WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia

Strengthening families & children within their home communities

Semi-Annual Progress Report

October 1, 2018 – April 30, 2019

West Virginia Department of
Health and Human Resources

Bureau for Children and Families

350 Capitol St. Room 730
Charleston, WV 25301
(304) 356-0268
www.dhhr.wv.gov

Table of Contents

I. Overview

West Virginia was awarded our approval to proceed with our Demonstration Project, Safe at Home West Virginia, on October 14, 2014. Safe at Home West Virginia is high fidelity wraparound aimed at 12-17-year old's currently in congregate care settings in West Virginia or out-of-state and those at risk of entering a congregate care setting. West Virginia also plans to universalize the use of the WV CANS across child serving systems.

Recognizing the way we have traditionally practiced may not always result in the best possible outcomes for our children and families, we are now engaging in a process that creates a new perspective. In partnership with youth and families, we will collaborate with both public and private stakeholders, including service providers, school personnel, behavioral health services, probation, and the judicial system to demonstrate that children currently in congregate care can be safely and successfully served within their communities. By providing a full continuum of supports to strengthen our families and fortifying our community-based services, we can demonstrate that youth currently in congregate care can achieve the same or higher indicators for safety and well-being while remaining in their home communities.

Safe at Home West Virginia Wraparound will help improve identification of a youth's and family's strengths and needs; reduce the reliance on congregate care and length of stay in congregate care; reduce the reliance on out-of-state residential care; improve the functioning of youth and families, including educational attainment goals for older youth; improve timelines for family reunification; and reduce re-entry into out-of-home care. The benefits of a wraparound approach to children and families include:

- One child and family team across all service environments;
- The family's wraparound plan unifies residential and community treatment;
- Wraparound helps families build long-term connections and supports in their communities;
- Provides concurrent community work while youth is in residential care for a smooth transition;
- Reduces the occurrence and negative impact of traumatic events in a child's life;
- Access to mobile crisis support, 24 hours per day, seven days per week; and
- Crisis stabilization without the need for the youth to enter/re-enter residential care.

As we begin to redirect funds from congregate care using a universal assessment and thresholds; changing our culture of relying on bricks and mortar approaches to treatment; and implementing wraparound to prevent, reduce, and support out-of-home care, we will free up funding to redirect into building our community-based interventions and supports. We will use the assessed target treatment needs from the WV CANS to guide our decision about the best evidence-informed treatment for the targeted needs at the community level and begin to develop a full array of proven interventions to meet the individual needs of children and families in their communities. This approach and model will lead to our children getting what they need, when they need it, and where they need it. It will also enhance our service delivery model to meet the needs and build on the strengths of the families of the children.

There are no significant changes in the design of our interventions to date.

Theory of Change

We implement CANS and NWI

So That

We have clear understanding of family strengths and needs

And

A framework/process to address those strengths and needs

So that

Families will receive the appropriate array of services and supports

And

Are more engaged and motivated to care for themselves

So that

Families become stabilized and/or have improved functioning

So that

Families have the knowledge and skills to identify and access community services and supports and can advocate for their needs

