Colorado Community Response

Colorado Department of Human Services

Final Evaluation Report
2014-2018

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Colorado Community Response Project Evaluation Report 2014-2018

1. Introduction

In 2013, Colorado Community Response (CCR) was selected as part of a group of cornerstone prevention programs formed or expanded under Governor Hickenlooper's master child welfare plan, "Keeping Kids Safe and Families Healthy 2.0". The goal of prevention programs, such as CCR, is to reduce the likelihood of entry or reentry into the child welfare system and prevent child maltreatment. The theory of change is that by engaging at-risk families in voluntary services the risk of child maltreatment will be mitigated by strengthening families' protective factors, building social capital, increasing financial stability and self-sufficiency, and improving family functioning and well-being. The CCR program provides comprehensive case management services with a focus on assisting families to access to concrete services, including one-time cash assistance (i.e. flex funds), by leveraging both formal systems and informal resources to meet their needs.

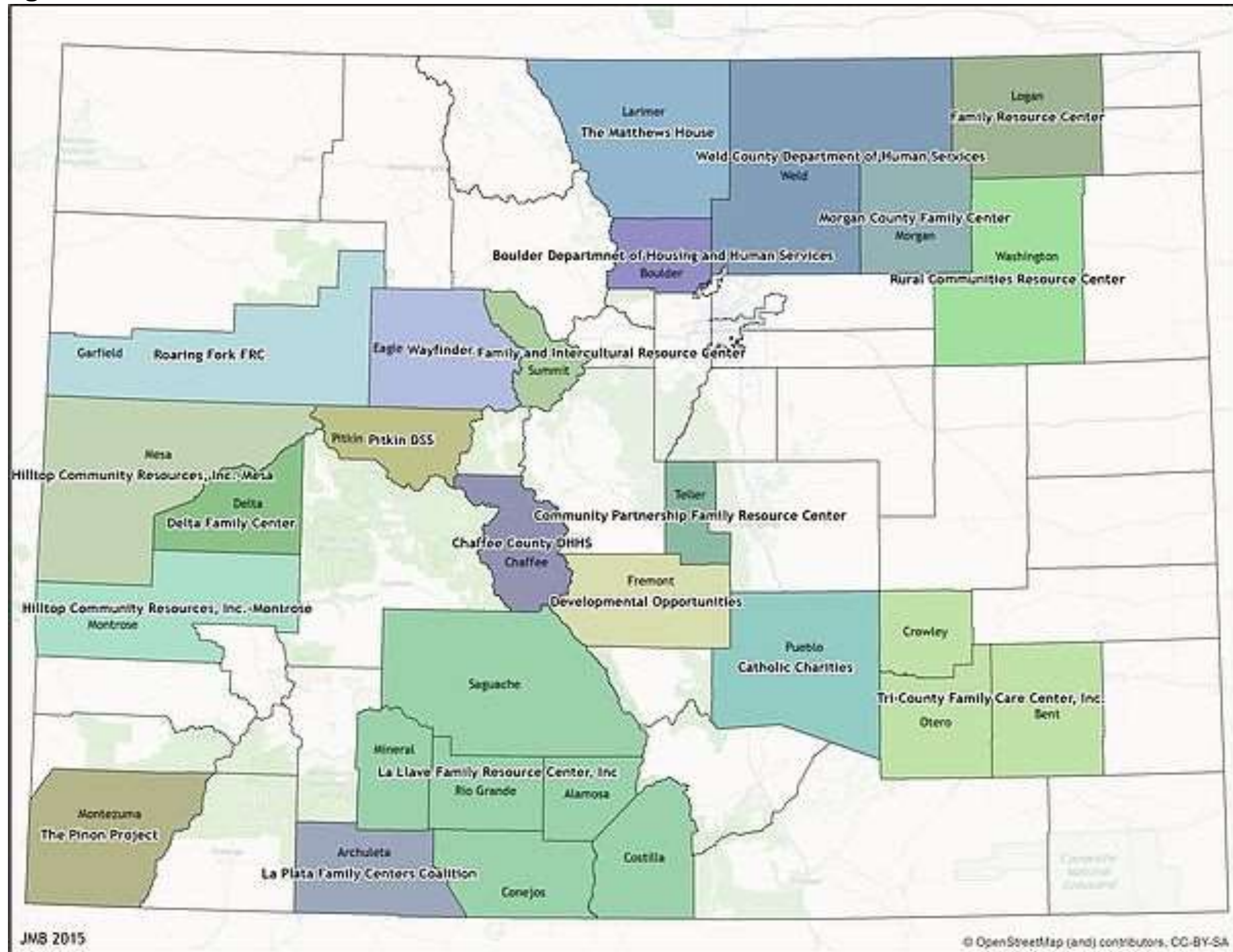
The Social Work Research Center (SWRC) in the School of Social Work at Colorado State University (CSU) and the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect (Kempe Center) were selected by CDHS as the evaluation team for CCR. After completing a four-month pre-pilot, the CCR pilot evaluation officially began in November 2014 with the first cohort of 12 sites. An additional cohort of nine sites was brought on in July 2015 and the evaluation was implemented in those sites at the time of program start-up.

1.1. Description of CCR

Colorado Community Response fills a gap in the child maltreatment prevention continuum by targeting voluntary services to families who are reported for child abuse or neglect to Child Protective Services (CPS), but are either: (1) screened out from receiving a response because the report does not rise to the level of imminent safety threat requiring CPS involvement; or (2) screened-in and assessed under either the high risk assessment (HRA) track or family assessment response (FAR) track, and have their cases closed without the provision of child welfare services.

Under the supervision of the Office of Early Childhood (OEC) in the Colorado Department of Human Services (CDHS), CCR was being delivered at 21 sites encompassing 28 counties in rural and suburban areas across Colorado (see Figure 1 on the following page).

Figure 1. ***CCR Sites***



On the following page, Table 1 displays the target population (screen out and/or closed assessment) and provider for each CCR site. CCR provider agencies included county departments of human services (DHS) (four sites), family resource centers (14 sites), other community-based non-profit agencies (two sites), and one local school district. All descriptive statistics are provided using data received from November 2014 through March 2018.

Table 1: ***Target Population and CCR Provider by Site***

Site (Cohort)	Target Population	CCR Provider
Archuleta (2)	Screened out/Closed after HRA	La Plata FRC*
Boulder (1)	Screened out (under 5 years old)	DHS
Chaffee (1)	Screened out/Closed after HRA	DHS
Delta (2)	Screened out/Closed after HRA	Delta County FRC*
Eagle (1)	Screened out/Closed after HRA	DHS
Fremont (2)	Screened out/Closed after FAR or HRA	Starpoint*
Garfield (2)	Screened out/Closed after FAR or HRA	FRC of Roaring Fork Schools*
Larimer (1)	Screened out/Closed after FAR or HRA	Matthew's House
Logan (1)	Screened out/Closed after HRA	Family Resource Center
Mesa (1)	Screened out/Closed after HRA	Hilltop*
Montezuma (2)	Screened out/Closed after HRA	Piñon Project*
Montrose (1)	Screened out/Closed after HRA	Hilltop*
Morgan (2)	Screened out/Closed after HRA	Morgan County FRC*
Otero-Bent-Crowley (1)	Screened out/Closed after HRA	Tri-County Family Care Center*
Pitkin (2)	Screened out/Closed after FAR or HRA	Aspen School District
Pueblo (2)	Screened out/Closed after HRA	Catholic Charities Diocese of Pueblo*
Saguache-Alamosa-Mineral-Rio Grande-Conejos-Costilla (1)	Screened out/Closed after HRA	La Llave FRC*
Summit (2)	Screened out/Closed after HRA	Family & Intercultural Resource Center*
Teller (1)	Screened out/Closed after HRA	Community Partnership FRC*
Washington (1)	Screened out/Closed after HRA (over 5 years old)	Rural Communities Resource Center*
Weld (1)	Screened out/Closed after HRA	DHS
*Community partner is a Family Resource Center (FRC) Association member.		

2. Evaluation Overview

This section details the design and methodology of the CCR process and outcome evaluation components, both of which are necessary to understand the impact of CCR in achieving its goals as well as how that impact was achieved. The evaluation team collected and analyzed data for the LEAD and LAG measures identified for the CCR program. LEAD measures assess something that leads to a goal and indicate whether the goal is likely to be achieved, while LAG measures evaluate a goal and indicate whether the goal has been achieved.[1] Based on survey data, LEAD measures include protective factors, family engagement, and provision of concrete services, which are the hypothesized drivers of CCR's long-term goal of child maltreatment prevention. Based on key administrative data indicators in Trails, the Colorado State Administered Child Welfare Information System (SACWIS), the LAG measure includes child welfare re-involvement, which ultimately represent the effectiveness of CCR as a child maltreatment prevention program.

2.1. Process Evaluation

The initial start-up of any new program, such as CCR, takes significant effort at both the local and state levels. The process evaluation is particularly important because of the: 1) experimental nature of the CCR program; and 2) decentralized nature of the child welfare system in Colorado, in which counties have considerable autonomy in the design and implementation of service delivery, which could contribute to variability in populations served and/or service provision across sites. Accordingly, a central goal of the process evaluation is to learn what may facilitate or impede the achievement of program goals. Specifically, the process evaluation seeks to:

1. Describe and assess how the CCR program was implemented in all sites in terms of program focus and priorities, client family characteristics, service models, provision of specific services, barriers to implementation, and variation in policies and procedures.
2. Document the specific operational mechanisms, such as protective factors enhancement, service provision, and family engagement (LEAD measures) that are intended to facilitate long-term program prevention effects (LAG measures).
3. Assess the response and receptivity of families to assistance efforts, with particular attention to their perceptions of engagement and CCR caseworkers' perceptions of their own abilities to voluntarily engage families.
4. Assess the type and frequency of services provided.

[1] McChesney, C., Covey, S., & Huling, J. (2012). *The 4 disciplines of execution: Achieving your wildly important goals*. London, Simon & Schuster.

5. Answer other questions policymakers have about the CCR program. This may involve the validation of underlying assumptions or expectations about certain approaches being more or less successful with certain types of families.

Process evaluation activities began in early 2014 for Cohort 1 sites with the goal of understanding CCR implementation as it was being installed. Interviews were held with key staff to learn about each site's community response practice, target population, referral processes, data collection and assessment procedures, service capacity, and technology access. This information was useful in both explaining implementation processes across the first CCR cohort and informing the proposed evaluation design. This same interview process was later conducted with the Cohort 2 sites prior to implementation in summer of 2015. In early 2016, an additional set of interviews was conducted with CCR workers and supervisors, to understand facilitators and barriers to outreach and engagement during early implementation followed by family interviews in 2017. In addition, staff were surveyed in February 2018, after practice was well established across all sites, to assess for facilitator and barriers to CCR outreach and service provision.

2.2. Outcome Evaluation

The outcome component of the CCR evaluation sought to determine whether CCR is effective in enhancing LEAD measures of family protective factors, economic security, and providing concrete services that meet family-stated needs. In addition, the CCR outcome evaluation sought to determine the impact on the LAG measure of preventing child maltreatment. The outcome evaluation design was a matched comparison group (MCG) utilizing a propensity score matching (PSM) technique. For the PSM, families who completed CCR and families who were not referred to the program were matched on case characteristics and demographics factors (e.g., screen out or assessment closure reason, number of children/adults in the home, ages of children in the home, number of prior referrals/assessments, and allegation type). Excel Referral Logs, housed on a secure SharePoint website hosted by the University of Colorado, were the mechanism by which referrals and enrollment were tracked.

It should be noted that the evaluation design is *correlational and not causal*. Therefore, we are only able to assess whether CCR is associated with better or worse outcomes, as opposed to assessing whether CCR causes better or worse outcomes. This is in part due to the notion that CCR recipients or matched comparison group families could have received any number of additional interventions and/or participated in other programs, which were unknown to the evaluation team. Although the matching process results in relatively similar distributions of matching variables between CCR completers and matched comparison group families, there may be differences in unmeasured variables that may affect outcomes (e.g., a family's baseline

social support level or motivation to engage with services). The following are a series of key questions that were central to the outcome evaluation design:

1. Are family needs correctly identified and are appropriate services provided based on those needs?
2. Are family protective factors maintained or enhanced through the CCR program?
3. Is child protection involvement of CCR participants reduced through the CCR program?
4. Are outcomes better for those families accepting CCR compared to those families who did not receive it?

3. Descriptive Statistics for CCR Referrals

The Cohort 1 evaluation was launched on November 1, 2014 with the provision of the first set of referrals to all sites. Although the CCR sites had potentially served families prior to this point, the data collection period officially began on this date. For all referrals received from that point forward, sites were asked to implement the full CCR data protocol, including all Caregiver and Worker Pre- and Posttest Surveys. In July 2015 a second cohort of nine sites was onboarded. This second cohort began participating in the evaluation and collecting data at the onset of CCR service provision. For all sites, the cut-off date was December 31, 2016 for CCR referral and March 31, 2017 for CCR case closure for child welfare re-involvement outcomes. These dates were selected to allow for a minimum of one year of follow-up, post case closure, to track outcomes through March 31, 2018 given that the average length of case was approximately 3 months. Survey analyses include all surveys received through March 31, 2017.

3.1. CCR Referrals and Acceptance Rates

Given the sheer volume of CPS cases that are either screened out or closed after assessment, and given that some of the CCR counties are mid-to-large sized, it is not surprising that the number of families eligible for CCR far exceeds the number of actual referrals. Furthermore, each CCR site was contracted to serve a specific number of families. As displayed in Table 2 on the following page, there were 18,081 families eligible to receive CCR (based on program and site-specific eligibility criteria), but only 8,522 of those families were actually referred to CCR for an overall referral rate of 47 percent. It should be noted that some families were eligible or referred to CCR more than once over the life of the project due to multiple screen outs and/or closed assessments.

Table 2 shows CCR referral, acceptance, and decline rates through March 2017, as well as the percentage of eligible cases referred in each site beginning in November 2014 for Cohort 1 and July 2015 for Cohort 2. For the 8,522 referrals from November 2014 through March 2017, the overall cross-site acceptance rate was 23 percent, although there was site-level variability

ranging from 10 percent to 48 percent. The overall acceptance rate is consistent with other voluntary prevention programs such as SafeCare Colorado and the Nurse-Family Partnership.

Table 2: ***Referrals and Acceptance/Decline Rates as of March 31, 2017***

Site (Cohort)	Eligible Referrals	Actual Referrals	% Eligible->Referred	Number Accepted	Acceptance Rate	Number Declined	Decline Rate
Archuleta (2)	182	170	93%	53	31%	112	66%
Boulder (1)	1,002	471	47%	124	26%	342	73%
Chaffee (1)	348	266	76%	59	22%	203	76%
Delta (2)	388	373	96%	88	24%	284	76%
Eagle (1)	661	311	47%	149	48%	151	49%
Fremont (2)	738	643	87%	67	10%	576	90%
Garfield (2)	254	217	85%	49	23%	166	76%
Larimer (1)	4,775	623	13%	267	43%	353	57%
Logan (1)	453	311	69%	41	13%	263	85%
Mesa (1)	3,584	1,263	35%	204	16%	1,059	84%
Montezuma (2)	333	300	90%	40	13%	260	87%
Montrose (1)	584	411	70%	69	17%	340	83%
Morgan (2)	566	524	93%	60	11%	461	88%
Otero (1)	592	211	36%	84	40%	123	58%
Pitkin (2)	127	119	94%	41	34%	77	65%
Pueblo (2)	1,206	454	38%	149	33%	297	65%
Saguache (1)	886	691	78%	108	16%	583	84%
Summit (2)	266	244	92%	64	26%	180	74%
Teller (1)	473	432	91%	97	22%	329	76%
Washington (1)	115	103	90%	32	31%	69	67%
Weld (1)	548	385	70%	81	21%	303	79%
Overall	**18,081**	**8,522**	**47%**	**1,926**	**23%**	**6,531**	**77%**

3.2. Decline Rates and Decline Reasons

As displayed above in Table 2, the cross-site decline/reason for not receiving services rate was 77 percent. It should be noted that there are passive and active declines. Active declines indicate situations where a caregiver tells a CCR worker that they are not interested in CCR services, which happened 28 percent of the time across sites. A passive decline indicates a situation where a caregiver was unable to be reached after multiple outreach attempts by a CCR worker or the caregiver was actually ineligible to participate in the program. The Referral Logs track up to six outreach attempts, although practice varies by site in terms of how many and the types of outreach attempts a worker may attempt before designating a referral "unable to reach." As shown in Table 3 on the following page, CCR workers made an average of about three outreach attempts per referral, across sites.

Table 3: ***Outreach Attempts and Decline Reasons by Site***

Site (Cohort)	Average number of outreach attempts	Number declined/not receiving services	Percent active declines	Percent unable to reach	Percent other reason not receiving services
Archuleta (2)	3.9	112	11%	48%	41%
Boulder (1)	3.5	342	36%	39%	25%
Chaffee (1)	3.6	203	32%	50%	18%
Delta (2)	3.7	284	32%	42%	25%
Eagle (1)	3.4	151	36%	44%	20%
Fremont (2)	4.2	576	28%	55%	18%
Garfield (2)	3.0	166	16%	55%	28%
Larimer (1)	2.5	353	34%	44%	22%
Logan (1)	2.7	263	16%	41%	43%
Mesa (1)	3.6	1059	39%	50%	12%
Montezuma (2)	2.4	260	15%	79%	6%
Montrose (1)	3.1	340	25%	55%	19%
Morgan (2)	3.3	461	21%	55%	24%
Otero (1)	3.5	123	25%	50%	24%
Pitkin (2)	4.6	77	29%	60%	12%
Pueblo (2)	2.6	297	14%	81%	4%
Saguache (1)	2.7	583	26%	53%	20%
Summit (2)	2.7	180	18%	44%	38%
Teller (1)	3.0	329	20%	27%	52%
Washington (1)	2.1	69	10%	43%	46%
Weld (1)	2.8	303	43%	36%	21%
Overall	**3.2**	**6,531**	**28%**	**50%**	**22%**

Sites ranged in their outreach efforts from four outreach attempts on the high end to two attempts per referral on the lower end. Through their efforts, staff were unable to reach half of all referrals to offer services. In part, this is due to the unreliable and oftentimes poor or outdated contact information available in Trails, particularly for screen outs where reporters may have limited information to provide to the hotline screeners. For the remaining 22 percent of referred families who did not ultimately receive CCR services, it was for other reasons including duplicate referrals and inappropriate referrals (such as those located out of service area, for whom a CPS case was already open, or for whom no child was in the home).

3.3. Length of Open Cases and Closure Reasons

On the following page, Table 4 shows how many cases closed in each site as of March 31, 2017 along with average length of open case and the percentage of closed cases due to various case

closure reasons. The CCR program design provides a guideline that families can be served for approximately 90-120 days. Overall, CCR cases are open for an average of 103 days and a median of 98 days which both fall within program guidelines.

Table 4: ***Case Closures as of March 31, 2017***

Site (Cohort)	Number closed cases	Average length of case (days)	Percent services completed	Percent family opt-out/ disengagement	Percent discontinued eligibility
Archuleta (2)	40	121	78%	13%	10%
Boulder (1)	96	78	76%	17%	7%
Chaffee (1)	48	105	56%	25%	19%
Delta (2)	77	90	64%	34%	3%
Eagle (1)	126	102	71%	24%	6%
Fremont (2)	55	118	60%	33%	7%
Garfield (2)	42	77	55%	29%	17%
Larimer (1)	215	93	68%	20%	12%
Logan (1)	32	97	41%	34%	0%
Mesa (1)	174	99	47%	43%	10%
Montezuma (2)	23	152	65%	30%	4%
Montrose (1)	59	95	41%	49%	10%
Morgan (2)	48	113	38%	56%	6%
Otero (1)	79	118	73%	14%	13%
Pitkin (2)	30	141	67%	17%	17%
Pueblo (2)	121	121	73%	16%	12%
Saguache (1)	90	99	66%	27%	8%
Summit (2)	56	97	84%	4%	13%
Teller (1)	86	118	87%	9%	3%
Washington (1)	30	109	43%	37%	20%
Weld (1)	60	100	47%	45%	8%
Overall	**1,587**	**103**	**64%**	**26%**	**10%**

On average, 17 out of 21 sites closed their cases within five days of program guidelines, while the remainder consistently fell above or below those timeframes with the majority of cases. On the low end, cases remained open for an average of 77 days, while on the high end cases remain open for an average of 152 days. **Overall, 64 percent of cases closed due to successful completion of CCR services as determined by the CCR worker.** Other reasons for case closure included families opting out of continued services, family disengagement or discontinued eligibility (e.g., family moved out of service area or a child welfare case was opened during the CCR service period).

