.0%	0	0.0%	0	0.0%	2	2.3%
15. My Project Worker asks for my family's opinions.	67	77.9%	19	22.1%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
16. My Project Worker welcomes my family's and my comments, ideas, and opinions and includes them in the plans for service.	69	80.2%	15	17.4%	1	1.2%	0	0.0%	0	0.0%	1	1.2%
17. The Project has helped me and my family reach our goals.	68	80.0%	15	17.7%	1	1.2%	0	0.0%	0	0.0%	1	1.2%

Kalamazoo Family Satisfaction Survey Results (as of 11/30/15)												
Questions	**Strongly Agree**		**Agree**		**Neutral**		**Disagree**		**Strongly Disagree**		**Does Not Apply**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
1. My family is getting the services we need.	133	68.2%	50	25.6%	11	5.6%	0	0.0%	1	0.5%	0	0.0%
2. My family is taught new ways to talk and work with each other.	81	41.8%	83	42.8%	24	12.4%	0	0.0%	0	0.0%	6	3.1%
3. My family is taught new and better ways to deal with our child(ren)'s behavior.	80	41.0%	76	39.0%	28	14.4%	2	1.0%	0	0.0%	9	4.6%
4. My family and I know how to contact other agencies to get our needs met.	123	63.1%	61	31.3%	7	3.6%	3	1.5%	1	0.5%	0	0.0%
5. My family is taught how to manage money better.	65	33.3%	68	34.9%	39	20.0%	2	1.0%	1	0.5%	20	10.3%
6. My family is taught to manage our time better.	68	35.1%	82	42.3%	28	14.4%	2	1.0%	0	0.0%	14	7.2%
7. My family is better able to understand and deal with our feelings.	81	41.8%	84	43.3%	26	13.4%	1	0.5%	0	0.0%	2	1.0%
8. My family gets help getting mental health services we need.	80	41.7%	57	29.7%	16	8.3%	3	1.6%	1	0.5%	35	18.2%
9. My family gets help getting substance abuse treatment services we need.	45	23.4%	41	21.4%	19	9.9%	2	1.0%	1	0.5%	84	43.8%
10. My family gets help in finding a place to live.	48	25.1%	38	19.9%	33	17.3%	3	1.6%	2	1.1%	67	35.1%
11. My family is taught ways to keep our family safe.	115	59.0%	60	30.8%	10	5.1%	2	1.0%	1	0.5%	7	3.6%
12. My family gets help in learning how to keep our home clean and safe (e.g. household chores and repairs, etc.).	65	33.3%	65	33.3%	12	6.2%	4	2.1%	1	0.5%	48	24.6%
13. The appointments with my Project Worker are at convenient places for my family.	156	80.0%	32	16.4%	6	3.1%	0	0.0%	0	0.0%	1	0.5%
14. My Project Worker schedules our appointments at times that work best for me and my family.	162	83.5%	30	15.5%	1	0.5%	0	0.0%	1	0.5%	0	0.0%
15. My Project Worker asks for my family's opinions.	149	76.8%	37	19.1%	5	2.6%	1	0.5%	2	1.0%	0	0.0%
16. My Project Worker welcomes my family's and my comments, ideas, and opinions and includes them in the plans for service.	158	81.0%	34	17.4%	2	1.0%	0	0.0%	1	0.5%	0	0.0%
17. The Project has helped me and my family reach our goals.	132	67.7%	47	24.1%	13	6.7%	1	0.5%	0	0.0%	2	1.0%