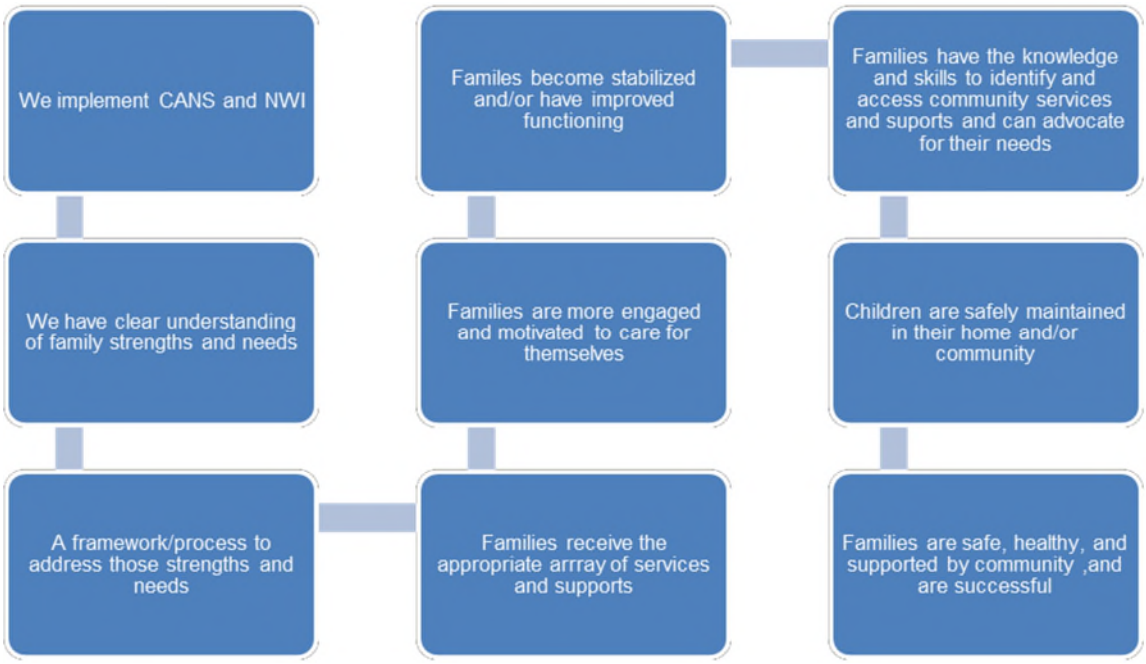
So that

Children are safely maintained in their home and/or community

And

Families are safe, healthy, supported by community, and are successful

Safe at Home West Virginia Theory of Change



Safe at Home West Virginia Logic Model

Inputs	Interventions	Outputs	Outcome Linkages	Short-term Outcomes	Intermediate/ System Outcomes
• Youth 12-17 in open cases • Flexible funding under Title IV-E waiver • CAPS/CANS tools • Caseworkers trained in wraparound service provision • Multi-disciplinary team • Courts • Coordinating agencies • Service providing agencies	• CAPS/CANS assessments to determine need for wraparound services • Intensive Care Coordination model of wraparound services • Next Steps model of wraparound services	• Number of youth[1] assessed with CAPS/CANS • Number of youth and families engaged in wraparound services while youth remains at home • Number of youth engaged in wraparound services while in non-congregate care out-of-home placement • Number of youth engaged in wraparound services while in congregate care	• Compre-hensive assessments lead to service plans better aligned to the needs of the youth and their families • Delivery of services tailored to the individual needs of the youth and families results in stronger families and youth with fewer intensive needs	• More youth leaving congregate care • Fewer youth in out-of-state placements on any given day • More youth return from out-of-state placements	• Fewer youth enter congregate care • The average time in congregate decreases • More youth remain in their home communities • Fewer youth enter foster care for the first time • Fewer youth re-enter foster care after discharge • Fewer youth experience a recurrence of maltreatment • Fewer youth experience physical or mental/ behavioral issues • More youth maintain or increase their academic performance

[1] All references to youth in the logic model refer to youth in open cases who are between 12 and 17.

II. Demonstration Status, Activities, and Accomplishments

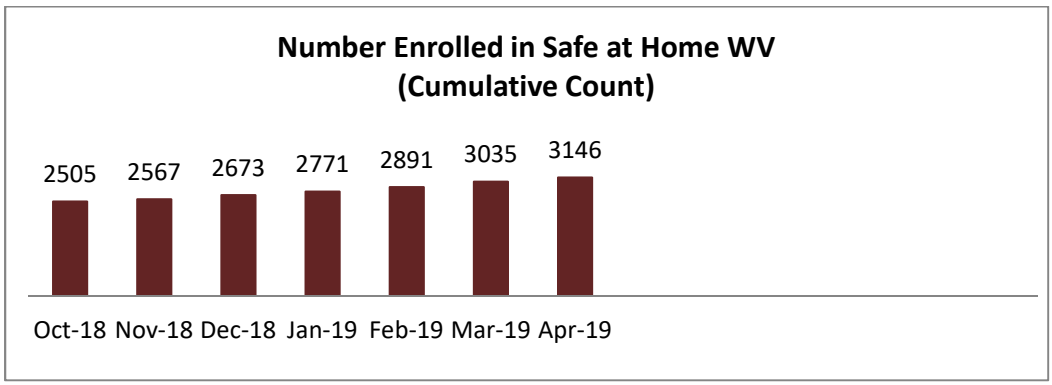
Current progress reporting period October 1, 2018 – April 30, 2019
Status, Activities, and Accomplishments