4. Caregiver and Worker Survey Findings

After reviewing the Request for Applications (RFA) and the CCR Program Manual draft provided by OEC, the evaluation team proposed four evaluation domains for the CCR survey component of the evaluation: (1) family engagement and goal setting, (2) protective factors, (3) economic/financial status, and (4) service provision. The rationale for the survey component was to gather data which were beyond the scope of what could be gathered from administrative data.

To collect data for each of these domains, the evaluation team conducted an instrument review to identify relevant, feasible, and psychometrically sound surveys and tools. Considerable attention was devoted to minimizing burden and survey fatigue for both families and CCR workers. Based on staff requests and piloting of survey procedures, Caregiver Survey administration was available via hardcopy and Qualtrics website and mobile app. As displayed in Table 5, some instruments were completed by CCR workers or caregivers directly, while others were administered by the CCR worker by engaging the caregiver in a dialogue and recording the caregiver's responses.

Table 5: ***CCR Instrumentation***

Instrument	Domain	Worker/Caregiver	Pre/Post
Protective Factors Survey (FRIENDS National Resource Center, 2010)	Protective factors	Caregiver	Pre/Post
Colorado Family Support Assessment 2.0 (Colorado Family Resource Center Association, rev. 2014)	Engagement and goal setting; Family self-reliance	CCR Worker*	Pre/Post
Income-Benefits Inventory	Economic/financial status	CCR Worker*	Pre/Post
Caregiver Engagement Scale (Yatchmenoff, 2005)	Engagement and goal setting	Caregiver	Post
Engagement (Gladstone, 2012)	Engagement and goal setting	CCR Worker	Post
Service Inventory	Service provision	CCR Worker	Post
*CCR worker completes via interview with the caregiver and records caregiver responses.			

Some instruments are also validated to be conducted as pre- and posttests, which allowed the evaluation team to assess change over time in the corresponding domains. The pre- and posttest surveys were developed by consolidating their respective sub-instruments in order to administer the minimal number of surveys to workers and caregivers. In addition, the Caregiver

Pre- and Posttest Surveys were available in Spanish. All survey data were analyzed at the cross-site level.

Table 6 shows the number of surveys received as well as response rates for all four CCR surveys. For pretest surveys, the response rate denominator was the number of intakes while the case closure date was the denominator for posttest survey response rates. While the cross-site response rates averaged around 86 percent for pretest surveys and between 45-55 percent for posttest surveys, some sites had substantially lower response rates for individual surveys.

Table 6: ***Survey Response Rates as of March 31, 2017***[2]

	Caregiver Pretest		Worker Pretest		Caregiver Posttest		Worker Posttest	
Site (Cohort)	Surveys Received	Response Rate	Surveys Received	Response Rate	Surveys Received	Response Rate	Surveys Received	Response Rate
Archuleta (2)	52	96%	48	89%	29	71%	28	68%
Boulder (1)	107	85%	107	85%	45	46%	56	57%
Chaffee (1)	61	91%	41	61%	28	49%	29	51%
Delta (2)	89	89%	93	93%	46	52%	76	86%
Eagle (1)	128	83%	133	86%	75	57%	75	57%
Fremont (2)	67	99%	69	101%	31	56%	32	58%
Garfield (2)	47	90%	50	96%	28	62%	31	69%
Larimer (1)	226	82%	229	83%	97	43%	102	46%
Logan (1)	24	52%	23	50%	2	6%	3	8%
Mesa (1)	169	76%	170	77%	29	16%	34	18%
Montezuma (2)	38	93%	33	80%	0	0%	4	17%
Montrose (1)	68	80%	73	86%	17	24%	35	49%
Morgan (2)	63	95%	60	91%	21	41%	21	41%
Otero (1)	82	95%	77	90%	49	60%	47	58%
Pitkin (2)	36	92%	37	95%	17	53%	19	59%
Pueblo (2)	150	94%	152	96%	86	65%	87	66%
Saguache (1)	121	95%	121	95%	58	52%	80	71%
Summit (2)	61	94%	61	94%	42	74%	46	81%
Teller (1)	99	97%	100	98%	75	83%	76	84%
Washington (1)	22	51%	23	53%	6	15%	7	18%
Weld (1)	69	87%	62	78%	24	40%	23	38%
Overall	**1,779**	**86%**	**1,762**	**86%**	**805**	**47%**	**911**	**53%**

[2] These are duplicated counts at the household level meaning if a family self-referred to the CCR program and completed an additional set of surveys both are included in these counts. However, for the purposes of analysis only the first set of surveys received per household were used, resulting in unduplicated counts.

4.1. Caregiver Pretest

The Caregiver Pretest survey was administered at the time of intake to all willing caregivers (see Appendix A). A total of 1,752 unduplicated Caregiver Pretest surveys were completed as of March 31, 2017. Data on the following demographic characteristics of caregivers completing the survey were collected: gender, age group, race/ethnicity, marital status, housing situation, household income, education level, and economic assistance being received. Of the primary caregivers who responded, 83 percent are female and 17 percent are male. For race/ethnicity, 58 percent of primary caregivers identified as White, 32 percent as Hispanic/Latino, six percent as Native American or Alaskan Native, three percent as Black/African American, and two percent as other. For marital status, 40 percent of primary caregivers reported being in a relationship and 60 percent reported being unpartnered. As displayed in Figure 2, 32 percent of primary caregivers were under 30 years of age, 41 percent were between 30 and 39 years old and 27 percent were 40 years and older.

Figure 2: ***Age of Primary Caregiver***

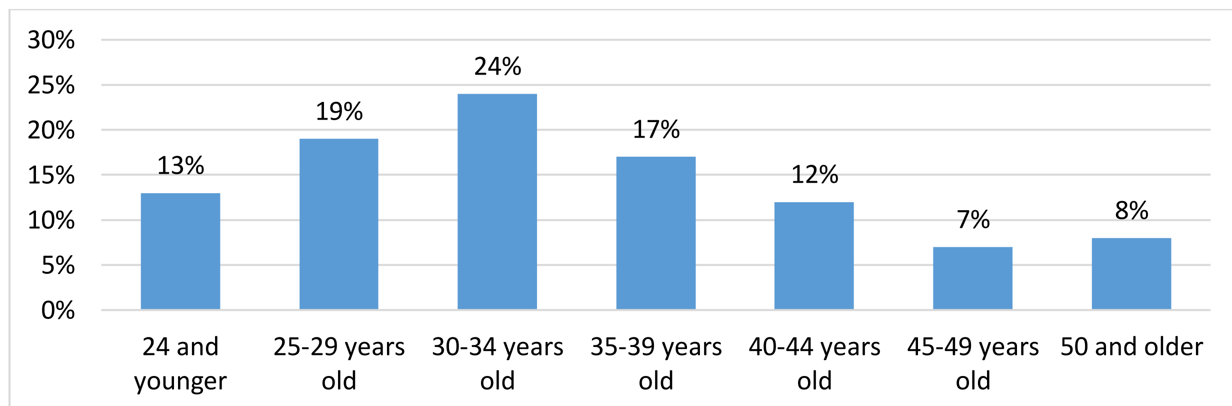
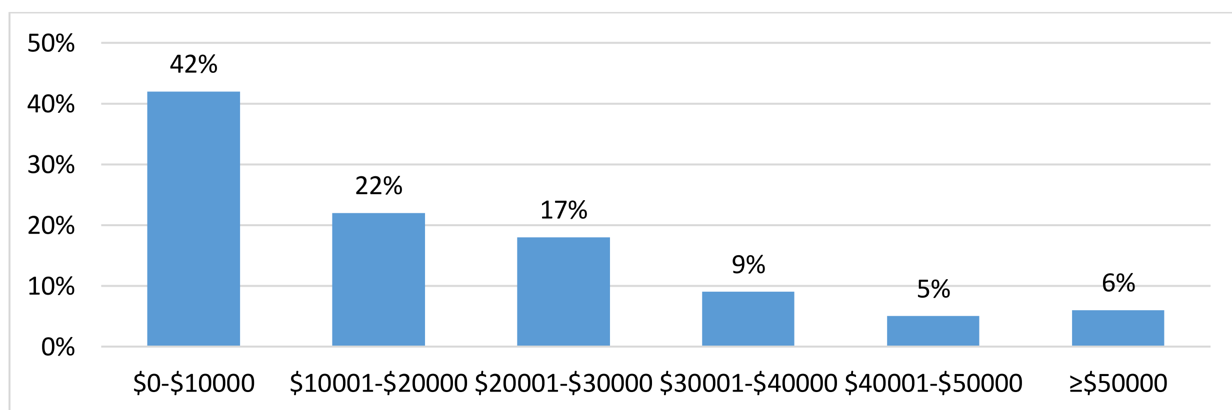


Figure 3 shows that about 80 percent of caregivers reported a household income of $30,000 or less per year, with 42 percent making less than $10,000.

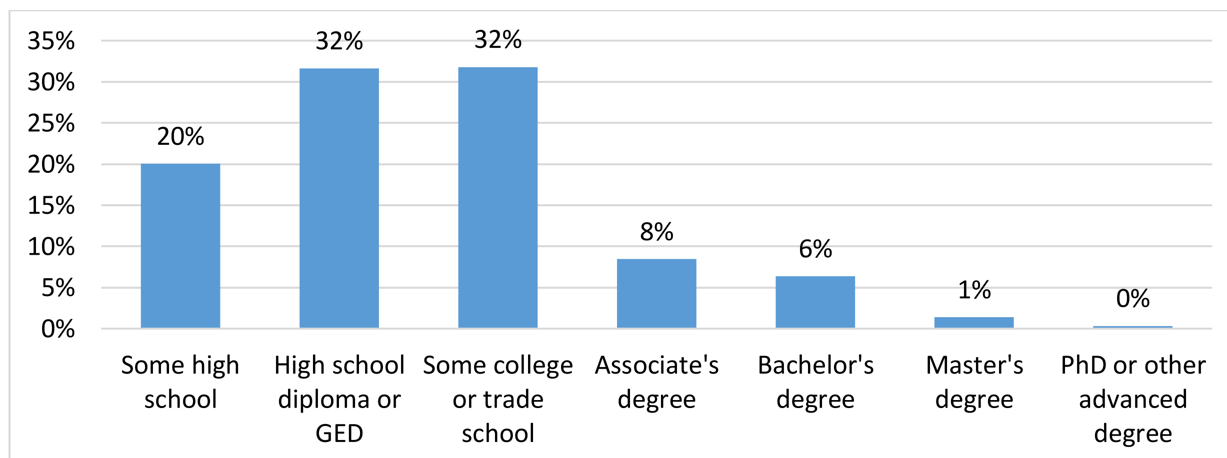
Figure 3: ***Household Income***



For housing, 58 percent of primary caregivers rent a home, 19 percent own a home, 19 percent were living in temporary housing arrangements or shared housing, and four percent were homeless. For public assistance, 73 percent of primary caregivers reported receiving Medicaid, followed by 59 percent receiving SNAP, 15 percent receiving TANF, 13 percent receiving an Earned Income Tax Credit, seven percent receiving Head Start or Early Head Start, while 17 percent reported not receiving any type of the aforementioned categories of economic assistance.

As displayed in Figure 4, 52 percent of primary caregivers reported having a high school diploma, GED, or some high school education, 32 percent reported having some college/trade school education, and 15 percent reported having an associate's degree, a bachelor's degree, or a graduate degree. All of these factors indicate that CCR is indeed meeting its target population of economically vulnerable families.

Figure 4: ***Caregiver Education Level***



The Caregiver Pretest also included the Protective Factors Survey (PFS), a 20-item survey which has undergone national field testing for reliability and validity for use with families engaged in child maltreatment prevention programs. The stated purpose of the PFS is to provide agencies with feedback regarding a snapshot of the families they serve, changes in protective factors, and areas where workers can focus on increasing individual family protective factors. Protective factors are a key area on interest for this evaluation due to research indicating that the presence of protective factors, conceptualized in contrast to risk factors, has been linked to lower incidence of child abuse and neglect.

The PFS is designed to be administered as both a pre- and posttest and is divided into five domains: Resiliency, Social Support, Concrete Support, Nurturing and Attachment, and Child

Development/Knowledge of Parenting.[3] Each item is scored on a 7-point scale, with 7 being the most positive response (i.e., strongly agree or all of the time), 4 being a neutral response, and 1 being the most negative response (i.e., strongly disagree or never).[4] The PFS User Manual recommends calculating the mean score of the items composing a domain to generate the domain's score, although cutoffs for high or low scores are not provided. [5]

Table 7 lists caregiver-completed PFS mean domain or item scores on the pretest in descending order. Pretest domain scores ranged from a low of 4.8 on a 7-point scale in Concrete Support to a high of 6.2 in Nurturing and Attachment. Standalone item scores ranged from a low of 4.5 for almost always knowing what to do as a parent to a high of 6.2 for praising the child when behaving well. Therefore, most caregivers indicated that the protective factor domain of Nurturing and Attachment, in addition to the Child Development/Knowledge of Parenting items of 'Maintaining Control while Disciplining Child' and 'Praising Child for Good Behavior' were present at the time of pretest survey completion (i.e., intake).

Table 7: ***Protective Factors Survey Pretest Mean Scores***

Domain or Item*	Number of Respondents	Mean Score (Standard Deviation)
Praises child when behaving well*	1,731	6.2 (1.0)
Nurturing and Attachment	1,731	6.2 (0.9)
Maintain control while disciplining child*	1,724	6.1 (1.2)
Know how to help child learn*	1,726	5.6 (1.5)
Social Support	1,730	5.3 (1.6)
Resiliency	1,726	5.3 (1.2)
Child misbehaves to upset me*	1,722	4.9 (2.0)
Concrete Support	1,724	4.8 (1.6)
Know What to do as a parent*	1,727	4.5 (1.9)
*Indicates a standalone item on the Protective Factors Survey		

[3] More information can be found in The Protective Factors Survey User Manual, which can be accessed at http://www.state.ia.us/earlychildhood/files/perform_measures/pfs_manual.pdf. Scores for six items were reverse-coded such that a higher score always indicates a more desirable response. Family functioning/resiliency, social support, concrete support, and nurturing and attachment are average scores of multiple survey items addressing the same domain. The five items constituting the child development/knowledge of parenting domain are reported separately as recommended by The PFS User Manual due to the nature of these items.

[4] However, for some items a lower score indicates a higher level of support or knowledge. These items were reverse-scored prior to calculating the mean of the domain with which the item was associated.

[5] Mean scores for four domains (Resiliency, Social Support, Concrete Support, and Nurturing and Attachment) are presented here since the developers do not recommend computing an average for the Child Development/Knowledge of the Parenting domain. The five individual item scores that comprise that domain are presented as well.

4.2. Worker Pretest

The Worker Pretest (see Appendix B) includes the Colorado Family Support Assessment 2.0 (CFSA2)[6], which is a family-level index of self-reliance, and the Income and Benefits Inventory, which describes whether a family is receiving a variety of different government services. The CFSA2 is administered to families by CCR workers using a conversation style format to identify family assets and areas for growth across 14 domains measuring family self-reliance. Each domain is scored from 1 to 5, where higher scores indicate areas of family strength and lower scores indicating family need. In addition, each domain includes a 'Prevention Line', with scores below the line (either a 1 or 2 for each domain) indicating the greatest potential need for support. The CFSA2 also allows the family to select areas that they are most ready to change, and to further assess their readiness to change in each area, which can be used in goal-setting with families and may or may not be the same domains falling below the prevention line.[7]

The number of respondents prioritizing a given area are presented in the last column of Table 8 on the following page, and domains are listed in descending order of proportion below prevention line.[8] A significant majority of CCR participants were below the prevention line for both the income domain and the cash savings domain, indicating that most families were below 200% of the federal poverty line adjusted for family size and that most families had no cash savings. Other domains ranged from a low of seven percent below the prevention line (substance abuse) to around 50 percent below the prevention line (debt management, adult education, and employment). Again, these factors indicate that CCR was indeed reaching its target population of economically vulnerable families.

Housing was the area that the highest percentage of families (44 percent) indicated that they would most like to change, while substance abuse and health coverage were the least commonly selected domains regarding desire to change (8 percent and 16 percent, respectively).

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[6] More information can be found in the Colorado Family Support Assessment 2.0 Administration Guidelines, which can be accessed at http://www.cofamilycentersportal.org/ETO/Quarterly%20Presentations%20and%20Documents/Regional%20Meeting%202015/Colorado%20Family%20Support%20Assessment_2.0_April-2015_administrationguidelines%20Regional.pdf

[7] The instrument also includes change readiness ratings in prioritized areas on a 1-10 scale and text fields to describe family goals. Use and interpretation of this section varied across sites precluding evaluation of these variables.

[8] Some areas listed in the change readiness section, including child development, parenting skills, and social support, are not included in the initial list of baseline domain assessment. As such, these areas do not have scores to report and are therefore missing data for all columns outside of change readiness in Table 8.

Table 8: ***CFSA2 Pretest Responses***

Domain	Number of Respondents*	Mean Score	Percent Below Prevention Line	Number (%) Prioritizing this Area
Income	1,494	1.6	90.0%	667 (37.8%)
Cash Savings	1,647	1.7	83.6%	527 (29.9%)
Debt Management	1,626	2.6	52.5%	467 (26.5%)
Adult Education	1,729	2.9	50.3%	467 (26.5%)
Employment	1,672	2.9	47.3%	675 (38.3%)
Housing	1,711	2.9	41.0%	791 (44.8%)
Child Care	1,102	3.5	29.8%	396 (22.4%)
Child Education	1,441	3.5	27.0%	430 (24.4%)
Mental Health	1,721	3.6	24.6%	654 (37.1%)
Physical Health	1,731	3.9	21.4%	359 (20.4%)
Food Security	1,757	3.2	20.3%	472 (26.8%)
Health Coverage	1,742	3.1	16.1%	277 (15.7%)
Transportation	1,747	4.1	14.4%	473 (26.8%)
Substance Abuse	1,693	4.6	7.3%	145 (8.2%)
Child Development	-	-	-	439 (24.9%)
Parenting Skills	-	-	-	649 (36.8%)
Social Support	-	-	-	365 (20.7%)

*Excludes those with missing values, or those selecting 'not enough information at this time' or 'not applicable [for the family]'

From the Income and Benefits Inventory, the proportion of families reportedly receiving each service at the time of the Worker Pretest are displayed in Table 9 on the following page in descending order of proportion receiving each service. [9] A majority of caregivers reported receiving health insurance assistance (78 percent), free or reduced lunch at school (63 percent), SNAP/Colorado Food Assistance Program (58 percent), and work earnings (51 percent).

[9] In addition to describing whether or not each service is received, the instrument also asks for the monthly monetary amount of assistance for services the family does receive, and if the family does not receive a service, whether or not they are eligible. These questions proved challenging for caregivers to answer consistently across sites, precluding evaluation of these variables.