Macomb Family Satisfaction Survey Results (as of 11/30/15)												
Questions	**Strongly Agree**		**Agree**		**Neutral**		**Disagree**		**Strongly Disagree**		**Does Not Apply**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
1. My family is getting the services we need.	59	64.8%	25	27.5%	5	5.5%	2	2.2%	0	0.0%	0	0.0%
2. My family is taught new ways to talk and work with each other.	41	45.1%	34	37.4%	12	13.2%	3	3.3%	0	0.0%	1	1.1%
3. My family is taught new and better ways to deal with our child(ren)'s behavior.	36	39.6%	42	46.2%	6	6.6%	4	4.4%	1	1.1%	2	2.2%
4. My family and I know how to contact other agencies to get our needs met.	41	45.1%	45	49.5%	4	4.4%	1	1.1%	0	0.0%	0	0.0%
5. My family is taught how to manage money better.	25	27.8%	37	41.1%	22	24.4%	4	4.4%	0	0.0%	2	2.2%
6. My family is taught to manage our time better.	28	31.5%	43	48.3%	12	13.5%	2	2.3%	0	0.0%	4	4.5%
7. My family is better able to understand and deal with our feelings.	41	45.1%	38	41.8%	8	8.8%	3	3.3%	0	0.0%	1	1.1%
8. My family gets help getting mental health services we need.	37	41.1%	38	42.2%	6	6.7%	2	2.2%	0	0.0%	7	7.8%
9. My family gets help getting substance abuse treatment services we need.	31	35.2%	19	21.6%	5	5.7%	2	2.3%	1	1.1%	30	34.1%
10. My family gets help in finding a place to live.	24	26.7%	23	25.6%	15	16.7%	4	4.4%	2	2.2%	22	24.4%
11. My family is taught ways to keep our family safe.	49	53.9%	35	38.5%	1	1.1%	1	1.1%	0	0.0%	5	5.5%
12. My family gets help in learning how to keep our home clean and safe (e.g. household chores and repairs, etc.).	36	40.0%	27	30.0%	10	11.1%	2	2.2%	0	0.0%	15	16.7%
13. The appointments with my Project Worker are at convenient places for my family.	64	71.9%	21	23.6%	1	1.1%	1	1.1%	0	0.0%	2	2.3%
14. My Project Worker schedules our appointments at times that work best for me and my family.	70	77.8%	18	20.0%	1	1.1%	0	0.0%	0	0.0%	1	1.1%
15. My Project Worker asks for my family's opinions.	65	72.2%	24	26.7%	1	1.1%	0	0.0%	0	0.0%	0	0.0%
16. My Project Worker welcomes my family's and my comments, ideas, and opinions and includes them in the plans for service.	68	75.6%	20	22.2%	0	0.0%	2	2.2%	0	0.0%	0	0.0%
17. The Project has helped me and my family reach our goals.	53	58.9%	29	32.2%	6	6.7%	1	1.1%	1	1.1%	0	0.0%

Muskegon Family Satisfaction Survey Results (as of 11/30/15)												
Questions	**Strongly Agree**		**Agree**		**Neutral**		**Disagree**		**Strongly Disagree**		**Does Not Apply**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
1. My family is getting the services we need.	104	70.3%	37	25.0%	3	2.0%	0	0.0%	1	0.7%	3	2.0%
2. My family is taught new ways to talk and work with each other.	70	47.0%	60	40.3%	10	6.7%	2	1.3%	1	0.7%	6	4.0%
3. My family is taught new and better ways to deal with our child(ren)'s behavior.	71	48.0%	57	38.5%	10	6.8%	0	0.0%	2	1.4%	8	5.4%
4. My family and I know how to contact other agencies to get our needs met.	88	59.5%	49	33.1%	6	4.1%	1	0.7%	0	0.0%	4	2.7%
5. My family is taught how to manage money better.	45	30.4%	51	34.5%	31	21.0%	3	2.0%	1	0.7%	17	11.5%
6. My family is taught to manage our time better.	60	40.5%	51	34.5%	19	12.8%	0	0.0%	1	0.7%	17	11.5%
7. My family is better able to understand and deal with our feelings.	67	45.0%	64	43.0%	9	6.0%	0	0.0%	1	0.7%	8	5.4%
8. My family gets help getting mental health services we need.	61	42.1%	56	38.6%	6	4.1%	1	0.7%	0	0.0%	21	14.5%
9. My family gets help getting substance abuse treatment services we need.	37	25.2%	30	20.4%	12	8.2%	3	2.0%	0	0.0%	65	44.2%
10. My family gets help in finding a place to live.	48	32.7%	22	15.0%	11	7.5%	4	2.7%	1	0.7%	61	41.5%
11. My family is taught ways to keep our family safe.	83	55.7%	54	36.2%	2	1.3%	0	0.0%	0	0.0%	10	6.7%
12. My family gets help in learning how to keep our home clean and safe (e.g. household chores and repairs, etc.).	64	43.0%	37	24.8%	9	6.0%	3	2.0%	0	0.0%	36	24.2%
13. The appointments with my Project Worker are at convenient places for my family.	99	67.4%	46	31.3%	1	0.7%	0	0.0%	0	0.0%	1	0.7%
14. My Project Worker schedules our appointments at times that work best for me and my family.	112	75.2%	35	23.5%	0	0.0%	1	0.7%	0	0.0%	1	0.7%
15. My Project Worker asks for my family's opinions.	110	74.3%	37	25.0%	0	0.0%	0	0.0%	1	0.7%	0	0.0%
16. My Project Worker welcomes my family's and my comments, ideas, and opinions and includes them in the plans for service.	108	72.5%	37	24.8%	1	0.7%	0	0.0%	1	0.7%	2	1.3%
17. The Project has helped me and my family reach our goals.	85	57.4%	49	33.1%	8	5.4%	0	0.0%	1	0.7%	5	3.4%