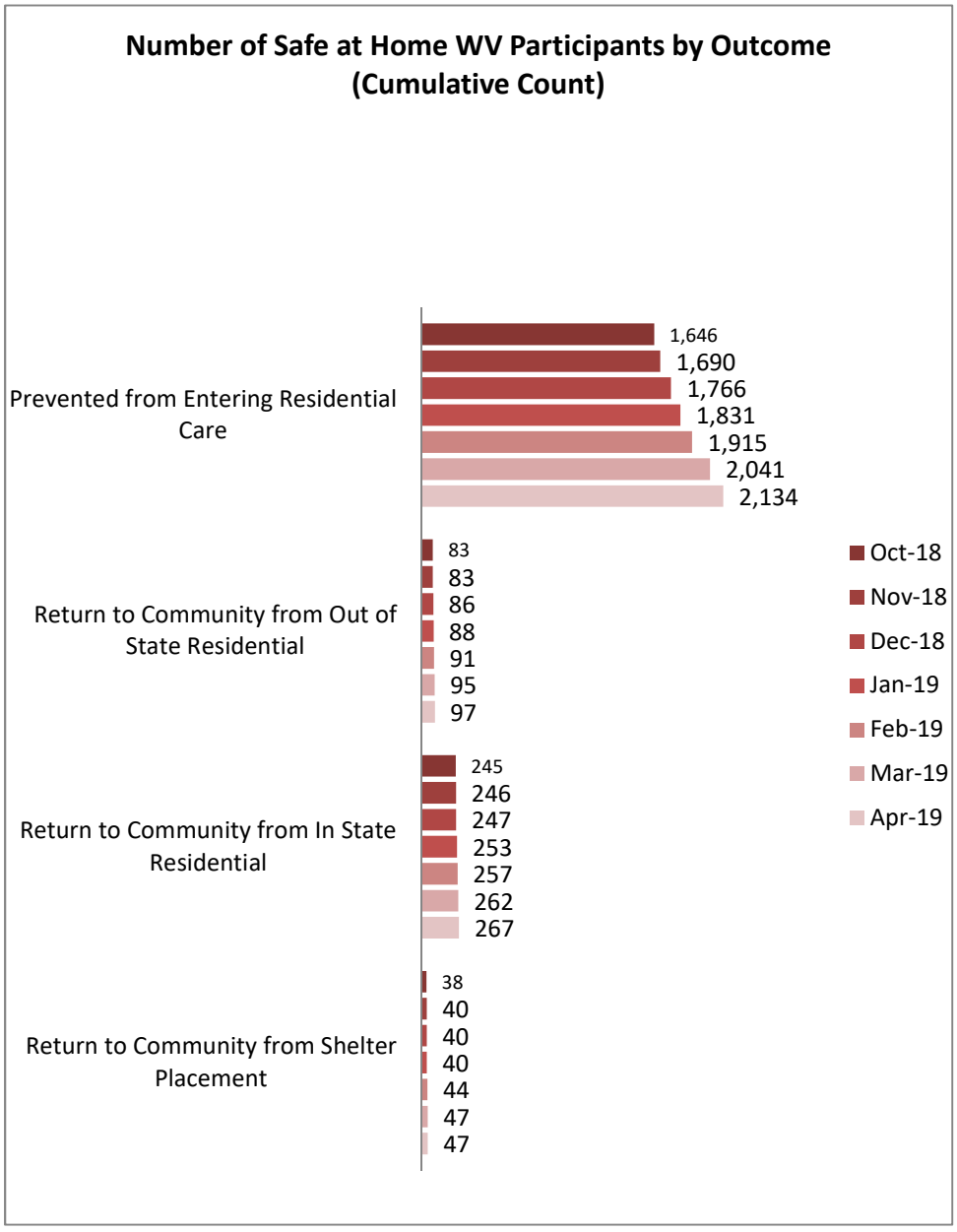
During the current reporting period Safe at Home WV continues working toward the goals and objectives set out in the Demonstration Project.