Table 9: ***Income and Benefits Inventory – Worker Pretest***

Income Source or Benefit	Number of Respondents	Percent Receiving
Health insurance	1,702	78.3%
Free or reduced price school meals	1,677	62.7%
Colorado Food Assistance Program (SNAP)	1,711	58.3%
Work earnings within last 30 days	1,675	51.2%
Earned Income Tax Credit (or state EIC)	1,675	30.0%
Food pantry/community meal use	1,714	26.6%
Women, Infants, and Children (WIC)	1,709	24.4%
Child support (court-ordered)	1,710	23.7%
Partner/spouse work earnings within last 30 days	1,599	19.4%
Disability benefits (SSI; SSDI)	1,717	16.5%
Utility assistance (Energy Outreach CO, LEAP)	1,707	15.2%
Colorado Works/TANF	1,692	15.1%
Colorado Preschool Project or Head Start	1,661	13.8%
Public housing voucher or subsidy (Section 8, etc.)	1,718	11.2%
Colorado Child Care Assistance Program	1,692	8.7%
Rental assistance	1,707	5.5%
Other household adult's work earnings within last 30 days	1,548	4.1%
SafeLink telephone	1,714	3.9%
Emergency assistance	1,711	3.5%
Social Security or other retirement/pension	1,708	3.5%
Unemployment insurance	1,703	1.6%
Foster child payments/adoption subsidy	1,717	0.6%
Worker's Compensation	1,711	0.6%
Kinship care payments	1,714	0.5%

4.3. Caregiver Posttest

The Caregiver Posttest (see Appendix C) was confidentially administered at the time of CCR case closure and contained three sections of questions: the Protective Factors Survey, a set of questions on feelings towards CCR and engagement with the program, and a set of questions around services received as a result of participation in CCR. The PFS was the only instrument in this survey which was administered as a pre-post measure so that change over time could be measured. Results from the posttest are presented alongside pretest results in Section 4.6. Caregiver posttests were primarily received from families who successfully completed CCR (e.g., they did not disengage/drop out from the program).

At posttest, caregivers were asked to report how they felt after the first and last time that they had contact with CCR. These responses are provided in Table 10 in descending order of the frequency of endorsements of each emotion at time of last contact, where p-values of less than .05 (in bold) indicate a statistically significant difference in caregiver responses for that feeling between the first and last contact. Caregivers reported a statistically significant increase in positive emotions from the first to last contact with CCR, including feeling respected (46 percent after first contact vs. 58 percent after last contact), thankful (72 percent vs. 86 percent), encouraged (49 percent vs. 62 percent), hopeful (56 percent vs. 64 percent), and comforted (45 percent vs. 53 percent). Similarly, statistically significant decreases in negative emotions, including feeling worried (21 percent after first contact vs. 5 percent after last contact), stressed (19 percent vs. 3 percent), and afraid (9 percent vs. 1.5 percent), were observed when comparing first and last contact with CCR.

Table 10: ***Caregiver Feelings after First and Last Contact with CCR***

Feeling	Number (%) Endorsed after First Contact	Number (%) Endorsed after Last Contact	First-Last Contact Percent Change p-value
Thankful	564 (72.0%)	668 (86.2%)	**<0.0001**
Hopeful	440 (56.2%)	495 (63.9%)	**0.001**
Encouraged	384 (49.0%)	478 (61.7%)	**<0.0001**
Respected	356 (45.5%)	447 (57.7%)	**<0.0001**
Comforted	355 (45.3%)	414 (53.4%)	**<0.0001**
Relieved	434 (55.4%)	410 (52.9%)	0.57
Worried	167 (21.3%)	37 (4.8%)	**<0.0001**
Stressed	152 (19.4%)	24 (3.1%)	**<0.0001**
Afraid	71 (9.1%)	11 (1.4%)	**<0.0001**
Discouraged	27 (3.5%)	11 (1.4%)	0.18
Angry	26 (3.3%)	7 (0.9%)	0.23
Disrespected	12 (1.5%)	6 (0.8%)	0.22

The Caregiver Posttest Survey also asks the caregiver a series of engagement questions about their overall feelings having worked with CCR and their CCR worker.[10] On the following page, Table 11 presents the proportion of caregivers who responded with either an ‘agree’ or ‘strongly agree’ for each item, in descending order of the percent of agreement. For 13 of 18 items, more than 90 percent of caregivers endorsed positive feelings regarding their CCR participation. The item with the highest percentage of agreement among caregivers was ‘my

[10] Response options for each item ranged from 1 (strongly disagree) to 5 (strongly agree). For all items, higher levels of agreement indicate more positive feelings toward CCR participation; there are no reverse-scored questions.

CCR worker and I respected each other' (99 percent), while the lowest percentage was the feeling of 'needing some help to make sure [my] kids have what they need' (76 percent).

Table 11: ***Caregiver Feelings about Working with CCR at Time of Posttest***

Item	Percent who Agree or Strongly Agree
My CCR worker and I respected each other.	99.0%
Overall, I am satisfied with how my family was treated with CCR.	98.2%
I would call CCR if my family needed help in the future.	98.0%
I could talk to my CCR worker about what's important to me.	97.8%
My CCR worker and I agreed about what's best for my child(ren).	97.4%
CCR listened to what my family had to say.	97.4%
Overall, I am satisfied with the help my family received through CCR.	96.9%
CCR understood my family's needs.	96.7%
CCR recognized the things that my family does well.	95.0%
CCR provided services to meet my family's needs.	94.5%
CCR helped me take care of problems in our lives.	92.7%
What CCR wanted me to do was the same as what I wanted.	92.7%
CCR considered my family's culture when working with us.	90.7%
CCR helped my family get stronger.	89.7%
Things got better for my child(ren) because CCR was involved.	85.7%
I am a better parent or caregiver because of my experience with CCR.	83.8%
I am better able to provide necessities because of my experience with CCR.	82.4%
My children are safer because of our experience with CCR.	79.7%
I needed some help to make sure my kids have what they need.	75.8%

On the following page, Table 12 describes caregiver-reported assistance received due to their involvement with CCR, listed in descending order of the percentage of caregivers receiving help from each group/agency.[11] Caregivers most frequently reported receiving assistance from mental health providers (43 percent), schools[12] (36 percent), or emergency food providers (32 percent) due to their involvement with CCR. CCR involvement also resulted in assistance from more informal social support networks, including neighborhood organizations (16 percent),

[11] Caregivers were instructed to skip this section if they did not receive help from any of the listed groups/agencies; the proportions reported in Table 12 assume any caregiver who selected none of these services received no services from that group/agency (as opposed to that information being missing or unavailable).

[12] Three CCR sites' community providers are school districts which may account for the high percentage of help received from schools.

neighbors/friends (13 percent), church or religious organizations (11 percent), and extended family (8 percent).

Table 12: ***Assistance Received due to CCR Involvement***

Group/Agency Providing Help	Percent of Caregivers Receiving Help
Mental Health Provider	43.4%
School	36.3%
Emergency Food Provider	32.0%
Support Group	23.4%
Job Service/Employment Security	21.1%
Health Care Provider	18.6%
Legal Services Provider	18.5%
Child Care/Head Start	18.0%
Neighborhood Organization	15.7%
Employment and Training Agency	13.5%
Youth Organization	13.0%
Neighbors/Friends	12.9%
Recreational Facility	11.2%
Church or Religious Organization	10.7%
Extended Family	8.1%
Domestic Violence Agency	7.0%
Alcohol/Drug Rehab Agency	4.3%
Other Group/Agency	3.3%

Finally, caregivers were asked to rate their overall satisfaction with their involvement in the CCR program. **Almost all caregivers who completed a posttest reported being better off as a result of participation in CCR (89 percent) and receiving all the help they needed (91 percent).** In addition, among caregivers who received services from agencies due to involvement with CCR, most rated the services they received as being very effective in helping with their family's problems (74 percent). A small number of caregivers (nine percent) reported needing help for housing, financial/cash assistance, and mental/health counseling that they did not receive.

4.4. Worker Posttest

The Worker Posttest (see Appendix D) included both Engagement and Service Inventory scales. In addition, the Worker Posttest included the CFSA2 and the Income-Benefits Inventory so that change over time could be measured. Results for these two instruments from the posttest are presented alongside pretest results in Section 4.6.

Results of the engagement scale are presented in Table 13 in descending order by the percent agreement.[13] The majority of workers responded positively to perceived engagement for each item, ranging from a high of 97 percent ("I think primary caregiver would say that s/he and I respect one another") to a low of 74 percent ("I think primary caregiver would say that working with my agency has given him/her more hope about how his/her life is going to go in the future").

Table 13: ***Worker Perception of Parent Engagement***

Item	Percent who Agree or Strongly Agree
I think primary caregiver would say that s/he and I respect one another.	96.9%
I think primary caregiver would say that my agency has helped her/his family take care of some of their problems.	88.2%
I think primary caregiver realized that s/he needed some help to make sure his/her kids have what they need.	84.7%
I think primary caregiver would say that s/he and I agreed about what is best for her/his child.	82.2%
I think primary caregiver believed s/he would get the help s/he really needed from my agency.	82.1%
I think primary caregiver really wanted to make use of the services that my agency provided to her/him.	80.8%
I think primary caregiver would say that what my agency wanted her/him to do is the same as what s/he wanted.	80.7%
I think primary caregiver would say that my agency helped her/his family get stronger.	75.5%
I think primary caregiver would say that things will get better for his/her children because my agency is involved.	74.4%
I think primary caregiver would say that working with my agency has given him/her more hope about how his/her life is going to go in the future.	73.6%
I think primary caregiver found it difficult to work with me.	2.1%

On the following page, Table 14 provides a description of the Service Inventory completed during the Worker Posttest in descending order of percentage of cases in which the service was provided. The inventory is structured as a matrix where the worker is instructed to select all circumstances that apply to the family for each service need. Workers reported that 57 percent of families received some form of material needs (e.g., housing, food/clothing, income, employment, etc.) due to their participation in CCR. Received by nearly a quarter of families

[13] Agreement denotes positive perceived engagement with the exception of the item 'I think primary caregiver found it difficult to work with me'.

each, parenting skills/discipline and social support were the second and third most frequently provided services.

Table 14: ***Worker Posttest Service Inventory***[14]

Service	Not needed by family (%)	Needed and already in place at start of CCR (%)	Service needed and not in place at start of CCR (%)	Info/ referral provided (%)	Service provided (%)
Material needs	7.3%	4.5%	32.1%	35.9%	57.3%
Parenting skills/discipline	28.4%	5.8%	26.8%	39.0%	23.3%
Social supports	34.9%	11.7%	23.6%	31.7%	21.6%
Child mental health	41.4%	11.1%	14.6%	28.5%	12.0%
Parent mental health	39.4%	10.4%	17.6%	31.7%	10.5%
Child education	48.1%	10.3%	13.4%	21.6%	9.6%
Child developmental/ cognitive disability	61.2%	7.7%	8.9%	13.9%	8.8%
Parent developmental/ cognitive disability	67.1%	3.5%	10.0%	12.2%	6.0%
Medical care	57.4%	12.9%	7.6%	12.5%	5.6%
Child physical disability or chronic health condition	73.3%	5.2%	3.5%	6.2%	2.6%
Substance abuse	72.6%	5.3%	4.8%	5.9%	2.3%
Domestic violence	66.6%	7.7%	4.4%	8.5%	2.3%
Parent physical disability or chronic health condition	68.2%	8.6%	5.1%	7.6%	2.0%

4.5. Worker and Caregiver Perception of Engagement Comparison

Many of the items related to engagement with the CCR program on the Worker and Caregiver Posttests were nearly identical, allowing comparisons between perceptions of workers and caregivers. A total of 718 pairs of workers and caregivers both completed the posttest survey allowing for comparisons of engagement. These results are presented in Table 15, on the following page, in descending order of percentage of caregivers who agreed.

[14] Workers were able to select multiple response options for each service provided. In some cases, workers did not select any response options for a given service. The proportion presented represents the number selecting each response over the total number of Worker Posttest surveys received (*N* = 917).

Table 15: ***Comparison of Perceptions of Engagement between Workers and Caregivers (N = 718)***

Engagement Item[15]	Workers Percent Agree	Caregivers Percent Agree	p-value
My CCR worker and I respected each other.	97.8%	99.2%	**0.02**
CCR helped me take care of problems in our lives.	91.0%	92.9%	0.09
What CCR wanted me to do was the same as what I wanted.	84.5%	92.5%	**<0.0001**
CCR helped my family get stronger.	81.0%	89.5%	**<0.0001**
Things got better for my child(ren) because CCR was involved.	79.2%	85.8%	**<0.0001**
I needed some help to make sure my kids have what they need.	86.1%	75.1%	**<0.0001**

For most engagement items, caregivers reported statistically significantly higher engagement than workers. This indicates that caregivers reported feeling more engaged in the program than workers believed them to be. For example, while only 79 percent of workers agreed or strongly agreed that caregiver would say things got better for the family because CCR was involved, 86 percent of caregivers agreed or strongly agreed with this statement.

4.6. Caregiver and Worker Pre-Post Comparisons

The Protective Factors Survey was administered to caregivers at both pretest and posttest (intake and case closure, respectively), facilitating comparisons between the two time periods at the case level. As shown in Table 16 on the following page, the average change in responses for each domain/item's mean score between pre- and posttest are listed in descending order of mean change over time. **Statistically significant positive change was observed in each domain/item from pretest to posttest**.

For the five Protective Factors Survey domains, the largest changes were observed in the domains of **Concrete Support** and **Social Support**, two of the core components of CCR, while a more modest increase was observed in the Resiliency domain and the smallest changes were observed in the Nurturing and Attachment domains. Table 16 also provides an indication of what proportion of families indicated improvement in each domain or item. For Concrete

[15] For workers, questions began with the phrase "I think the primary caregiver would say…" 'I' or 'My' was substituted with 'primary caregiver' and 'Our' was substituted with 'his/her family'. For example, the first item asks the worker whether they think the primary caregiver realized s/he needed some help to make sure her/his kids have what they need. Initial items were reverse coded between the two surveys.

Support and Resiliency, a majority of families indicated positive change (greater than 50 percent) between pretest (intake) and posttest (case closure).

Table 16: ***Change in Protective Factors Domains/Items from Pretest to Posttest***

Domain or Item*	*N***	Mean Pretest	Mean Posttest	Mean Change	Pre-Post Mean Change p-value***	Percent of Families with Positive Pre-Post Change
Concrete Support	751	4.83	5.48	0.65	**<0.0001**	55.9%
Social Support	754	5.39	5.87	0.47	**<0.0001**	48.7%
Know what to do as a parent*	746	4.56	4.99	0.43	**<0.0001**	40.6%
Resiliency	751	5.35	5.66	0.32	**<0.0001**	54.9%
Know how to help child learn*	745	5.66	5.95	0.30	**<0.0001**	35.0%
Child misbehaves to upset me*	742	4.96	5.17	0.20	**0.003**	36.7%
Praises child when behaving well*	750	6.23	6.38	0.15	**<0.0001**	27.3%
Maintain control while disciplining child*	746	6.11	6.23	0.13	**0.0004**	24.3%
Nurturing and Attachment	750	6.26	6.38	0.12	**<0.0001**	39.6%

*Indicates a standalone item on the Protective Factors Survey
**Includes only those with valid responses for the item/domain for both the pretest and posttest.
***Calculated using Wilcoxon Signed-Rank Test

On the following page, Table 17 displays the change in scores for domains on the CFSA 2.0 that caregivers indicated wanting to make change through CCR. Table 17 also shows the percentage of respondents below the “prevention line” at pretest and posttest listed in descending order of the number of caregivers wanting to make change in each domain. **The percentage of families below the prevention line decreased in all domains identified by caregivers as key “readiness for change” areas between pretest and posttest.** Furthermore, these results were statistically significant in 13 of the 14 domains. This indicates that there was an improvement in self-reliance, over time, for families that completed CCR and that families were motivated to make change in areas that they were ready for, as opposed to just the areas where they may have fallen below the prevention line.

Table 17: ***Change in Percentage of Families below the Prevention Line on CFSA2 Domains from Pretest to Posttest***

Domain	Number wanting to change area*	Average Change in 5-point scale (p-value)**	Percent Below Prevention Line – Pre	Percent Below Prevention Line - Post	Prevention Line Pre-Post Change p-value***
Housing	352	+0.68 **(<0.0001)**	61.9%	33.5%	**<0.0001**
Employment	290	+0.65 **(<0.0001)**	69.0%	45.9%	**<0.0001**
Mental Health	283	+0.66 **(<0.0001)**	39.2%	14.1%	**<0.0001**
Cash Savings	241	+0.27 **(<0.0001)**	86.3%	76.4%	**0.001**
Food Security	230	+0.59 **(<0.0001)**	48.3%	13.5%	**<0.0001**
Income	226	+0.09 **(0.01)**	96.0%	92.9%	**0.05**
Transportation	211	+0.77 **(<0.0001)**	27.0%	8.1%	**<0.0001**
Adult Education	208	+0.14 **(0.02)**	57.7%	52.9%	0.13
Debt Management	204	+0.58 **(<0.0001)**	70.1%	44.1%	**<0.0001**
Physical Health	165	+0.45 **(<0.0001)**	37.6%	23.0%	**<0.0001**
Child Education	152	+0.42 **(<0.0001)**	36.2%	17.8%	**<0.0001**
Child Care	127	+0.89 **(<0.0001)**	58.3%	16.5%	**<0.0001**
Health Coverage	122	+0.28 **(0.002)**	42.6%	19.7%	**<0.0001**
Substance Abuse	67	+0.54 **(<0.0001)**	31.3%	9.0%	**0.0006**

*Excludes those with a value of missing, N/A, or unknown in the either the Worker Pretest or Posttest.
**Calculated using Wilcoxon Signed Rank Test.
***Calculated using McNemar's Test to account for paired measures within individuals.

Change in the Income-Benefits Inventory between pretest and posttest are presented in Table 18 on the following page, listed in descending order of the percent receiving each income/benefit source at the time of posttest with posttest percentages that are less than their pretest counterparts denoted in italics. For slightly over half of benefit types, the change proportion of families receiving them did not change significantly between pre- and posttest. However, **significantly more families reportedly receiving some income or benefits in the following areas: health insurance, free/reduced school lunch, SNAP, EITC, food pantry, utility assistance, public housing, Colorado Child Care Assistance Program, rental assistance, and emergency assistance.**

Utility assistance and food pantry use saw the largest increases, with a five percent or greater increase in the proportion of families receiving each of these services. Use of SafeLink telephones and foster child payments/adoption subsidies saw no change in percentage of families reporting receipt between pre- and posttest. While social security/retirement, SSI/SSDI, child support and WIC saw fewer families reporting receipt of these income/benefits sources it should be noted that these decreases were both small (between 0.1 percent and 2.2 percent) and not statistically significant.

Table 18: ***Change in Income-Benefits from Pretest to Posttest***

Benefit	Pretest Percent Receiving	Posttest Percent Receiving	Pre-Post Percent Change p-value
Health insurance	79.5%	82.5%	**0.02**
Free or reduced-price school meals	61.6%	66.1%	**0.0007**
SNAP	57.6%	61.6%	**0.002**
EITC	30.3%	34.2%	**0.02**
Food pantry/community meal use	25.6%	30.6%	**0.004**
WIC	25.6%	23.4%	0.07
Child support	22.0%	20.3%	0.18
Utility assistance	12.9%	19.8%	**<0.0001**
SSI/SSDI	18.0%	17.7%	0.75
TANF	15.0%	16.5%	0.23
Colorado Preschool Project or Head Start	14.9%	15.9%	0.44
Public housing voucher/subsidy	10.3%	12.7%	**0.007**
Colorado Child Care Assistance Program	8.7%	11.9%	**0.001**
Rent assistance	4.6%	8.9%	**0.0001**
Emergency assistance	4.2%	8.6%	**0.0001**
SafeLink phone	4.0%	4.0%	>0.99
Social security or other retirement/pension	3.7%	3.6%	0.83
Unemployment insurance	1.6%	1.7%	0.81
Worker's compensation	0.8%	1.0%	0.53
Kinship care payments	0.4%	0.7%	0.41
Foster child payments/adoption subsidy	0.4%	0.4%	>0.99

5. CCR Interviews and Staff Surveys

The purpose of this section is to describe how CCR staff experienced their work in the CCR program, and to illustrate the site variation in CCR practice during the early implementation period. Family interviews also are included to provide in-depth information about caregiver perceptions about CCR. Finally, the findings from an inclusive staff survey that took place near the end of the evaluation are presented. Together, these sections highlight the evolution of CCR programing over time and in response to feedback loops established by the evaluation process.

5.1. CCR Staff Interview Methods

Alongside state program staff, evaluators requested participation of CCR advocates and supervisors in semi-structured interviews about their work. The request and interviews took place during the early implementation period in January 2016 (see Appendix E for a list of interview questions). A research assistant facilitated the interviews using the GoToMeeting

platform and, upon obtaining permission from participants, recorded each hour-long interview. An evaluator developed transcripts of interview segments pertaining to family engagement and success stories. The evaluator grouped non-transcribed interview response notes (e.g., information on program components, demographics, and program organization) in an Excel document for analysis. An evaluator coded the interview contents according to emerging themes and distinct outliers. The following analysis is based on data from 15 CCR advocate interviews and eight CCR supervisor interviews for a total of 23 staff interviews representing 17 of the 21 CCR sites.

To analyze descriptions of outreach by advocates, an evaluator coded sections of the interviews using in-vivo coding to capture unique language in NVivo 11. The evaluator analyzed assigned codes to develop emerging themes from interviews. The evaluator then recoded nodes to fit the overall content of the interviews. Then, the evaluator employed two quasi-statistical methods. First, the evaluator tallied frequently mentioned words and compared each to emergent themes to identify key words. Second, the evaluator analyzed key words in their original context.

Finally, to highlight outreach protocol, the evaluator created a within-case display for each CCR advocate's approach as explained during the interview. The display used for this analysis was a type of decision modeling. The purpose of this method was to outline the public/outward steps taken by CCR advocates through the course of the initial outreach contact, as well as the internal decision-making reported by CCR advocates. To develop the display, the evaluator highlighted assumptions, key conditions, decision points, and associated actions in each interview. The evaluator organized protocols by similarities to arrive at the decision model most commonly employed across advocates.

5.2. CCR Staff Interview Findings

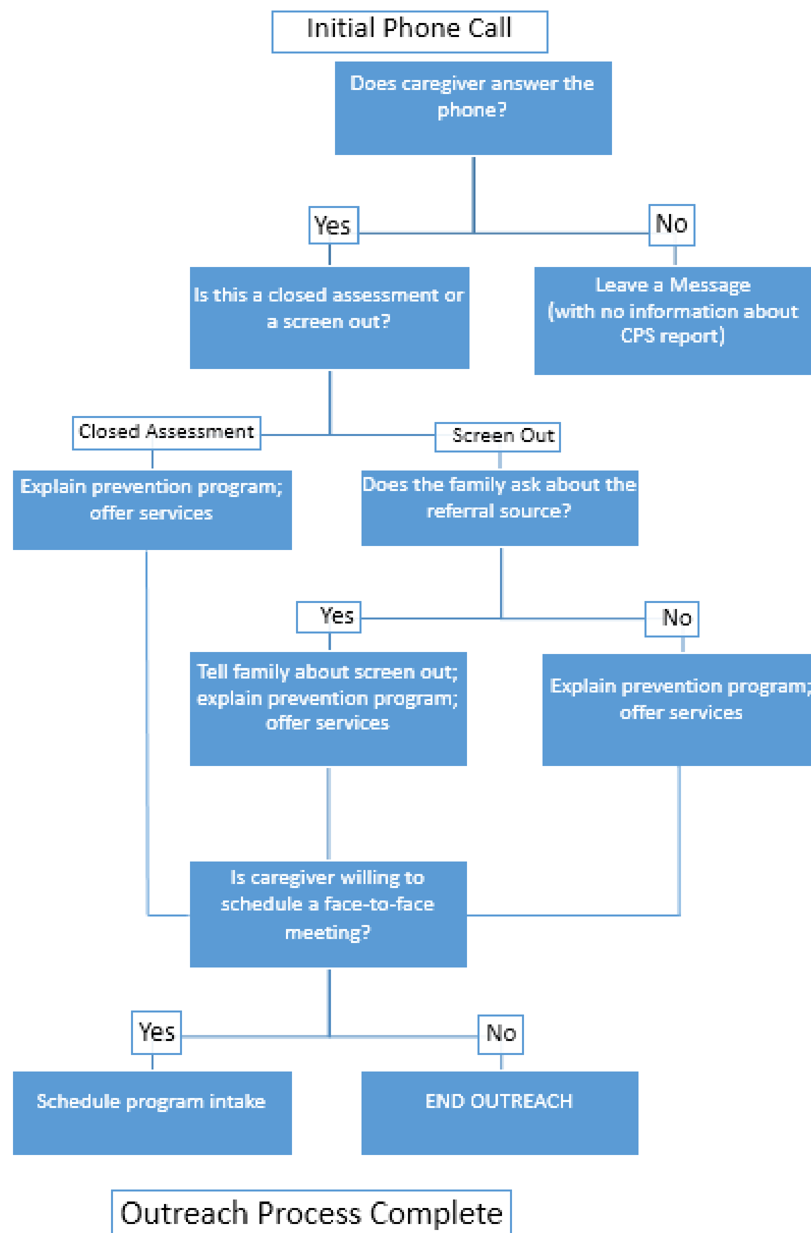
Fifteen CCR advocates interviewed in January 2016 had an average of 11 years of experience working with children and families while the eight supervisors averaged 22 years. About half the advocates worked full time in CCR, whereas the rest had other responsibilities at their agency. All but one supervisor had advocates involved in programs other than CCR, and some supervisors periodically served in an advocate role. Throughout the 23 interviews with CCR advocates and supervisors, the site variability of CCR programing was evident. Answers to variations of the question, "What is CCR?" ranged widely in outreach strategies, core elements, approaches to goal setting, length of involvement for participants, approval and use of flex funding, financial literacy programming, and utilization of community resources. In many instances, CCR staff cited the flexibility to allow for local control and determination of programing as a strength. Staff pointed out the need to adapt to local issues such as community characteristics, economic concerns, and other unique challenges. Program adaptation can be a

strength in this context, though it can also create challenges for drawing conclusions about efficacy of the overall program across jurisdictions.

5.2.1. Outreach Efforts

Figure 5 represents the typical CCR outreach protocol. Four decision points determine the trajectory of the outreach effort, and are outside the advocate's immediate control (e.g. responses by the family or characteristics of the referral).

Figure 5: ***Typical CCR Outreach Protocol***



Most CCR staff believe that the bulk of referrals to CCR were appropriate for outreach, with the exception of those situations where there are environmental risks to advocates in the field. Typically, staff reported that they received the right amount of information from each referral. Most interviewees indicated a positive relationship with their respective child welfare agency, though some misunderstanding about child welfare processes and objectives was evident.

Most advocates stated that the association with their local child welfare program was a barrier to family acceptance of CCR. Advocates speculated or observed that families were “leery,” “on guard,” “feel(ing) like they’re being watched,” or “freak(ing) out” upon hearing CCR got their information from DHS. Because of this, advocates differed in their approach to sharing their referral source. Some chose to be up front and share this information before proceeding with outreach, whereas most expressed a preference to wait until the intake, or until and *if* families asked about where their information was gathered.

When discussing strategies to promote acceptance of the program during outreach, advocates consistently recounted the importance of emphasizing the voluntary nature of the program to families. They also described themselves to families as having a strong understanding of available resources in the community. Many identified the importance of appearing nonjudgmental to the family’s situation. One worker stated, “Treat [families] with respect, they're going to talk to you with respect and they're gonna be more welcoming…letting you come into their homes or coming to see you.” A small number of advocates discussed a strategy to distance themselves and CCR from the child welfare agency. As one advocate recounted, “We come in as, ‘we’re not them. This is who we are. Let’s just sit down and talk about what we might have that might be helpful for you and if it is helpful, then we’ll look at what that might look like for a few months, and see if we can support you through this.’”

5.2.2. Program Components

These staff interviews took place early in the implementation process of CCR. Thus, there was considerable variability in staff understanding of core elements of CCR. However, staff consistently expressed that resources and referrals for other community services were the most common and helpful part of CCR. Staff also highlighted goal setting with families as a core element to the program. Staff identified family development and parent education as other important parts of CCR’s service array.

Early in the program, state administrators also identified goal setting as a core component of CCR. At their request, this interview process examined how implementation of that component was taking place in the field. Advocates articulated the importance of family-driven, goal-focused planning. One advocate said that her approach was to ask families “Where do you see your family in six months?” Several workers mentioned the helpfulness of the CFSA2 (the

standard assessment tool for CCR). However, several stated the tool felt intrusive and burdensome due to the level and type of information needed for completion.

At the time of these interviews, the length of involvement for families in CCR varied by site, advocate, and family needs. Most of the advocates stated they liked the flexibility to meet with families as long as necessary in the program, particularly when assisting families with goal attainment, which might take longer in some cases. However, some advocates stated their individual sites placed restrictions as to the length of service.

Similarly, staff outlined site-specific rules for the use of flex funding. Some sites limited each family to one use of funding, and many had team or supervisor review processes prior to funding approval. Advocates commonly requested flex funding for family needs such as housing, rent, transportation, and utilities. Funding also went to families for basic needs like food, home furnishings, or clothing. Most sites offered financial literacy programing. Sometimes these programs were required as a stipulation of flex funding receipt.

Many CCR staff work for Family Resource Centers (FRCs). These FRCs have established reputation and tenure in communities. Advocates leveraged these established relationships to assist families in making connections as part of goal attainment. Advocates and supervisors stated there are shortages of community resources that CCR families need (e.g., affordable housing). Other identified service needs included transportation, parenting and family supports, mental health services, legal services, substance abuse treatment, and domestic violence resources.

5.2.3. Success Stories

When asked about a success story from their experience working in the CCR program, staff typically recounted situations where families made supportive connections with community networks as a way of bolstering goal attainment. The following stories are representative of successes achieved by families in CCR.

> We got the **extended family involved**, we got them in with a **church that was very supportive** of them and they started going, and then our next goals were…to get them a place to live. We helped them with rental and getting them into a place, and now both **parents are working**, using daycare, and the **two children are in school**. So…they're **doing very well**, they **help out** with… programs here at [the FRC], so I felt like that was a real **success story**.

> We've been working with a lot of folks that…their previous supports were unhealthy supports, and not conducive to raising a child. And so we really worked a lot around trying to help these families develop some other **social networks** that can be supports for them. And I think that's been really helpful,

> and I just think **because of CCR, we're able to do stuff that we couldn't do in the past.** We're able to help families…with getting their **GED**, we've had four people come into our program that identified getting their education as a goal that started and finished. And, the **flex funds** paid for the GED testing, which I mean, it was $75, but it was $75 she didn't have. When she wasn't able to get there to a class, we were able to help her find **transportation** and without that, she wouldn't have been able to do it.
>
> One gal I started working with, it was a single mother…had just left an abusive relationship, and had identified that she wanted to move out, she was living with her parents, wanted to move out from that home and get her GED. So by the time we were done, in the course of the time that we worked with her, which was, over, I'd say, it was about 20 weeks, she was able to **get her GED**, then she **enrolled in the community college**, and was going to beauty school, and has since **moved out of her parents' house** and is **doing quite well**.
>
> But it was a really, really awesome experience working with them because they were really **motivated**, considering that they were so young and to see how **motivated** they were to actually complete the program and kind of **push forward** and **learn new things** was amazing, and I think that was…one of the best, rewarding families that I actually want to say that I've worked with.
>
> They were just really able to connect with [the caseworker], and they were open, they **wanted a change**. I think that's a big part of it, is coming to the place where they **realize that they can change**, and they get a little glimmer of **hope** that they see something going differently for them, and they keep going with it. Just their **engagement**, I think their engagement has everything to do with it.

Likewise, staff had predominantly positive reflections of their respective roles in CCR. Even if not engaged in direct services with families, supervisors said they enjoyed hearing about families making positive changes and seeing families who may not have otherwise engaged in or sought out prevention services. Supervisors also appreciated seeing growth in family engagement skills in the advocates they managed. Most advocates stated they enjoyed building relationships with families. Several said they liked seeing the success and changes in families, and as part of that, appreciated the flexibility of CCR and the availability of flex funding to provide support to families. They also continually emphasized their appreciation of the voluntary, family-driven nature of CCR.

5.2.4. Barriers to Success

The interviews included a question about the barriers to success for those families who initially engaged with CCR but did not follow through to service completion and/or goal attainment. More than half of the staff attributed lack of success in CCR to family lapses in engagement.

Advocates said families might not be ready for change or able to meet identified goals. Many staff identified transience and frequent moves by families as barriers to completion of CCR. Advocates also described barriers in families with multiple, co-occurring issues such as substance abuse, mental health concerns, or new involvement with the child welfare agency.

Evaluators presented these findings to state program staff soon after analysis. Program staff described using these early staff observations of CCR implementation as guidance for further program instruction, standardization, and decision-making.

5.3. CCR Caregiver Interview Methods

A convenience sample of participants in the CCR program completed semi-structured interviews about their experiences (see Appendix F for the list of interview questions). Upon closure in the referral log, a research assistant contacted families in early 2017 via telephone to gauge interest in participation. Upon completion of each interview, families received $50 as compensation for their time.

An evaluator trained in interviewing techniques facilitated the interviews in person or via telephone and recorded each 30-minute to one-hour interview after obtaining permission from the caregiver. The evaluator took notes on each recording in an Excel spreadsheet, and directly transcribed particularly descriptive or unique statements. Analytic methods mimicked those of the staff interviews described in Section 5.1. The resulting analysis is on the compilation of data from 13 caregivers who completed the CCR program.

5.4. CCR Caregiver Interview Findings

The 13 caregivers interviewed represented 10 of the 21 sites: Boulder, Delta, Eagle, Mesa, Otero, Saguache, Pitkin, Pueblo, Washington, and Weld. Caregiver roles for the interviewees included two fathers, a grandparent, and an aunt. The rest were mothers of the children identified in the initial CPS referral. Seven caregivers came to the attention of the CCR program from a screened-out referral while the remaining six caregivers were eligible following a closed CPS assessment. Upon service acceptance, the primary programmatic goals for families varied: parenting skills (3), mental health (2), food security (2), housing (2), transportation (1), employment (1), income (1), and child development (1). Most interviewees closed their CCR case with services complete. However, one family subsequently became involved with their local child welfare agency, one family moved, one family decided to close the case, and one family disengaged.

5.4.1 Outreach

The majority of caregivers stated they were comfortable with the outreach process. Several acknowledged the relationship of the CCR program with “social services,” but did not express

extensive concern about that connection. Three caregivers said they were not sure how the CCR program got their name or information, but emphasized the outreach came at the right time for their family. Other caregivers described tangible offers of help as the overarching purpose of the initial contact by the CCR advocate.

When asked about initial worries about participation in the CCR program, caregivers expressed concerns over confidentiality and involving an outsider in their family issues. One caregiver stated, "I was kind of standoffish. I didn't want any part…the feeling of somebody else wanting to be a part of your life." She went on to express that the CCR advocate was "persuasive… [she told me she was] here to help and not here to judge, and I think that's what did it for me." Three caregivers explicitly stated they were reluctant to get involved in CCR for fear of stigma for themselves or their children. This concern made confidentially a key assurance necessary for caregiver engagement. One caregiver stated, "I know once you're in the system, working with something like this, then you're always in the system. I was worried about being a stereotype." Another caregiver similarly expressed, "My only concern was confidentiality. She was it [the only option] and…this is a small town."

When asked to reflect on initial outreach and their interest in working with their CCR advocate, most caregivers expressed that the help s/he offered was applicable and timely to their situation. One caregiver stated, "I was already in crisis. I was scared…he was smiling, so kind and sincere. He asked me, 'What do you need? What does your family need?' I didn't know how to answer the question, 'what do you need?' He just, listened to my story, like you're doing now…he'd jot down some notes…he found out I needed health care…he brought my daughters boots for the winter." The value of a family-driven approach was mirrored in several other comments by caregivers, including one mother who emphasized, "[the CCR advocate] was extremely understanding…never once telling us we were wrong, or 'we'll do it this way.' We'd done a lot of different methods, and it seemed like nothing worked, and she said, 'I understand. I'm not going to tell you what to do or that you're wrong.' This is big. This isn't always the case." Said one caregiver of his CCR advocates, "…they're really nice people…they're trying to help. Me, I was always raised to help people. Like, you see somebody broke down on the side of the road, I like to stop to see if I can help."

5.4.2 Program Components: Goal Setting

The interviewer asked caregivers about how goals were set with their family. Most caregivers again stated they directed their own goal setting in the CCR program. One caregiver described the goal prioritization in this way, "We sat down and she gave me a piece of paper to fill out where I needed help, and where I saw there was more need than others. I explained to her what I needed to do and she said, 'Okay, let's get to work.' She did a great job." Many caregivers described developing working relationships with their CCR advocate to accomplish

goals. This included texting, phone calls, and regular visits to discuss progress and barriers. One caregiver described having the CCR advocate's outside perspective was helpful, "When you talk to somebody else, who's not part of your family, it made it feel good, less negative, like, 'I could do that.'" Overall, for those families who expressed their knowledge and understanding of the goals set forth in the program, caregivers stated they were better off for having participated in CCR, and that they had increased capacities to address other issues in their life. One caregiver speculated about what might have happened if CCR had not intervened, "We would have never gotten our place, and we would have had to go live with my mother-in-law. And that would have not been good." Another told of setting up long-term resources in her community that will be a continued resource as she establishes a new life for herself and her children after leaving a violent relationship.

5.4.3 Program Components: Financial Assistance

Many caregivers recounted difficulty accessing financial resources as their primary concern while participating in CCR. In these cases, caregivers expressed their goals in the program were directly tied to overcoming poverty-related challenges. Caregivers delineated three approaches that addressed this need specifically: (1) flex funding (i.e., one-time cash assistance), (2) access to financial assistance programs, and (3) enhancing financial literacy. Just over half of the caregivers received flex funding to assist in achieving goals for their families. Uses of flex funding varied; caregivers recalled assistance with car repair, laundry, counseling for symptoms of PTSD, summer camp, energy bills, specialized licensing for a technical trade, and housing costs. Other caregivers expressed they had experienced prior difficulty in applying for or receiving TANF, SNAP, SSI, or medical assistance, and shared their CCR advocate helped to reduce barriers to accessing these programs. Only a small number of those interviewed stated they participated in a formal financial literacy program while in CCR, but several expressed learning strategies tied to common financial literacy approaches such as understanding their credit, creating a budget, and intentionally tracking spending to increase awareness of cash flow.

5.4.4 Program Components: Mental Health Services

In this small group of caregivers, some recalled experiencing difficulty accessing specialized services for one or more of their children with mental health or developmental needs. Two caregivers discussed frustration with accessing services in their community, and stated their last resort was to call CPS on their own family. One caregiver noted her child's behavior had reached a crisis point, and she called the police to maintain safety for her other child. She stated the police encouraged her and her partner to call CPS, "The cops said, 'If you need help, call CPS. They don't just come to take your kids away, sometimes they come to help you.' And we were like, 'Well, I guess we'll give it a try.'" The other caregiver stated she had called DHS on

multiple occasions because she did not believe she could continue to parent her child in her home. Both caregivers said their CCR advocate had been unsuccessful in helping them access further help in the community, because there were no resources available for their unique situations. These two CCR cases closed when one child went to residential treatment and the other child moved up on a waiting list for longer-term services.

5.4.5 Overall Impression of CCR

At the conclusion of each interview, the evaluator asked the caregiver about advice they would give to a friend or family member if approached by someone from CCR. All caregivers shared they would tell a friend or family member to try the program to see if it could help with their concerns. One caregiver said she would tell a friend, “Once you understand that the end goal is to help the child…then you feel like, ‘Okay, she’s on my team. Not the opposite.’ It’s another resource. It takes a village to raise a child and this person… is there to give you more resources and help with whatever they can.”