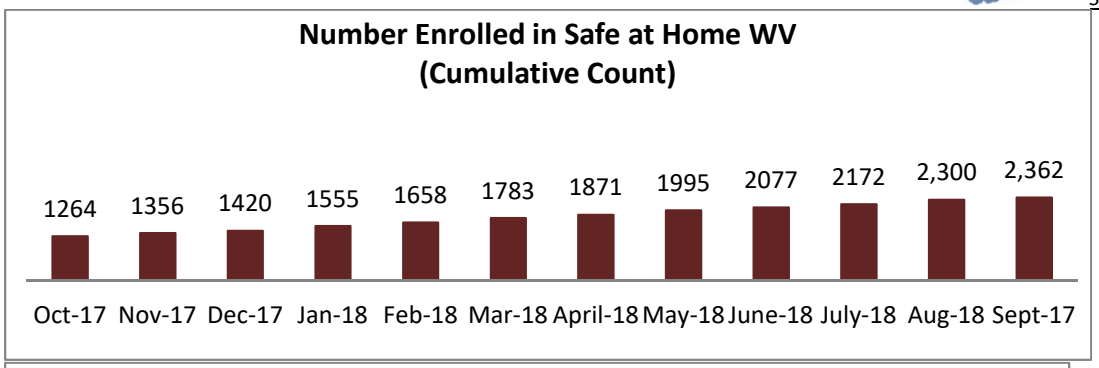
As of April 30, 2019, 3146 youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 97 youth from out-of-state residential placement back to West Virginia, 267 Youth have stepped down from in-state residential placement to their communities, and 47 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 2134 at risk youth.

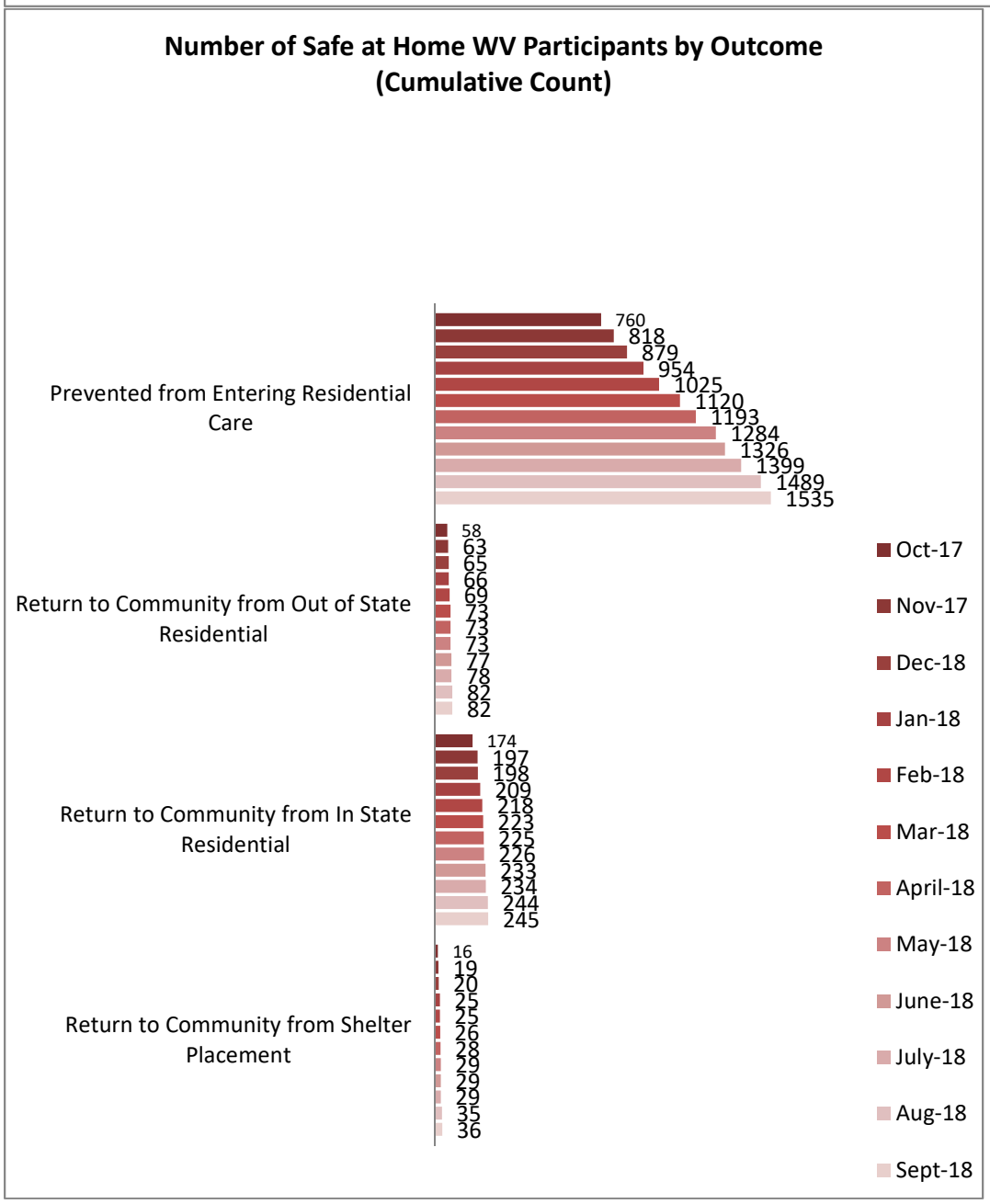
The breakdown of placement type at time of enrollment is as follows:

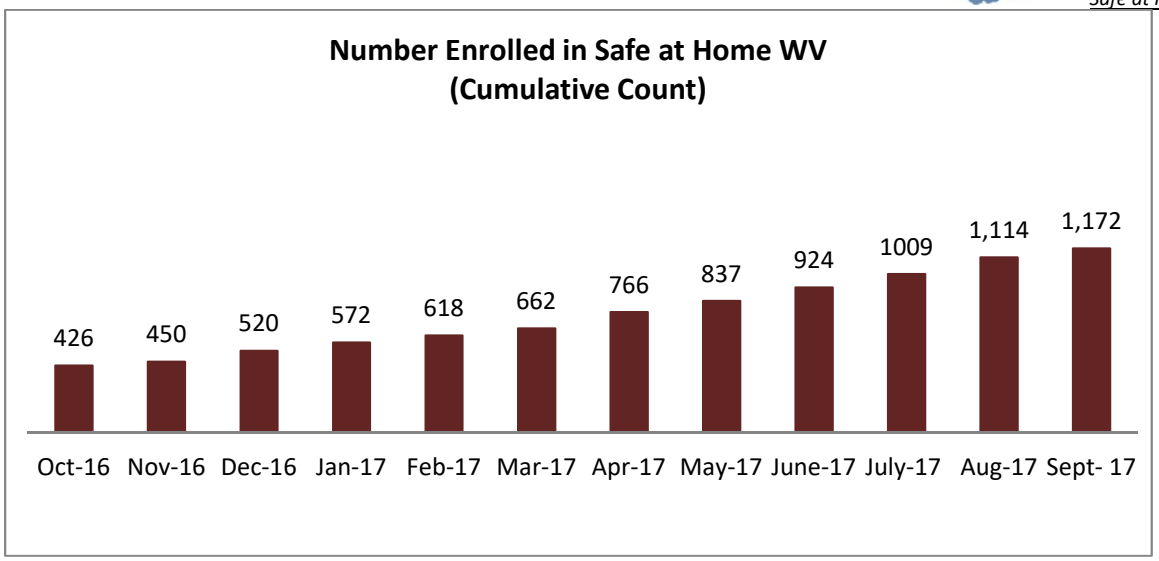
- 158 were or are in out-of-state residential placement at time of enrollment with 97 returning to WV
- 493 were or are in in-state residential placement at time of enrollment with 267 returning to community
- 2409 were or are prevention cases at time of enrollment with only 275 entering residential placement
- 47 returning to their community from emergency shelter placement