5.5 CCR Staff Survey Methods

In early 2018, near the conclusion of this evaluation, evaluators administered a web-based survey to the entire population of supervisors and advocates for the 21 CCR sites. Evaluators delivered the survey (see Appendix G for the list of survey questions) via Qualtrics link during a regularly scheduled cross-site teleconference. Evaluators were available on the teleconference during this time to answer any questions about the survey or administration. This strategy afforded a 90% response rate. An evaluator thematically analyzed all open-ended survey responses to summarize common themes and highlight key quotes. Categorical and continuous variables were analyzed using reporting features within Qualtrics or through file transfer into Microsoft Excel.

5.6 CCR Staff Survey Findings

The survey yielded 53 total respondents. These staff represented 20 of the 21 sites. Almost all sites had both the roles of supervisor and advocate represented in the responses, with 31 advocates, 19 supervisors, and three administrative representatives from different sites. One respondent did not complete the entire survey, but their completed responses are included in the analysis whenever available. Around half the advocates, nearly all the supervisors, and all the administrators indicated that the CCR program was not their only responsibility at their respective agencies. Those with other roles spent an average of 48% of their time devoted to CCR. Due to the relatively small size of some programs, a third of supervisors conveyed they also conduct outreach and/or carry a CCR caseload as needed. One respondent designated she is both an advocate and her own supervisor due to the small size of her site.

5.6.1 Staff Background

Respondents reported a variety of experiences with service provision to children and families prior to their work with CCR. A third of the advocates reported more than 10 years of experience in child/family service provision with others reporting less than one year of experience. Similarly, just under half of supervisors reported more than 10 years of experience while two reported under a year of experience. Over half stated they have a four-year degree while 12 have attained a master's degree. All supervisors had at least some college experience. For those advocates and supervisors who attended college, most majored in the social sciences (sociology, psychology, social work, etc.) or education. For advocates, however, there were notable exceptions including Biology, Law, and Graphic Design. At the time of the survey, just under half of advocates had been with CCR for between one and two years. Eight advocates had been with CCR for three or more years (most likely since the origination of the program). A majority of supervisors had been with CCR for a year or more.

5.6.2 Caseloads

Advocates estimated at the time of the survey they were actively outreaching to an average of 12 families, though responses ranged from one to 50. Advocates stated they have an average of 11 cases on their current caseloads, with responses ranging from two to 22. The most frequently mentioned caseload size was 15, which matched the average caseload size advocates stated would be ideal. Advocates also indicated variability as to how much time on average is spent with each family on their caseloads, with four spending less than one hour and three spending more than four hours per family. Regardless of time spent, almost all reported they maintained weekly communication with families on their caseload in the form of phone calls, emails, or visits. A portion said they communicate with families between three and four times per week.

Most supervisors estimated that they provided supervision to advocates on average of one time per week or more. Most also reported they assisted advocates in managing their caseloads by using data tracking systems (i.e. Salesforce) as well as being available as needed to provide consultation on emergent or crisis situations.

One challenge presented by respondents was data entry or "paperwork." Specific problems included dual entry into Salesforce and other systems like Efforts to Outcomes (ETO) and Mobile Caddy to accommodate accountability to multiple entities. Several respondents recounted the past year's transition to Salesforce as being a challenge, but also noted this transition has gotten easier over time.

5.6.3 Outreach

Based on lessons learned from the initial staff interviews, evaluators surveyed staff about the outreach process. The evolution of programs and protocols was clear between early implementation and the survey, though some challenges and barriers to effective outreach remained similar. Reliable, current, or accurate contact information at the time of referral still remained a challenge at the onset of the outreach process. When asked about other data systems accessed to obtain more reliable contact information, 13 sites reported using ETO. Seven sites reported accessing Trails to get reliable information, either in person or by asking a DHS partner to research on their behalf. Five sites reported access to school-based data through their district or local Head Start programs. Other options for information search included Salesforce and CoCourts. Three sites indicated they use the Colorado Benefits Management System (CBMS) to research current contact information for families.

When contact information provided in the referral was inaccurate or missing, all 20 sites reported other thoughts, ideas, and suggestions for contacting families. Most commonly, sites stated they had processes in place to contact DHS staff from child welfare for additional information. Some of these sites specifically mentioned contacts within eligibility programs such as TANF, Medicaid, and SNAP. Upon connecting with DHS professionals, sites requested additional addresses and phone numbers used by the family and described success at gaining information. Other sites mentioned reaching out to schools, other professionals who may have contacts for the family, other programs within their own agency, and a local Boys and Girls club with the intent to obtain contact information. One advocate co-located in a child welfare agency stated that one approach was to call the reporter back to see if s/he had more information.

Another approach named by sites was the use of social media. In six sites, at least one respondent from that site mentioned Facebook as a reliable method for outreach. Several reported creating a 'work' Facebook account to use when outreaching. One respondent stated, "Facebook is a great way to get ahold of families. Even when their phones are off they still answer Facebook."

In the absence of additional information, some sites recounted stopping by the family home, the parents' place of work, or reaching out to mutual friends of the family. However, many respondents indicate this was the part of CCR they least enjoyed. One advocate shared this initial contact is problematic because it is hard to know how families will react to the approach, "…with the violence that has grown within our society, we, as advocates, must ensure we are taking all precautions to be safe." Another advocate said, "the hardest part of CCR is often the outreach and tricky task of offering services without putting the caregiver on the defense (though they are often surprisingly welcoming)."

When asked about barriers during outreach, several people mentioned families in the CCR eligible population are transient or homeless, so it is difficult to locate the family to pursue engagement. Similarly, lack of reliable cell service in rural areas and disconnected phone numbers were barriers to outreach. Many respondents stated they see families either actively or passively avoiding the advocate during outreach, either by not showing for scheduled visits or by never answering phone calls.

Many advocates suggested speeches or strategies for uniform outreach. One advocate developed an engagement speech echoed by another advocate at their agency, "I am a Colorado Community Response specialist with [X] County and have been given your information as someone that may need some temporary supports or referrals available in our community. Our program is totally voluntary and non-intrusive. We can assist as little or as much as you would like based on your needs and the services available to you."

Prior to conducting the intake, respondents split on disclosing to families that they obtained their information from DHS through screened out referrals. This was similar to the interviews conducted earlier in the life of the program. However, a notable difference is that no respondents reported never disclosing the source of the referral. Eighteen advocates responded they "sometimes" tell the family at the time of outreach, whereas 19 reported they "always" tell the family the source of the referral information during initial outreach. When asked to explain, the "always" group stated this was about building trust and transparency from the onset of engagement. The "sometimes" group elaborated they preferred to start the engagement on a "positive note" and that families often don't ask about the source of the referral during initial outreach prior to intake.

The survey presented the percentage of active declines of CCR outreach in the site for each respondent. Respondents reflected on the reasons a family might actively decline CCR based on their experiences. Opinions centered on the family either not identifying or seeing participation as necessary. Several advocates expressed families are in "crisis mode" a lot of the time and do not have time or energy to engage. Similar to earlier interviews, 15 respondents brought up fear of association with DHS or the government in general. Several advocates reflected caregiver concerns that the CCR program involves telling someone from an outside entity the private details of a family's life, "…some families are reluctant to open up their lives to a stranger."

The survey also presented respondents with the percentage of families completing an intake with CCR, but then disengaging prior to completion of services. When asked about barriers to remaining in CCR for the duration of the program, answers varied widely across respondents, though most centered on family circumstances such as frequent moves, substance abuse, legal issues, domestic violence, and other unpredictable events. One respondent said, "I feel like the

sporadic and chaotic nature of the lives that some of these families live contributes to them disengaging or opting out [of CCR].”

In contrast to interviews early in the CCR process, collaboration with and understanding of DHS emerged as a clear strength in CCR programming. While much of this seemed centered on the initial referral process, respondents also regularly articulated an understanding of the processes employed in their corresponding child welfare agency. All sites utilized regular meetings and communication with DHS child welfare staff by at least one representative of CCR, even when not co-located. Several sites discussed attending the Review Evaluate Direct (RED) team meetings at DHS to help in screening referrals to the agency. Other strategies for collaboration were attending Family Engagement Meetings with families and conducting ‘warm hand-offs’ with those families who started with child welfare involvement and were transitioned to CCR.

5.6.4 CCR Services

When asked to describe the CCR program, evaluators noted considerable uniformity in recounting of core program components. Respondents consistently noted that the intention of CCR is to prevent child maltreatment and to help families stabilize using protective factors as milestones. Again, most mentioned the ability to connect families with community resources to promote sustainable change. Similarly, the majority of respondents agreed that services in CCR are complete when the family meets at least one goal and participates in a closing meeting to complete closing documentation.

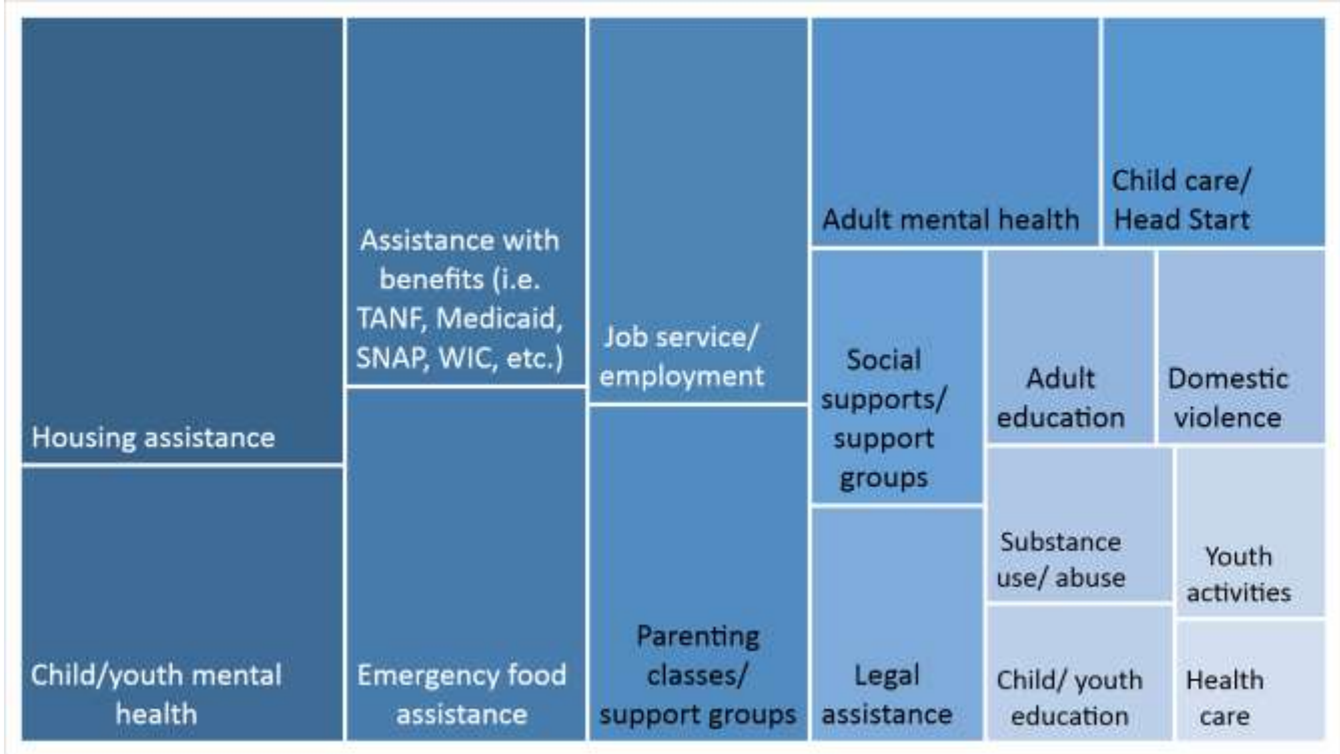
Survey respondents stated they most enjoy working and engaging with families in their CCR role. In particular, they reported feeling rewarded as they watched families set and reach goals, overcome barriers, and access resources in the community. Respondents also appreciated the flexibility of the CCR program. One respondent stated they enjoy, “working with families and being able to connect them with services and resources that otherwise they didn’t know existed in the community.” Several respondents specifically said they enjoyed state program staff, state leadership, and the working relationship that had grown along with the program.

While program guidance suggests keeping cases open no longer than 120 days, several advocates responded that they had encountered situations where families would have a “last minute goal” or a new crisis. One advocate stated, “…it doesn’t feel right closing them out right when you start to make some headway.” Similarly, a supervisor wrote, “our caseworker has spoken to [state program staff] about keeping families longer when they are in active crisis and closing their case would be detrimental to the caregiver/children/family.” Some responses, however, indicated sometimes cases languish due to lack of active progress or partial disengagement by the family.

Advocates and supervisors regularly stated throughout the survey that flex funding is an important part of the CCR program. When asked for examples of how these funds were used, the majority named rent, car repairs, utility payments, child care, and tangible goods such as food and clothing. One advocate recounted using flex funds to pay for glasses for a woman with no insurance so that she could safely drive her children to school. Another described helping a family who was living in a camper during the winter to move to more adequate shelter, both through flex funding and working out an arrangement for in-kind services with a new landlord. Still others discussed helping families engage in prosocial community activities such as recreation center passes and afterschool programming for children.

The survey presented participants with a list of common services developed from staff interviews, and staff identified at least three of the most common service and resource needs for families receiving CCR. On the following page, Figure 6 illustrates the distribution of responses, where darker green areas indicate areas of higher response and lighter green areas indicate less common needs. At the high end, CCR workers designated 39 selections of "housing assistance" and on the low end, there were 5 selections for "health care." Similarly, 17 of the 20 sites represented had at least one person mention affordable and accessible housing as an *unmet* service need commonly encountered by CCR families in their communities.

Figure 6: ***Distribution of Most Common Service Needs for Families Receiving CCR***



6. Outcome Evaluation

A propensity score matching (PSM) technique was applied to families who completed CCR services to generate a comparison group from the pool of CCR-eligible families who were not referred to the program during the project period. However, due to a number of considerations with evaluation implications, the evaluation team recommended that the PSM analysis exclude five sites (Otero-Bent-Crowley, Logan, Washington, Montezuma, and Weld). This recommendation was based on the following factors:

- Ongoing data quality issues were persistent in some sites such that the Referral Log (the source of treatment family data) was not reflective of site practice, and/or that the site did not implement CCR as intended.
- The small size of some sites created a scenario in which a substantial majority of eligible families were offered services so that there was not a large enough pool of potential comparison group families from which to conduct the PSM analysis.

As a result, the five sites with size, data quality, and/or practice issues were excluded from the outcome and within-completers analysis using Trails data but included in all other descriptive and survey analyses. This includes all basic, site-level program descriptive statistics derived from the log for referral rates, acceptance/decline rates, and survey response rates, as well as inclusion in all cross-site Caregiver and Worker pre- and post-survey analyses. All remaining sites were included in the outcome analysis using Trails data (at the cross-site level), in addition to all other descriptive and survey analyses.

6.1. Treatment versus Control Outcome Analysis Methods

In non-randomized designs, treatment and control/non-treated groups may differ considerably in their family, household, or case characteristics, leading to challenges in understanding the effect of the treatment or program being evaluated in whatever outcomes may be experienced between groups. Defined as the probability of receiving a treatment given a set of explanatory variables, propensity scores are used to ensure that the groups are as similar as possible based on observed matching variables when assessing causal effects. In practice, the success of PSM is judged by whether “balance” on the chosen family/household/case characteristics is achieved between the treatment and control groups after its use.[16,17,18]

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[16] Biondi-Zoccai, G., Romagnoli, E., Agostoni, P., Capodanno, D., Castagno, D., D’Ascenzo, F., Modena, M. G. (2011). Are propensity scores really superior to standard multivariable analysis? *Contemporary Clinical Trials, 32,* 731-740.

[17] Newgard, C. D., Hedges, J. R., Arthur, M., Mullins, R. J. (2004). Advanced statistics: The propensity score – a method for estimating treatment effect in observational research. *Academic Emergency Medicine, 11,* 953-961.

[18] D’Agostino, Jr., R. B., & D’Agostino Sr., R. B. (2007). Estimating treatment effects using observational data. *The Journal of the American Medical Association, 297,* 314-316.

Propensity score matching is essentially a three-step analytic procedure. The first step is to identify a set of covariates that will be used to calculate a propensity score, and then calculating the propensity score via logistic regression. The second step is to match treatment subjects to non-treated/comparisons subjects on the basis of the estimated propensity score. At this point, balance of covariates between the treatment group and matched comparison group can be assessed. The third step is the outcome analysis, in which outcomes are compared between the treatment and matched comparison group.

Treatment subjects were defined as any categorically eligible caregiver completing CCR. Candidates for the non-treated/comparison group subjects were defined as any categorically eligible caregiver who was not referred to CCR following their first stint of eligibility (e.g., their first CPS screen out or closed assessment) during the project period. This was an attempt to remain consistent in determining which referral was the index referral, and which referrals were subsequent to that date and could be considered outcomes for both groups.

Propensity score matching was completed via the gmatch macro in SAS version 9.4,[19] using a greedy matching algorithm, in May 2017. Matching took place at the site level so that each referred primary caretaker[20] was matched to a non-referred caretaker from the same CCR site. A caliper of 0.1 was set for each site, meaning the difference between propensity scores of matched treatment and control subjects cannot be greater than 0.1. This improves the ability of the propensity score matching to balance distributions of covariates between treatment and control group subjects, while potentially slightly sacrificing the number of eligible treatment group subjects for whom a suitable match can be found.

6.2. Treatment versus Control Outcome Analysis Results

For the purposes of this evaluation, the treated group consisted of CCR completers. A completer was defined as a family that:

a) Had a case closure reason of 'Services Completed'
b) Had a case closure date before on or before March 31, 2017, and
c) Had an index CPS referral date on or before December 31, 2016.

As outcome data were pulled through March 31, 2018, this treatment definition ensured that all treatment families had one full year of follow up in which to measure outcomes. Potential

[19] Bergstralh, E., Kosanke, J. (2003). Locally written SAS macros: gmatch. Mayo Clinic. Available online at http://www.mayo.edu/research/departments-divisions/department-health-sciences-research/division-biomedical-statistics-informatics/software/locally-written-sas-macros.

[20] Primary caregiver ID was used as a proxy for household in the PSM process, as households could receive be eligible to receive CCR (with a screen out or closed assessment) multiple times during the eligibility period, some of which may have resulted in a referral to CCR and some of which may not have. Matched comparison group eligible households consisted of primary caregivers who were never referred to CCR services.

matched comparison group referrals were defined as the first referral during the eligibility period among families that:

a) Did not receive a referral to CCR, and
b) Had an index CPS referral date on or before December 31, 2016.

This allowed for at least one year of follow-up plus 90 days in which to measure outcomes for comparison group families. The one-year follow-up period in which outcomes were measured for the MCG began 90 days after the initial CPS referral date, to take into account the time between the referral and CCR service provision for treatment families.

A total of 589 completers with comparison group matches were identified via the propensity score matching process described above, completed in May 2017. The following ten variables were used to match treatment families to comparison group families: (1) referral pathway, (2) number of children in the home, (3) age of youngest child, (4) number of adults in the home, (5) primary caretaker age, (6) number of prior CPS referrals, (7) number of prior CPS assessments, and whether the report included an (8) abuse allegation, a (9) neglect allegation, or an (10) emotional abuse/neglect allegation. A breakdown of specific allegations collapsed into the abuse, neglect, and emotional abuse/neglect categories are presented in Table 19. It should be noted that sexual abuse allegations are not eligible for CCR and are therefore not included.

Table 19: ***Allegation Categories***

Collapsed Category	Specific Allegation	
Abuse	-Physical Abuse	
Neglect	-Environmental Neglect -Parent Substance Abuse -Medical Neglect -Educational Neglect -Failure to Protect -Incarcerated Parent -Child Disability	-Lack of Supervision -Drug Exposed Child -Domestic Violence -Abandonment -Incapable Parent -Failure to Thrive -Inability to Cope
Emotional Abuse/Neglect	-Emotional Abuse -Emotional Neglect	

The distribution of matching variables between completers and the matched comparison group is displayed in Table 20 on the following page. In general, completers and their matched comparison counterparts had similar distributions of matching variables. However, CCR completers were slightly more likely to have an allegation of emotional abuse or neglect than the comparison group, while the comparison group was slightly more likely to have a neglect allegation. In addition, the treatment group was slightly more likely to have become eligible for CCR via referral assigned to the FAR, while the comparison group was slightly more likely to

have been assigned to the HRA pathway after from the initial referral. Number of adults in the home, number of children in the home, primary caretaker age, and history of CPS referrals and assessments were relatively evenly distributed between the two groups.

The current federal standard for re-reports is a year. In order to meet that standard with these analyses, the CCR referral cut-off was December 31, 2016. In order to allow for three months of service provision a case closure cut-off of March 31, 2017 was applied allowing the evaluation team to track families for a minimum of one year through March 2018.

A power analysis was completed in May 2017 based on our new sample size and preliminary findings from a smaller sample of treatment and matched comparison subjects from an earlier time period. Those findings indicated that 4.5% of treatment subjects had a subsequent founded assessment with one year of follow-up compared to 9.0% of matched comparison group subjects. Our power analysis of equality of two proportions, assuming a sample size in each group of 589, outcome proportions of 4.5% and 9.0%, and $\alpha=0.05$, indicated that we had a statistical power of .843 to detect a significant difference.

Table 20: ***Distribution of Matching Variables between CCR Completers and the Matched Comparison Group***

Matching Variable	Completers (*N* = 589)	Matched Comparison (*N* = 589)
Pathway		
FAR	15.5%	11.2%
HRA	22.9%	26.2%
Screen-out	61.6%	62.7%
Number of Children in Home		
1 child	36.5%	37.4%
2 children	31.4%	30.9%
3 or more	32.1%	31.8%
Age of Youngest Child		
1 year old or less	26.0%	24.8%
2 or older	74.0%	75.2%
Number of Adults in Home		
1 adult	48.4%	48.4%
2 or more adults	51.6%	51.6%
Primary Caretaker Age		
Less than 30 years old	34.8%	36.0%
30-40 years old	41.6%	41.4%
41 years old or greater	23.6%	22.6%

Matching Variable	Completers (*N* = 589)	Matched Comparison (*N* = 589)
Prior CPS Referrals		
0 prior referrals	33.6%	33.8%
1 or 2 prior referrals	28.5%	27.5%
3 or more prior referrals	37.9%	38.7%
Prior CPS Assessments		
0 prior assessments	47.5%	46.5%
1 prior assessment	18.5%	18.2%
2 or more prior assessments	34.0%	35.3%
Referral included Neglect Allegation (other than Emotional Neglect)		
Yes	79.8%	82.8%
No	20.2%	17.2%
Referral included Physical Abuse Allegation (Other than Emotional Abuse)		
Yes	23.3%	19.9%
No	76.7%	80.1%
Referral included Emotional Neglect or Abuse Allegation		
Yes	8.7%	6.5%
No	91.3%	93.5%

Five different child protection outcomes were assessed in the comparison of the treatment and comparison groups; subsequent referral, subsequent assessment, subsequent referral open for services, subsequent founded assessment, and subsequent out-of-home (OOH) placement. All subsequent referrals with a sexual abuse allegation were excluded from both the treatment and comparison groups, as initial referrals with an allegation of sexual abuse were not eligible to receive CCR and sexual abuse is not addressed by the CCR program. Results of the outcome evaluation are presented in Table 21.

Table 21: ***Outcome Comparison between CCR Completers and Matched Comparison Group***

Outcome Category	CCR Completers (*N* = 589)	Matched Comparison (*N* = 589)	p-value†
Subsequent Referral			
Yes	247 (41.9%)	229 (38.9%)	0.29
No	342 (58.1%)	360 (61.1%)	
Subsequent Assessment			
Yes	146 (24.8%)	152 (25.8%)	0.73
No	443 (75.2%)	437 (74.2%)	

Outcome Category	CCR Completers (*N* = 589)	Matched Comparison (*N* = 589)	p-value†
Subsequent Referral Open for Services			0.53
Yes	32 (5.4%)	38 (6.5%)	
No	557 (94.6%)	551 (93.5%)	
Subsequent Founded Assessment			
Yes	30 (5.1%)	48 (8.2%)	**0.047**
No	559 (94.9%)	541 (91.8%)	
Subsequent OOH Placement			
Yes	12 (2.0%)	25 (4.2%)	**0.047**
No	577 (98.0%)	564 (95.8%)	

*For the CCR Completers group, outcomes are included if they occurred within 1 year of the CCR Completion date. For the Matched Comparison Group, outcomes are included if they occurred within 1 year of 90 days post-index referral.
†p-value calculated using McNemar's Exact Test, significance indicated at α<0.05.

CCR completers were significantly less likely to have a subsequent founded assessment or out-of-home placement than their matched comparison group counterparts (*p* = 0.047 for both outcomes). The three other child welfare re-involvement outcomes, including subsequent referrals (MCG: 38.9 percent vs. CCR: 41.9 percent, *p* = .29), subsequent assessments (25.8 percent vs. 24.8 percent, *p* = 0.73), and subsequent referral open for services (6.5 percent vs. 5.4 percent, *p* = 0.53) did not result in statistically significant differences between the completer and matched comparison groups.

6.3. Within-Completers Analysis Methods

A cross-site within-completers analysis was completed to attempt to identify any characteristics of CCR program completers that might be associated with their likelihood of a subsequent CPS assessment. The goal of this analysis was to test whether certain family or case characteristics impact the effectiveness of CCR in preventing child welfare re-involvement, and to assess whether positive changes in lead indicators (e.g. protective factors) are related to positive changes in child welfare re-involvement. CPS assessments were utilized as the outcome of interest in this analysis as a balance between subsequent CPS referrals, which is a less meaningful indicator in terms of costly child welfare system re-involvement, and founded assessments or OOH placements, which are events that happen too infrequently to facilitate multiple predictor variables in a model.

Specific factors that were assessed in regards to subsequent CPS assessments included: index CPS referral type (screen-out or closed assessments that resulted in the initial referral to CCR); index CPS referral reasons (abuse or neglect); number of prior CPS assessments; CCR provider

type (Community versus CPS provider agency); demographics including income, caregiver age, caregiver marital status, caregiver race/ethnicity, caregiver education level, number of children and adults in the household; and change in protective factors from pretest to posttest (from the Protective Factors Survey which was administered as part of the Caregiver Pre- and Posttests).

After eliminating completers from the five sites with data quality issues five (Otero-Bent-Crowley, Logan, Washington, Montezuma, and Weld) hierarchical logistic regression analysis was used to calculate odds ratios and 95% confidence intervals on the sample of all other CCR completers through March 31, 2016. The outcome of the analysis was the presence of a subsequent accepted referral within one year of CCR completion date. An initial model included only variables from Trails (referral type, reasons, prior assessments, provider types, and caregiver age, number of children and adults in the household) retaining potentially important predictors ($p < 0.10$).

Demographic variables from Trails plus caregiver pretest values (income, marital status, race/ethnicity, education level, and protective factors scores at intake) were then included in a second model. Finally, a final model included demographic variables, caregiver pretest values, and binary indicators of positive change in protective factors domains from pretest to posttest. Income was included in the final model in order to adjust for baseline income when measuring change in financial supports. The final model included all completers that completed both a Caregiver Pretest and a Posttest and did not have any missing predictor information ($N = 494$).

6.4. Within-Completers Analysis Results

In the initial model including only demographics displayed in Table 22 on the following page, the number of prior assessments and the caregiver's age were significant predictors of subsequent assessment. Specifically, subsequent assessments were less likely in those with no prior assessments than those with two or more prior assessments, and in caregivers over 40 years of age compared to caregivers under 30. In a second model including data from Trails as well as demographic and protective factors survey values from the Caregiver Pretest, prior assessments, caregiver's age, and household income at baseline were significant. Caregivers with lower income at baseline were more likely to have a subsequent accepted referral. Pretest protective factors domains, (e.g. resiliency, concrete support, social support, and nurturing) were not significant predictors of subsequent accepted outcomes. However, the final model suggests that after adjusting for baseline income, positive changes in concrete support from pretest to posttest trended towards lower odds of subsequent assessment, although this finding was not statistically significant ($p = 0.07$). This indicates that improvements in concrete support over the course of the program may be one mechanism for preventing subsequent child welfare re-involvement.

Table 22: ***Predictors of Subsequent Assessments within One Year of CCR Completion Date among CCR Completers***

Predictors	Initial Model* OR (95% CI)	Second Model† OR (95% CI)	Final Model OR (95% CI)
Number of Prior Assessments			
0	**0.53 (0.35-0.79)**	**0.57 (0.38-0.88)**	**0.56 (0.34-0.93)**
1	0.90 (0.55-1.47)	1.06 (0.63-1.76)	1.22 (0.67-2.22)
2 or more	Ref	Ref	Ref
Caregiver Age Category			
Less than 30 years old	Ref	Ref	Ref
30 to 40 years old	0.83 (0.55-1.23)	0.84 (0.55-1.27)	0.83 (0.51-1.35)
Greater than 40 years old	**0.52 (0.32-0.85)**	**0.49 (0.29-0.83)**	**0.46 (0.24-0.87)**
Caregiver Income (per category increase)	N/A	**0.85 (0.74-0.98)**	0.94 (0.80-1.10)
Positive Change in Concrete Support Domain (from pretest to posttest)	N/A	N/A	0.67 (0.43-1.04)

*Trails variables only
† Trails variables plus caregiver pretest demographic and protective factors values
‡ Variables from Trails, the caregiver pretest, and change from pretest to posttest in protective factors

7. Discussion

This section discusses evaluation conclusions, limitations, and implications of the process and outcome findings, and offers recommendations for future evaluation of Colorado Community Response.

7.1. Conclusions

Key LEAD measures associated with the project, as obtained via survey measures, show that families who complete the program are benefiting by improving multiple domains of family functioning as well as building protective factors. For example, statistically significant positive changes were observed from pretest to posttest for all five protective factors, with the largest changes observed in the concrete support and social support domains, which represent success in achieving two goals of the CCR program: building social capital and providing concrete supports. Furthermore, the percentage of families below the prevention line decreased in all domains identified by caregivers as key “readiness for change” areas, which indicates that there was an improvement in self-reliance, over time, for families that completed CCR. In addition, significantly more families reported accessing income or benefits at the time of CCR case closure than they had at intake from various public assistance programs which would be

expected to enhance their overall financial stability, another goal of the CCR program. Families also reported positive perceptions of the CCR program and of their level of engagement with their CCR worker – often times perceiving the relationship in a more positive light than even the worker's think they are. These caregivers also indicated that they had received all the help they needed as a result of their involvement with the program.

Child welfare outcome findings for the LAG measure of child welfare re-involvement indicated that CCR completers had significantly fewer subsequent founded assessments or out-of-home placements than their matched comparison counterparts. These LEAD and LAG outcome measures are consistent with the theory of change for child maltreatment prevention initially developed for the project, and suggest that CCR is an effective program for strengthening families and preventing child welfare re-involvement. Given the significant financial costs, disruption to families, and harm experienced by children related to these child welfare re-involvement outcomes, these are encouraging findings.

7.2. Limitations

As of the end of data collection in March 2017, there was a great deal of variation present in the current CCR program across sites. This variation ranges from the target population (screened-out cases and cases closed after assessment, with some sites also serving youth in conflict cases), service model, referral processes, assessment approaches, length of service period, and type of CCR provider agency. Such variations were exacerbated by turnover in some sites where adequate staffing became an issue, particularly in smaller sites where there were fewer agency resources to fill in the gaps as staff were lost before new staff could be hired. These variations represent a limitation of the evaluation and have significant implications for meaningful and reliable evaluation of the CCR program as a whole given that CCR services and/or approach in one site may vary substantially from CCR in another site which may impact program effectiveness in ways that are difficult to quantify using administrative data and survey methods alone; this is particularly true given the cross-site nature of the evaluation which is necessary given the relatively low rates of service provision and completion at the individual site levels, especially in smaller sites.

The original study design included a randomized controlled trial for four sites in Cohort 1 and all Cohort 2 sites. RCTs are often considered the 'gold standard' in evaluation designs as they minimize biases in treatment vs. control group selection. An RCT was preferred by OEC and recommended by the evaluation team. However, some CCR sites did not support randomly assigning referrals based on the following concerns: meeting program capacity, ethics of denying services to some families, preference to selecting families for the program, and interrupting existing community response practice. To accommodate these concerns, a dual-design pilot was implemented. The first design was an RCT with automated referrals from

Trails, the statewide child welfare administrative data system, randomized to either a treatment or control group by the evaluation team. The second design was a matched comparison group, in which sites referred eligible participants to CCR based on their own criteria.

However, the typical approach to RCT data analysis, the Intent-to-Treat (ITT) approach, would be of limited utility due the low rates of program acceptance (the cross-site acceptance rate was 23%), as the majority of “treatment” families never actually received CCR. This is because the indicator of treatment in the RCT was whether or not the family was *referred* to CCR; any referred family would have been treated as a CCR case. Many families randomized to receive the treatment were either unreachable based on the contact information provided to the CCR worker or declined participation. As a result, the RCT was replaced by a MCG analysis utilizing propensity score matching within all sites, regardless of initial design. This allowed for the most robust, meaningful analysis possible of CCR completers versus a comparison group of families who were never referred to CCR which was preferable due to the significant limitations to the ITT approach given low program uptake.

Regarding the PSM, although the most rigorous design that could be applied to the CCR program evaluation given the context, a number of limitations are inherent to this study design. Although PSM can match on observed variables (i.e., variables for which data is collected), there is the possibility that unobserved variables may differ between the treatment and matched comparison groups. For example, we were unable to match on variables such as race/ethnicity and level of severity of the CPS referral. Another example of potential unmeasured confounding includes motivation or willingness to change. Those families that completed CCR may also be families least likely to experience child welfare re-involvement because completing the program is an indicator of motivation to improve their situation, potentially biasing results in favor of the treatment group. These factors may differ between the treatment and matched comparison groups and may also be related to outcomes in ways unknown to the evaluation team.

Related to this, the PSM was also limited in the number of variables available to match on, in part because often times little information is collected for screened out referrals (e.g. lack of risk assessment variables), which was one of the eligible CCR populations. Matching took place within counties, so that each completer was required to have a match within the same jurisdiction. This was deemed necessary given that administration of both CCR and child welfare services occurs at the county level (or regional level for consortium sites), and program and county characteristics (such as service availability) vary across jurisdictions. Though necessary, this likely reduced the sample size in the outcomes analysis, as not all completers had matches available within their county.

For the pre-post survey analysis, Caregiver Posttest surveys were usually completed for CCR families that completed services, as surveys could not be completed for families that disengaged. It is possible that those who did not complete posttest surveys had more negative feelings towards the program than those who did, which could potentially bias survey results in favor of the program. In addition, the pre-post survey analyses did not have a comparison group; it is possible that survey responses would have improved over time regardless of program participation. However, it is encouraging to note that responses improved across both caregiver and worker surveys and across domains. Although it would be resource intensive, future evaluation efforts of similar programs may want to consider pre-post surveys on a comparison group that did not receive the intervention to account for potential bias and strengthen findings related to change in family functioning and protective factors. Such measures could also be used to improve the analysis of the theory of change mechanism. For example, having pre-post survey data on the comparison group would allow evaluators to assess whether changes in protective factors mediated the relationship between program completion and child welfare re-involvement outcomes.

Finally, regarding the interviews, limitations spanned three main areas. First, because the group was a convenience sample relying on volunteers for interviews, the interviewees did not represent all sites in the project; indeed, some sites had multiple interviewees per site, while others had one or none. Further, regarding the caregiver sample, many caregivers were either unable to reach due to inaccurate contact information at the time of the recruitment, failed to return phone calls or were no-shows to scheduled interviews (passive declines), or actively declined participation. This limits the interview findings in terms of generalizability, as staff or caregivers from non-represented sites or who declined to participate may have different impressions of CCR than what was captured here. Lastly, while OEC and not Kempe held the contracts for the CCR providers and conducted caregiver interviews after case closure (and also did not share the identity of the interviewees with the sites), respondents may have exhibited social desirability bias when recounting their experiences with CCR, minimizing negative sentiments.

Appendix A. CCR Caregiver Pretest Survey

CCR Caregiver Pretest

Date: ______________ Site: _______________________ Participant ID: ________________

1. **What is your gender?** ☐ Male ☐ Female
2. **What is your age (in years)?** _______
3. **What is your race/ethnicity? (Mark all that apply)**
   - ☐ Native American or Alaskan Native
   - ☐ Asian
   - ☐ African American
   - ☐ African Nationals/Caribbean Islanders
   - ☐ Hispanic or Latino
   - ☐ Middle Eastern
   - ☐ Native Hawaiian/Pacific Islanders
   - ☐ White (Non Hispanic/European American)
   - ☐ Other (please specify): _____________
4. **What is your marital status? (Please choose one)**
   - ☐ Married
   - ☐ Partnered
   - ☐ Single
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Separated
5. **What is your family housing situation? (Please choose one)**
   - ☐ Own
   - ☐ Rent
   - ☐ Shared housing with relatives/friends
   - ☐ Temporary (shelter, temporary with friends/relatives)
   - ☐ Homeless
6. **What is your annual household income? (Please choose one)**
   - ☐ $0-$10,000
   - ☐ $10,001-$20,000
   - ☐ $20,001-$30,000
   - ☐ $30,001-$40,000
   - ☐ $40,001-$50,000
   - ☐ more than $50,001
7. **What is the highest level of education that you've completed? (Please choose one)**
   - ☐ Elementary or junior high school
   - ☐ Some high school
   - ☐ High school diploma or GED
   - ☐ Trade/Vocational Training
   - ☐ Some college
   - ☐ 2-year college degree (Associate's)
   - ☐ 4-year college degree (Bachelor's)
   - ☐ Master's degree
   - ☐ PhD or other advanced degree

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

- ☐ Food Stamps
- ☐ TANF
- ☐ Medicaid (State Health Insurance)
- ☐ Head Start/Early Head Start Services
- ☐ Earned Income Tax Credit
- ☐ None of the above

Please check the box that best describes how often the statements are true for your family:

	Never	Very Rarely	Rarely	About Half the Time	Frequently	Very Frequently	Always
9. In my family we talk about problems.	☐	☐	☐	☐	☐	☐	☐
10. When we argue, my family listens to "both sides of the story."	☐	☐	☐	☐	☐	☐	☐
11. In my family, we take time to listen to each other.	☐	☐	☐	☐	☐	☐	☐
12. My family pulls together when things are stressful.	☐	☐	☐	☐	☐	☐	☐
13. My family is able to solve our problems.	☐	☐	☐	☐	☐	☐	☐

Please check the box that best describes how much you agree or disagree with the following statements:

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
14. I have others who will listen when I need to talk about my problems.	☐	☐	☐	☐	☐	☐	☐
15. When I am lonely, there are several people I can talk to.	☐	☐	☐	☐	☐	☐	☐
16. I would have no idea where to turn if my family needed food or housing.	☐	☐	☐	☐	☐	☐	☐
17. I wouldn't know where to go for help if I had trouble making ends meet.	☐	☐	☐	☐	☐	☐	☐
18. If there is a crisis, I have others I can talk to.	☐	☐	☐	☐	☐	☐	☐
19. If I needed help finding a job, I wouldn't know where to go for help.	☐	☐	☐	☐	☐	☐	☐

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 services*. Please write the child's age and date of birth and then answer questions with this child in mind.

20. Child's Age: ____________

21. Child's Date of Birth: ____/____/____

Please check the box that best describes how much you agree or disagree with the following statements.

	Strongly Disagree	Mostly Disagree	Slightly Disagree	Neutral	Slightly Agree	Mostly Agree	Strongly Agree
22. There are many times when I don't know what to do as a parent.	☐	☐	☐	☐	☐	☐	☐
23. I know how to help my child learn.	☐	☐	☐	☐	☐	☐	☐
24. My child misbehaves just to upset me.	☐	☐	☐	☐	☐	☐	☐

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
25. I praise my child when he/she behaves well.	☐	☐	☐	☐	☐	☐	☐
26. When I discipline my child, I lose control.	☐	☐	☐	☐	☐	☐	☐
27. I am happy being with my child.	☐	☐	☐	☐	☐	☐	☐
28. My child and I are very close to each other.	☐	☐	☐	☐	☐	☐	☐
29. I am able to soothe my child when he/she is upset.	☐	☐	☐	☐	☐	☐	☐
30. I spend time with my child doing what he/she likes to do.	☐	☐	☐	☐	☐	☐	☐

Thank you for your time!