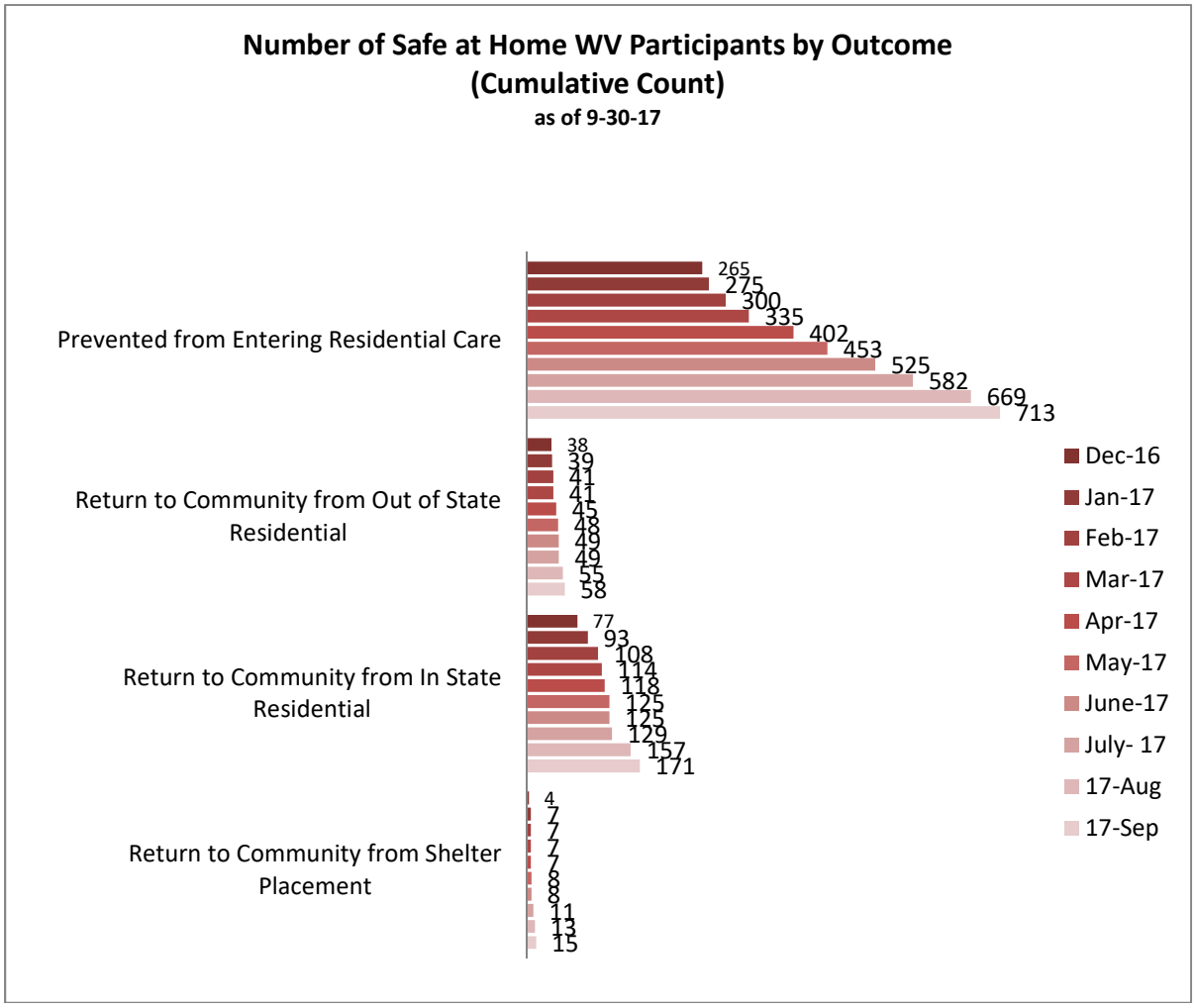

Number Enrolled in Safe at Home WV
(Cumulative Count)
2505
2567
2673
2771
2891
3035
3146
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19

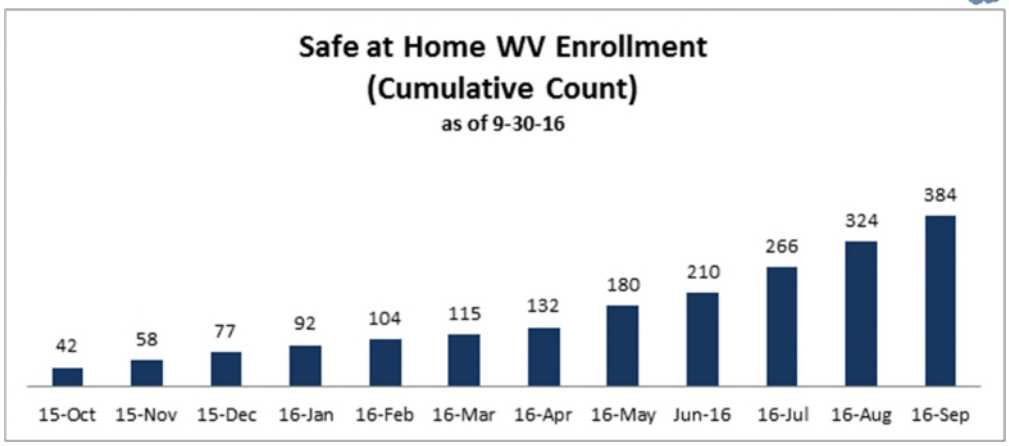

Number of Safe at Home WV Participants by Outcome
(Cumulative Count)
Prevented from Entering Residential Care
1,646
1,690
1,766
1,831
1,915
2,041
2,134
Return to Community from Out of State Residential
83
83
86
88
91
95
97
Return to Community from In State Residential
245
246
247
253
257
262
267
Return to Community from Shelter Placement
38
40
40
40
44
47
47
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19