Appendix B. CCR Worker Pretest Survey

CCR Worker Pretest

Date: ________________ Site: __________________ Participant ID: ________________

1. **Income:** Assesses family income adequacy using Federal Poverty Level (FPL)* guidelines

- **How many people are in your family (including yourself)?__________**
- **What is your total annual family income before tax?__________**
- Income does not include noncash such as CCAP, Medicaid, and SNAP, but it does include TANF, SSI, or other cast benefits.

❑	5	Family income is greater than 300% of poverty adjusted for family size.
❑	4	Family income is between 251%-300% of poverty adjusted for family size.
❑	3	Family income is between 201%-250% of poverty adjusted for family size.
		Prevention Line
❑	2	Family income is between 101-200% adjusted for family size.
❑	1	Family income is between 0-100% of poverty adjusted for family size.
❑	N/I	*Not enough information at this time*

*use table below (2014 FPL) or go to http://www.safetyweb.org/fpl.php for an online calculator.

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$11,670	$15,521	$17,505	$23,340	$29,175	$35,010	$46,680
2	15,730	20,921	23,595	31,460	39,325	47,190	62,920
3	19,790	26,321	29,685	39,580	49,475	59,370	79,160
4	23,850	31,721	35,775	47,700	59,625	71,550	95,400
5	27,910	37,120	41,865	55,820	69,775	83,730	111,640
6	31,970	42,520	47,955	63,940	79,925	95,910	127,880
7	36,030	47,920	54,045	72,060	90,075	108,090	144,120
8	40,090	53,320	60,135	80,180	100,225	120,270	160,360

2. **Employment:** Assesses the status and stability of employment

- Adult = Individuals responsible for children in the family.
- Employable = 1) Does not have a disability (not receiving SSI/SSD), 2) is over the age of 16, 3) is not retired, and/or 4) desires or needs employment.
- Stable Employment = in a permanent (regular/dependable) position for 3 months or longer.
- Benefits = earned vacation/sick/holiday pay; retirement plans; and/or health insurance.
- Full-time =at least 30 hours per week

❑	5	At least one adult has full-time stable employment AND access to employer-based benefits
❑	4	At least one adult has full-time stable employment
❑	3	At least one adult in the family is employed full-time AND no adult has stable employment
		Prevention Line
❑	2	At least one adult in the family has temporary or part-time employment AND no adult has full-time employment
❑	1	All employable adults in the family are not employed.
❑	N/I	*Not enough information at this time*
❑	N/A	*All adults are not employable*

3. Housing: Assesses the ability of the family to obtain appropriate housing of choice based on their circumstances

- Housing-cost burden calculation = monthly rent/mortgage ÷ monthly before tax income (e.g. $1000 rent ÷ $2000 monthly gross pay = 50% of income).
- Substandard = Any home that is not safe and adequate (i.e., dry, clean, pest-free, contaminant-free, well ventilated, and well maintained)

	Score	Description
❑	5	Without subsidies, owning or renting without cost burden (monthly mortgage/rent below 30% monthly pretax income). **AND** Living in a neighborhood of choice.
❑	4	Without subsidies, owning or renting without cost burden (monthly mortgage/rent below 30% monthly pretax income).
❑	3	**Any of the following:** • Living in steady subsidized or transitional housing that is safe and adequate • Monthly rent/ mortgage is 30-49.9% of monthly pretax income (moderate cost burden).
		Prevention Line
❑	2	**Any of the following:** • Living in substandard housing • Receiving short-term rental assistance • Facing threatened eviction or foreclosure • Monthly rent/ mortgage is 50% or more of monthly pretax income (severe cost burden).
❑	1	**Any of the following:** • Homeless • "Couch surfing" • Living in a shelter • Doubling up with others (do not include voluntary roommate situations) • Eviction notice • Forced displacement (fire; flood; discharge from institution with no housing).
❑	N/I	*Not enough information at this time*

4. Transportation: Assesses the degree to which family transportation needs are met

	Score	Description
❑	5	All family members **always** have transportation needs met through public transportation, a car, or a regular ride (100% of the time)
❑	4	All family members have transportation needs met at least **most of the time** through public transportation, a car, or a regular ride (about 3 out of 4 times /75%-99% of the time)
❑	3	All family members can find a way to meet basic transportation needs **some of the time** through public transportation, a car, or a regular ride (about 2 out of 4 times - 50% to 74% of the time)
		Prevention Line
❑	2	At least one family member's transportation needs are **inconsistently met** through public transportation, a car, or a regular ride (about 1 out of 4 times 25-49% of the time)
❑	1	Any family member **rarely** has transportation needs met through public transportation, a car, or a regular ride (< than 25% of the time)
❑	N/I	*Not enough information at this time*

5. Food Security: Assesses a family's level of food security based on USDA definitions

- According to the USDA, "food insecurity is limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways". http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement.aspx
- Families receiving public assistance for food will score 1 or 2 when they meet the conditions of very low or low food security, respectively; Families receiving public assistance for food should not score higher than a 3.
- Public assistance for food = food bank access within past month or enrolled in SNAP, WIC, food stamps, and/or Free/Reduced school lunch

Score	Description
❑ 5	**High food security:** Family members have no problems, or anxiety about, accessing enough quality food with variety
❑ 4	**Marginal food security** *without* reliance on public assistance for food. • Family members have anxiety about accessing food, but the quantity, quality, and variety of their food intake are not reduced **AND** family does not rely on public assistance for food.
❑ 3	**Reliance on public assistance for food** • The quantity, quality, and variety of food intake are not reduced **AND** the family relies on public assistance for food.
	Prevention Line
❑ 2	**Low food security** (disruption in *quality* and *variety* of food intake) Family has enough food **AND** any of the following: • They rely on a few types of lost-cost foods. • They can't afford to eat balanced meals.
❑ 1	**Very low food security** (disruption in *quantity* of food intake) • *Food intake reduced* for one or more family members because the household lacks money or other resources for food.
❑ N/I	*Not enough information at this time*

6. Child Care: Assesses the family's ability to obtain reliable, affordable, and quality childcare

- Unreliable = provider can't be counted on for pre-arranged care or inconvenient hours
- Quality=low provider/child ratios; developmentally appropriate toys; safe inside and outside play and sleep areas; adqueate supervision; little or no TV time; healthy food; caring and trained staff.
- Low quality = parent has concern about quality (e.g., high provider/child ratios; concerned that provider is unable to meet child's needs).
- Unaffordable = other basic needs are sacrificed to pay for child care
- Subsidies = Colorado Child Care Assistance Program (CCAP) or other public assistance programs that cover child care expenses
- For school-aged children under 12, consider out-of-school child care needs (e.g., summer, before/after school)

Score	Description
❑ 5	All of the following: • Child care is reliable • Child care is affordable **without subsidies** • Child care is quality • Reliable back-up child care options are available when needed
❑ 4	All of the following: • Child care is reliable • Child care is affordable **without subsidies** • Child care is quality
❑ 3	All of the following: • Child care is reliable • Child care is affordable **with subsidies** • Child care is quality
	Prevention Line
❑ 2	Any of the following (with or without CCAP or public assistance programs): • Child care is unreliable • Child care is low quality • Child care is unaffordable
❑ 1	Any of the following: • Needs child care, but none is available/ accessible. • Child is unsupervised and may be unsafe..
❑ N/I	*Not enough information at this time*
❑ N/A	*(No children < 12, children are in someone else's care (e.g. foster care),or family is able to adequately care for children and does not need child care)*

7. Child Education: Assesses school-aged children's access to and engagement in educational institutions

- Home-schooled children are enrolled in school if Colorado homeschool requirements are met: http://www.cde.state.co.us/choice/homeschool_law
- Consider teenagers, even if parents, as children unless they are emancipated minors or living as a stand-alone family unit
- School-aged = Grades 1-12.
- Truancy = 4 unexcused absences from public school in the past month.

❑	5	No child in the family has truancy / disciplinary actions at school AND all children are meeting academic achievement expectations AND any child is exceeding academic achievement expectations.
❑	4	No child in the family has truancy / disciplinary actions at school AND all children are meeting academic achievement expectations.
❑	3	No child in the family has truancy / disciplinary actions at school AND any child in the family is not meeting academic achievement expectations and is receiving academic support services.
		Prevention Line
❑	2	Any child in the family is experiencing any of the following: • Truancy or disciplinary actions at school • Not meeting academic achievement expectations and is not receiving academic support services
❑	1	Any child in the family is not enrolled in school
❑	N/I	*Not enough information at this time*
❑	N/A	*All children are not school-aged or have earned GED*

8. Adult Education: Assesses adult(s) academic, institution-based achievements

- Adult = Individual(s) responsible for children in the family; include emancipated minors
- Teen parents: If living with adult caregivers, consider teen parent's education in Child Education Domain; if living as a stand-alone family unit, then consider teen parent's education in Adult Education Domain.

❑	5	All adults in the family have a high school diploma or GED and have obtained any of the following: • A professional certification or training • An Associate's degree • A Bachelor's degree or higher
❑	4	At least one adult in the family has a high school diploma or GED and has obtained any of the following: • A professional certification or training • An Associate's degree • A Bachelor's degree or higher
❑	3	At least one adult in the family has a high school diploma or GED and is enrolled in post-secondary education or specialized training (professional certificate program, Associate's, Bachelor's).
		Prevention Line
❑	2	At least one adult in the family has a high school diploma or GED and is not pursuing further education.
❑	1	No adult in the family has a GED or high school diploma.
❑	N/I	*Not enough information at this time*

9. Cash Savings: Assesses the degree to which a family is building liquid assets via cash savings

- Cash savings refer to assets that are or can be quickly converted to cash without penalty. Examples include cash, checking, savings, money market, government-issued bonds.

❑	5	Three months or more of monthly income saved
❑	4	One to three months of monthly income saved
❑	3	Some but less than one month of monthly income of cash savings
		Prevention Line
❑	2	No cash savings and has plan or has just begun to implement cash savings
❑	1	No cash savings and no desire/ability to set savings goals
❑	N/I	*Not enough information at this time*

10. Debt Management: Assesses the degree to which a family is managing debt

❑	5	Family is debt-free
❑	4	Income pays towards debt and debt reducing (pays more than minimum monthly payments and is not adding to debt)
❑	3	Income pays towards debt and debt stabilized (pays minimum monthly payments and is not adding to debt)
		Prevention Line
❑	2	Income pays towards debt but debt increasing (pays minimum monthly payments and is adding to debt).
❑	1	Inability or limited ability to pay down debt (may be making payments but cannot meet minimum required payments)
❑	N/I	*Not enough information at this time*

11. Health Coverage: Assesses the degree to which family members have adequate medical health insurance

- Underinsured = unable to pay out-of-pocket medical expenses (family does not seek care because of out-of-pocket payments; family unable to pay current medical expenses)

❑	5	All family members have basic primary health insurance (other than Medicaid, CHP+, or CCIP) AND All family members have dental insurance.
❑	4	All family members have basic primary health insurance (other than Medicaid, CHP+, or CCIP)
❑	3	All family members have basic primary health insurance AND At least one family member receives coverage through: • Medicaid • CHP+ • CCIP
		Prevention Line
❑	2	Any of the following: • Some family members are uninsured • Family is underinsured.
❑	1	All family members are uninsured.
❑	N/I	*Not enough information at this time*

12. Physical Health: Assesses degree to which any family member's physical health concerns interfere with life activities

- Important life activities include work, school, caring for children, managing a household (shopping, preparing meals, cleaning, etc.), or reaching developmental milestones for young children
- Consider the impact of a family members' physical health concerns on other family members as well as themselves

❑	5	Family member(s) have no known ongoing physical health problems
❑	4	Family member(s) physical health concerns **typically do not** interfere with important life activities • In past month, health concerns taken care of without work/school absences
❑	3	Family member(s) physical health concerns **only occasionally** interfere with important life activities **Any of the following** • Missed work/school 1 time last month due to illness/treatments • Was late to work/school/scheduled appts, but not more than 1 time in the past month due to illness/treatments
		Prevention Line
❑	2	Family member(s) physical health concerns **considerably** interfere with important life activities **Any of the following** • Missed work/school 2 or more times in past month due to illness/treatments • Late to work/school/scheduled appts 2 or more times in past month due to illness/treatments • Work opportunities limited due to health concerns • Physical health concerns create considerable stress and/or disrupt family functioning
❑	1	Family member(s) physical health concerns **prohibit** important life activities
❑	N/I	*Not enough information at this time*

13. Mental Health: Assesses degree to which any family member's mental health issues interfere with life activities

- Important life activities include work, school, caring for children, managing a household (shopping, preparing meals, cleaning, etc.), or reaching developmental milestones for young children
- Consider the impact of family members' mental health issues on other family members as well themselves
- Mental health issues can include symptoms of illnesses (e.g., anxiety, depression) without diagnosis

❑	5	Family member(s) have no known ongoing mental health problems
❑	4	Family member(s) mental health concerns **typically do not** interfere with important life activities • In past month, mental health concerns taken care of without work/school absences
❑	3	Family member(s) mental health concerns **only occasionally** interfere with important life activities **Any of the following** • Missed work/school 1 time last month due to illness/treatments • Was late to work/school/scheduled appts, but not more than 1 time in the past month due to illness/treatments
		Prevention Line
❑	2	Family member(s) mental health concerns **considerably** interfere with important life activities **Any of the following** • Missed work/school 2 or more times in past month due to illness/treatments • Late to work/school/scheduled appts 2 or more times in past month due to illness/treatments • Work opportunities limited due to health concerns • Mental health concerns create considerable stress and/or disrupt family functioning
❑	1	Family member(s) mental health concerns **prohibit** important life activities
❑	N/I	*Not enough information at this time*

14. Substance Abuse: Assesses degree to which any family member's substance abuse interfere with important life activities

- Important life activities include work, school, caring for children, managing a household (shopping, preparing meals, cleaning, etc.)
- Consider the impact of family members' substance use on other family members as well as themselves

❑	5	**Any of the following:** • Abstains from substances • May use prescription drugs as prescribed or alcohol/marijuana (aged 21+) without negative consequences • Continued sobriety for one year or longer
❑	4	Continued sobriety for at least 6 months but less than one year
❑	3	**Any of the following:** • Family member(s) occasionally experience negative consequences from substances, but does not interfere with life activities • Continued sobriety for at least 3 months but less than 6 months
		Prevention Line
❑	2	**Any of the following:** • Misses or is late to work/school due to substance use • Substance abuse create considerable stress and/or disrupt family functioning • Continued sobriety for less than 3 months • Use of substances by underage youth during past month but does not prohibit important life activities or create an unsafe environment
❑	1	**Any of the following:** • Abuse of substances by a family member prohibits important life activities • Abuse of substances by a family member creates an unsafe environment
❑	N/I	*Not enough information at this time*

Please check the area(s) where you would MOST like to make a change:

Area	Rating	Area	Rating
☐ Employment	_______	☐ Adult Education	_______
☐ Housing	_______	☐ Income	_______
☐ Transportation	_______	☐ Cash Savings	_______
☐ Food Security	_______	☐ Debt Management	_______
☐ Child Care	_______	☐ Health Coverage	_______
☐ Child Education	_______	☐ Physical Health	_______
☐ Child Development	_______	☐ Mental Health	_______
☐ Parenting Skills	_______	☐ Substance Use	_______
☐ Social Support	_______	☐ Other	_______

15. On a scale from 1 to 10, how ready are you to make a change in those areas? Please mark your rating next to the items that you checked above.

1	2	3	4	5	6	7	8	9	10
Not at all Ready									Extremely Ready

16. Please describe your goals in each of the areas you identified above:

Income and Benefits Inventory

Please tell me whether you receive any of the following sources of income:

17. Colorado Child Care Assistance Program
    - ☐ Yes If yes, monthly amount: $____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

18. Colorado Preschool Project or Head Start
    - ☐ Yes If yes, monthly amount: $____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

19. Free or reduced price school meals
    - ☐ Yes If yes, monthly amount: $____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

20. Health Insurance (e.g. Colorado Child Health Plan Plus, Colorado Indigent Care Program, Colorado Medical Assistance program, or other health insurance)
    - ☐ Yes If yes, monthly amount: $____________
      If yes, please specify: ____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

21. Colorado Food Assistance Program (SNAP)
    - ☐ Yes If yes, monthly amount: $____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

22. Colorado Works/Temporary Assistance to Needy Families (TANF)
    - ☐ Yes If yes, monthly amount: $____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

23. Disability benefits (SSI; SSDI)
    - ☐ Yes If yes, monthly amount: $____________
      If yes, please specify: ____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

24. Worker's Compensation
    - ☐ Yes If yes, monthly amount: $____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

25. Child Support (court-ordered)
    - ☐ Yes If yes, monthly amount: $____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

26. Public housing voucher or subsidy (Section 8, etc.)
    - ☐ Yes If yes, monthly amount: $____________
      If yes, please specify: ____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

27. Rental assistance
    - ☐ Yes If yes, monthly amount: $____________
    - ☐ No If no, potentially eligible? ☐ Yes ☐ No

28. WIC (Women, Infants, and Children's Assistance)
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

29. Earned Income Tax Credit or state earned income credit
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

30. Unemployment Insurance
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

31. Social security benefits (SSA) or other private/government retirement pension
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

32. Utility assistance (Energy Outreach CO, LEAP)
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

33. Emergency assistance
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

34. Foster child payments/adoption subsidy
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

35. Kinship Care payments
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

36. Food pantry/community meal use
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

37. Safelink telephone
☐ Yes If yes, monthly amount: $____________
☐ No If no, potentially eligible? ☐ Yes ☐ No

38. Work earnings within last 30 days, including self-employment, before taxes or other deductions
☐ Yes If yes, monthly amount: $____________
☐ No If no, is caregiver looking for work? ☐ Yes ☐ No

39. Partner/Spouse's work earnings within last 30 days, including self-employment, before taxes or other deductions
☐ Yes If yes, monthly amount: $____________
☐ No If no, is partner/spouse looking for work? ☐ Yes ☐ No

40. Other household adult's work earnings within last 30 days, including self-employment, before taxes or other deductions
☐ Yes If yes, monthly amount: $____________
☐ No If no, is other adult looking for work? ☐ Yes ☐ No

41. Any other sources of income, specify:

☐ Yes — If yes, monthly amount: $______________

If yes, please specify: ______________

☐ No

42. Total monthly income based on Income and Benefits Inventory: $ ___________ /month

43. From month to month, is this amount:

☐ About the same

☐ Usually higher

☐ Usually lower

Appendix C. CCR Caregiver Posttest Survey

The CCR Caregiver Posttest included a restatement of the Protective Factors Survey questions from the Caregiver Pretest Survey (minus demographic questions) followed by:

21. How did you feel after the first time you had contact with CCR? Check all that apply:

☐ Relieved	☐ Thankful	☐ Disrespected
☐ Worried	☐ Afraid	☐ Angry
☐ Stressed	☐ Encouraged	☐ Comforted
☐ Respected	☐ Hopeful	☐ Discouraged

22. How did you feel after the last time you had contact with CCR? Check all that apply:

☐ Relieved	☐ Thankful	☐ Disrespected
☐ Worried	☐ Afraid	☐ Angry
☐ Stressed	☐ Encouraged	☐ Comforted
☐ Respected	☐ Hopeful	☐ Discouraged

Please select the answer that is closest to how you feel *right now* about working with CCR.

		Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
23.	My CCR worker and I agreed about what's best for my child(ren).	☐	☐	☐	☐	☐
24.	I needed some help to make sure my kids have what they need.	☐	☐	☐	☐	☐
25.	I could talk to my CCR worker about what's important to me.	☐	☐	☐	☐	☐
26.	CCR helped me take care of problems in our lives.	☐	☐	☐	☐	☐
27.	What CCR wanted me to do was the same as what I wanted.	☐	☐	☐	☐	☐
28.	Things got better for my child(ren) because CCR was involved.	☐	☐	☐	☐	☐
29.	My CCR worker and I respected each other.	☐	☐	☐	☐	☐
30.	CCR helped my family get stronger.	☐	☐	☐	☐	☐
31.	CCR listened to what my family had to say.	☐	☐	☐	☐	☐
32.	CCR understood my family's needs.	☐	☐	☐	☐	☐
33.	CCR recognized the things that my family does well.	☐	☐	☐	☐	☐
34.	CCR considered my family's culture when working with us.	☐	☐	☐	☐	☐
35.	I am a better parent or caregiver because of my experience with CCR.	☐	☐	☐	☐	☐
36.	My children are safer because of our experience with CCR.	☐	☐	☐	☐	☐
37.	I am better able to provide necessities like food, clothing, shelter, or medical services because of my experience with CCR.	☐	☐	☐	☐	☐
38.	CCR provided services to meet my family's needs.	☐	☐	☐	☐	☐
39.	Overall, I am satisfied with how my family was treated by CCR.	☐	☐	☐	☐	☐

CCR Caregiver Posttest 3

		Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
40.	Overall, I am satisfied with the help my family received through CCR.	☐	☐	☐	☐	☐
41.	I would call CCR if my family needed help in the future.	☐	☐	☐	☐	☐

42. Did your family receive help from any of the following groups/agencies because of your involvement with CCR? *Check all that apply.*

☐ School
☐ Neighborhood organization
☐ Mental health provider
☐ Alcohol/drug rehab agency
☐ Youth organization
☐ Neighbors/friends
☐ Legal services provider
☐ Support group
☐ Child care/Head Start
☐ Domestic violence agency
☐ Emergency food provider
☐ Extended family
☐ Health care provider
☐ Job service/employment security
☐ Employment and training agency
☐ Church or religious organization
☐ Recreational facility (ex: YMCA)
☐ Other (please specify): - ____________________

If you did not receive help from any of these groups/agencies, please skip to Question 44.

43. If you received help or services, how effective were they in helping with your problems?

☐ Not at all effective
☐ Slightly effective
☐ Moderately effective
☐ Very effective

44. Was there any help that you or your family needed but did not receive?

☐ No
☐ Yes. *Please tell us what help you needed but did not receive:*

____

____

45. Overall, is your family better off or worse off because of your experience with CCR? Check only one response:

☐ We are better off ☐ We are the same ☐ We are worse off

Thank you for your time!

Appendix D. CCR Worker Posttest Survey

The CCR Worker Posttest included a restatement of the CFSA II (minus the goal setting questions) and Income-Benefits Inventory from the Worker Pretest Survey followed by:

The following sections are to be completed WITHOUT the caregiver's assistance.

Parent Engagement

In this section we are interested in your feelings about the primary caregiver's involvement with your agency, as well as your relationship with the primary caregiver. There are no right or wrong answers to any of these questions.

	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
44. I think primary caregiver believed s/he would get the help s/he really needed from my agency.	☐	☐	☐	☐	☐
45. I think primary caregiver realized that s/he needed some help to make sure his/her kids have what they need.	☐	☐	☐	☐	☐
46. I think primary caregiver really wanted to make use of the services that my agency provided to her/him.	☐	☐	☐	☐	☐
47. I think primary caregiver found it difficult to work with me.	☐	☐	☐	☐	☐
48. I think primary caregiver would say that working with my agency has given him/her more hope about how his/her life is going to go in the future.	☐	☐	☐	☐	☐
49. I think primary caregiver would say that s/he and I respect one another.	☐	☐	☐	☐	☐
50. I think primary caregiver would say that s/he and I agreed about what is best for her/his child.	☐	☐	☐	☐	☐
51. I think primary caregiver would say that things will get better for him/her children because my agency is involved.	☐	☐	☐	☐	☐
52. I think primary caregiver would say that what my agency wanted her/him to do is the same as what s/he wanted.	☐	☐	☐	☐	☐
53. I think primary caregiver would say that my agency has helped her/his family take care of some of their problems.	☐	☐	☐	☐	☐
54. I think primary caregiver would say that my agency helped her/his family get stronger.	☐	☐	☐	☐	☐

CCR Worker Posttest - FINAL 10

55. The following is a list of services that are sometimes provided to families.

For each service, please check *all* circumstances that applied for this family. If column (1), "Service not needed by family" is selected, please proceed to the next service need:

For each *service need*, please answer the following questions.	(1) *Service not needed by family*	(2) *Service needed and already in place at start of case*	(3) *Service needed and not in place at start of case*	(4) *Info/ referral provided*	(5) *Service provided*
a. Material Needs (e.g., housing, food/clothing, income, employment, etc.)	☐	☐	☐	☐	☐
b. Substance Abuse (e.g., alcohol, prescription drugs, illicit drugs, etc.)	☐	☐	☐	☐	☐
c. Parent developmental/cognitive disability	☐	☐	☐	☐	☐
d. Parent physical disability or chronic health condition	☐	☐	☐	☐	☐
e. Child developmental/cognitive disability	☐	☐	☐	☐	☐
f. Child physical disability or chronic health condition	☐	☐	☐	☐	☐
g. Parent mental health	☐	☐	☐	☐	☐
h. Child mental health	☐	☐	☐	☐	☐
i. Parenting Skills/Discipline	☐	☐	☐	☐	☐
j. Domestic Violence	☐	☐	☐	☐	☐
k. Child Education (e.g., school attendance, progress, etc.)	☐	☐	☐	☐	☐
l. Medical care	☐	☐	☐	☐	☐
m. Social Supports (e.g., extended family, friends, neighbors, etc.)	☐	☐	☐	☐	☐

Thank you for your time!

Appendix E. CCR Staff Interview Protocols

Interview Protocol for CCR Supervisors

1. How long have you been practicing in a social work-related field/with families?
    a. How long have you been supervising? Did you practice in the field prior to that?
    b. When did you start as a CCR supervisor?
        i. How many people do you supervise?
        ii. Do you supervise CCR only or other things as well?
        iii. Do you also take CCR cases as a worker? How often?

2. You receive referrals that child welfare has screened out or has closed after assessment (interviewer will know based on site design, and will tailor question).
    a. Tell us about your referral process. **(MCG only)**
        i. What information do you get about families in advance of outreaching?
        ii. What other information, if any, would help you in your work with families referred for CCR?
        iii. Is there any information you get that you wish you didn't get?
        iv. Based on the referrals you received, do you believe these families were appropriate for CCR (Target Population)?
    b. Can you describe your relationship with the child welfare agency? (**Community agency-administered programs only**)?
        i. What has contributed positively or negatively to the relationship?

3. We would like to know more about the resources your team utilizes or other agencies your team partners with in the community.
    a. How do your team access community resources needed for the families you work with? (Prompt: What resources does your community need more of? What resources do your team use often?)

4. What would you describe are the core program elements of CCR or the core services your agency provides through CCR? (Prompts: protective factors, financial assistance, goal setting?)
    a. Do you follow a preset program model for all CCR families that receive services? (E.g. Wayfinder, Parents as Teachers, etc.)

5. We want to know more about the outreach process and how you are able to engage families to participate in CCR.
    a. What do you believe has contributed to your worker's ability to successfully engage families to participate in CCR?
    b. What do you believe have been barriers to your worker's ability to engage families in CCR?

c. If your agency serves both screened out and closed after assessment families, do you find that families from each group have a different level of interest in participating?

6. We want to know about your agency's experience providing CCR services to families who agree to work with you.
    a. On average, how long are workers involved with CCR families? Do you think that length of time allows them to achieve their goals?
    b. Have you heard any feedback regarding the CFSA from workers or families? (Prompt: negative or positive uses, family's experience using it as it relates to information sharing/goal setting)
    c. Flex funding:
        i. Tell us about how you utilized flex funding with families? What were the criteria for applying for the flexible funding and how often do you approve requests for flex funding?
    d. Financial literacy:
        i. What kinds of support were offered to increase financial literacy?
        ii. Did your team utilize a curriculum or program to improve financial literacy with CCR families? If so which one?
        iii. From your perspective, what aspects of that program have been most successful with the CCR families?
    e. What do you perceive as the most important factors in cases where families achieve their goals? (Prompts: What do you do as a supervisor to help workers in these situations? What do workers do to help make families successful? What do the families do to help create success?)
    f. For families who accept CCR but do not complete services/achieve their goals, what do you think can be learned?
        i. Are there barriers to families achieving their goals?
        ii. How or when do you make the decision to close cases where families have disengaged?

7. What do you enjoy about supervising in the CCR program?
    a. What do you wish was different/what do you think can be done to improve the CCR program?

8. Is there anything else you believe would be helpful for us to know when evaluating CCR?

Interview Protocol for CCR Workers

1. How long have you been practicing in a social work-related field/with families?

2. When did you start as a CCR worker?

3. You receive referrals that child welfare has screened out or has closed after assessment (interviewer will know based on site design, and will tailor question).
    a. Tell us about your referral process. **(MCG only)**
        i. What information do you get about families in advance of outreaching?
        ii. What other information, if any, would help you in your work with families referred for CCR?
        iii. Is there any information you get that you wish you didn't get?
        iv. Based on the referrals you received, do you believe these families were appropriate for CCR (Target Population)?
    b. Can you describe your relationship with the child welfare agency? (**Community agency-administered programs only**)?
        i. What has contributed positively or negatively to the relationship?

4. What would you describe are the core program elements of CCR or the core services you provide through CCR? (Prompts: protective factors, financial assistance, goal setting?)
    a. Do you follow a preset program model for all CCR families that receive services? (E.g. Wayfinder, Parents as Teachers, etc.)

5. We want to know more about the outreach process and how you are able to engage families to participate in CCR.
    a. How do you explain the CCR program to families?
    b. What, if any, information do you share with families about the CCR referral?
    c. What do you believe has contributed to your ability to successfully engage families to participate in CCR?
    d. What do you believe have been barriers to your ability to engage families in CCR?
    e. Across Colorado, families accept to participate in CCR services about 30% of the time. Thinking about the families who you have outreached to, but have declined to participate, what are the factors that you believe contributed to their decision?
    f. If your agency serves both screened out and closed after assessment families, do you find that families from each group have a different level of interest in participating?

6. We want to know about your experience providing CCR services to families who agree to work with you.
    a. Can you tell us how you approach goal setting with a family?
        i. On average, how long are you involved with CCR families? Do you think that length of time allows them to achieve their goals?

ii. Tell us your experience with using the CFSA with CCR families.
iii. What was the families' perception of the CFSA as it relates to sharing information and family goal setting?

b. Flex funding:
   i. Tell us about how you utilized flex funding with families? What were the criteria for applying for the flexible funding and how often do you request flex funding?
c. Financial literacy:
   i. What kinds of support were offered to increase financial literacy?
   ii. Did you utilize a curriculum or program to improve financial literacy with CCR families? If so which one?
   iii. From your perspective, what aspects of that program have been most successful with the CCR families?
d. Can you provide an example of a family who achieved their goals through their participation with CCR? (Success story?)
   i. What do you think contributed to their success? (Prompts: What did you do to help make this a success? What did the family do to help make this a success?)
e. Can you provide an example of a family who accepted CCR, but did not successfully complete services/achieve their goals?
   i. What do you think can be learned from those families who did not complete services?

7. We are interested in hearing more about your experience as a CCR worker.
   a. Are you a dedicated full-time CCR worker? If no, what is your percentage of time spent on CCR and/or what other roles do you have?
   b. How do you access community resources needed for the families you work with? (Prompt: What resources does your community need more of? What resources do you use often?)
   c. What do you enjoy about working in the CCR program?
      What do you think can be done to improve the CCR program?

6. Is there anything else you believe would be helpful for us to know when evaluating CCR?

Appendix F. CCR Caregiver Interview Protocol

Description of Interviewee:

- What agency and worker delivered CCR? ____________________________
- Reason for case closure (as indicated in Referral Log): _________________________________

1. We want to know more about the outreach process and how your family agreed to participate in the CCR program. Try to think back to when you first agreed to do CCR--
    a. How was CCR explained to you?
    b. Do you remember when your CCR worker first reached out to you? What was that like?
    c. What made you want to work with your CCR worker? What did he/she do?
    d. Did you have any worries when you first started working with CCR? If so, what were they?
2. We want to know about your experience receiving CCR services.
    a. Can you tell us how you set goals with your CCR worker? What was that like? Did your worker use the CFSA? How did you use it?
    b. Did you feel like you met all the goals you made in the CCR program?
        i. If yes, what did you do to meet those goals? What did your CCR worker do?
        ii. If not, why not?
    c. Can you tell us about the resources provided as part of your participation in CCR (both formal and informal)?
    d. What resources did you need that were not available?
    e. Flex funding:
        i. Did you use any funding from CCR? What was the funding used for? How did that impact your family?
    f. Financial literacy:
        i. Did you get any support with understanding or improving your family's financial situation? What was that like?
    g. Think about your family before and after you participated in CCR: what changes occurred?
3. If a friend or family member was considering participating in CRR, what would you tell them about your experience?
4. How was the decision made to close your case when you stopped working with CCR?
5. Is there anything else you believe would be helpful for us to know when evaluating CCR?

Appendix G. CCR Staff Survey Protocol

Note: The survey will be customized based on respondent. Some questions will only display for workers and others for supervisors. Certain questions will be tailored so that information is pre-populated based on site. For example, in questions pertaining to outreach acceptance and active decline statistics can be inserted so that the worker/supervisor is primed to respond based on their specific engagement rates.

Survey Intro:

We are asking you to complete a survey about your experience working in the Colorado Community Response program (CCR). We are interested in your experiences, perceptions, and opinions about the program generally and your job specifically, including challenges you face in your day-to-day work. There are no right or wrong answers. Below is some additional information about the survey and the protections we have put in place for participants:

- This survey is not a performance assessment - we have no intention of using your answers as a judgement of your competence or effectiveness as a CCR staff member. Rather your answers will help illuminate challenges and best practices that will inform future training and implementation of CCR as well as provide context to other evaluation findings.
- Your answers will become part of summary reports in which no individual staff members are directly identified. For example, data will be summarized in the following way: "13 out of 22 staff had been with the program for 2 years or longer; common challenges to engaging families reported by 20 out of 22 staff include X, Y, and Z..."
- Data from your site is included within this survey to help inform your answers - this data was pulled from the original evaluation Referral Logs that were in use in the sites from November 2014-June 2017. These data help tell the story of CCR in your site - your answers provide meaningful context to those numbers. Even if you are a newer staff, you may find them useful.

The survey should take no more than 25 minutes to complete and you are being provided with the opportunity to complete the survey in lieu of the monthly implementation call today. Please try to complete the survey in one sitting during the time provided today.

Thank you for your time!

Should you have any questions or feedback about this survey, please contact Heather Allan, Evaluation Coordinator at the Kempe Center at heather.allan@ucdenver.edu.

Question	Response Type/Set
Staff Background	
1. What is your role in the agency?	Supervisor/Worker
2. Do you have any other roles besides CCR at your agency?	Y/N
3. If yes, what percentage of your time is dedicated to CCR?	Open-Ended (%)
If Supervisor:	Y/N

4. Do you outreach or provide services to CCR families? 5. How often do you provide supervision to your CCR advocate? 6. Please describe how you monitor CCR advocate caseload?	Less than once per month 1-3 times per month Once per week More than once per week Open-ended
If Worker: 7. How many CCR referrals are you currently outreaching to? 8. What is your current caseload (i.e. how many open/active CCR cases are you working with right now)? 9. In your opinion, how many cases is an ideal CCR caseload? 10. On average, how many hours per week do you spend on *each* family on your CCR caseload? This may be in-person or phone contacts and includes work you are doing on behalf of a family (e.g. working on a referral).	Open-ended (#) Open-ended (#) Open-ended (#) < 1 hour 1-2 hours 2-3 hours 3-4 hours > 4 hours
11. How long have you worked in the CCR program?	0-3 months 4-6 months 7-12 months 1-2 years > 3 years
12. Please describe the core components of the CCR program as you understand them.	Open-ended
13. How do you collaborate with your county CPS partner to ensure that you receive adequate referrals and county partners understand the CCR program model?	Open-ended
14. Prior to the CCR program, how long did you work in a child/family serving agency?	<1 year 1-5 years 6-10 years >10 years
15. What is the highest level of education that you have completed?	Some high school High school diploma/GED Some college Associate's Degree (please specify major) Bachelor's Degree (please specify major) Master's Degree (please specify) PhD or other advanced degree (please specify)
Referral and Outreach	
16. Are there other data systems you access in an attempt to obtain more reliable contact information (TRAILS, CBMS, ETO, etc.)?	Yes (please specify) No
17. Do you have thoughts, ideas, or suggestions on how to reach families referred to CCR when contact	Yes (please explain) No

information provided in the referral is inaccurate or missing?	
18. Besides inaccurate/missing contact information, what are the main barriers you encounter when attempting to outreach to referred families?	Open-ended
19. When you first speak to families, how do you explain the CCR program to them?	Open-ended
20. During the outreach process (prior to intake), how often do you tell families that you received their referral from child welfare?	Always Sometimes Never
21. You answered that you (always/sometimes/never) disclose to the family that you received their CCR referral from child welfare during the outreach process. Please share how and why you do/don't explain the origins of the CCR referral to the family.	Open-ended
22. Your site, XXX, has an XXX acceptance rate. What contributes to your XXX families agreeing to participate in CCR?	open-ended
23. Your site, XXX, has an XXX *active* decline rate. What contributes to XXX families declining to participate in CCR?	open-ended
Services	
24. Following an intake, what do you do to help families remain engaged in the program?	open-ended
25. In your site, XXX, XXX percent of families have their case closed after "successful completion of CCR services." How do you define a "successful completion of services?"	open-ended
26. In your site, XXX, XXX percent of families disengage or opt-out after intake. What are barriers to families remaining engaged through the entire CCR program?	open-ended
27. On average, how frequently do you communicate with your open CCR families?	Less than once a week 1-2 times per week 3-4 times per week 5 or more times per week
28. The average length of a CCR case in XXX site is XXX days. Program guidelines stipulate that CCR cases should be open between 3-4 months (90-120 days). What situations, if any, cause you to keep cases open for longer than the guidelines suggest?	Open-ended
29. The average length of a CCR case in XXX site is XXX days. Program guidelines stipulate that CCR cases should be open between 3-4 months (90-120 days). What situations, if any, cause you to keep cases open for less time than the guidelines suggest, excluding	Open-ended

cases of family disengagement or discontinued eligibility?	
30. Financial education is a core component of the CCR program. How do you address this in your work with families?	Open-ended
31. What are examples of how you have used flex funding with families?	Open-ended
32. What are the services/resources requested by the families you serve? Please select at least 3.	Child/youth education Adult education Child/youth mental health Adult mental health Substance use/abuse Youth organizations/extracurriculars (e.g. Boys and Girls Club) Social supports/support groups Legal assistance Child care/Head Start Domestic violence Emergency food assistance Health care Job service/employment Church or religious organization Housing assistance Parenting classes/support groups Assistance with benefits (i.e. TANF, Medicaid, SNAP, WIC, etc.)
33. Are there any services that your CCR families need but are not available in your community?	Yes (please specify) No, our community has adequate services to meet family needs
34. For services that are available, what are the barriers to accessing those services?	Open-ended
General Feedback	
35. On a scale of 1-10 where 1 is "not effective at all" and 10 is "extremely effective", how effective do you think CCR is at helping families achieve the following goals:	-To increase families' protective capacities by promoting individual, family, & community strengths -Connecting families to vital economic and other support services through resource referral -Helping families work towards economic self-sufficiency through financial education and coaching -Providing cash assistance (flex funds) for immediate needs related to child and family well-being
36. What do you enjoy the most about working in the CCR program?	
37. What do you enjoy the least about working in the CCR program?	
38. Is there anything else you would like us to know about your work with CCR?	