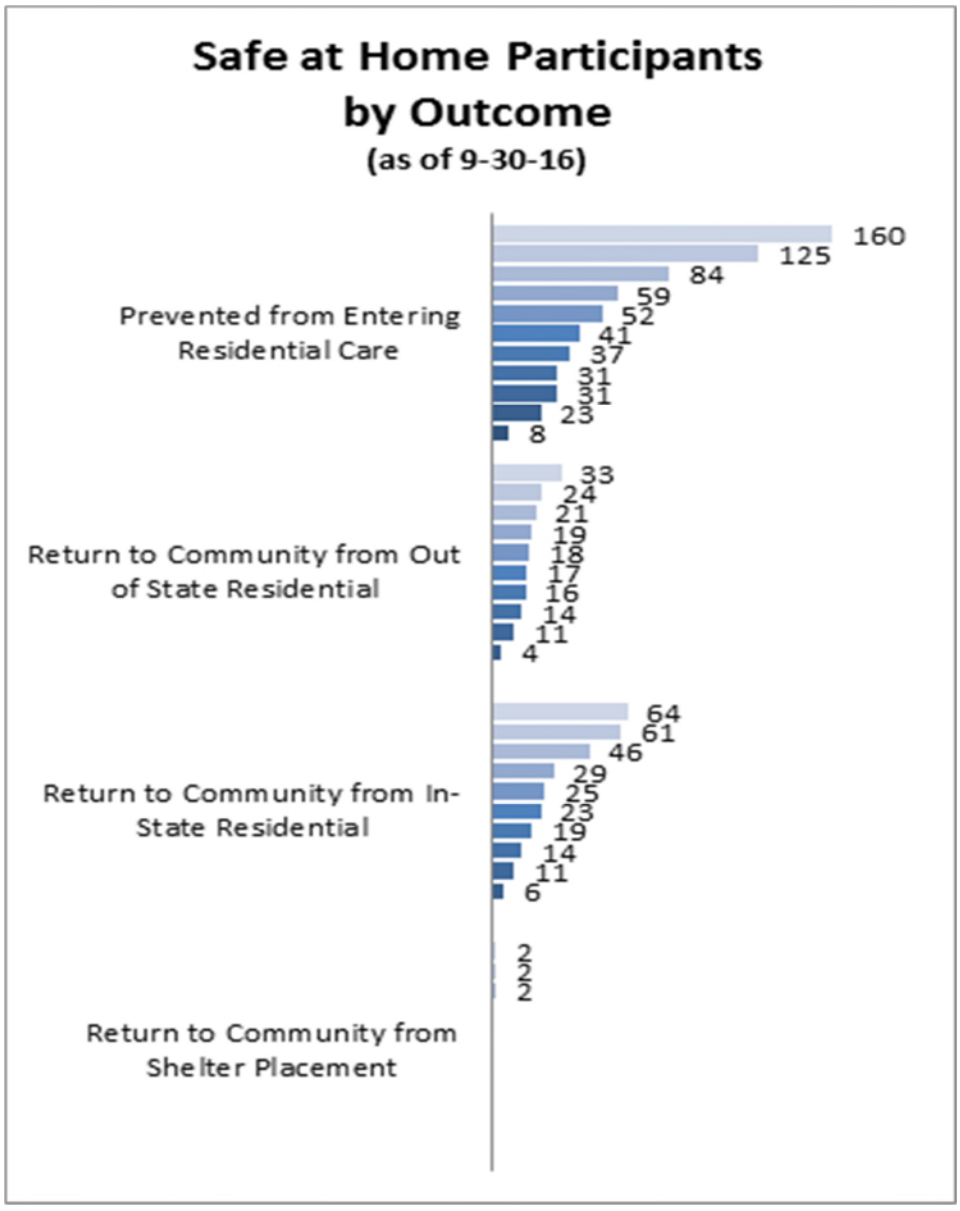

Number Enrolled in Safe at Home WV
(Cumulative Count)
1264
1356
1420
1555
1658
1783
1871
1995
2077
2172
2,300
2,362
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
April-18
May-18
June-18
July-18
Aug-18
Sept-17

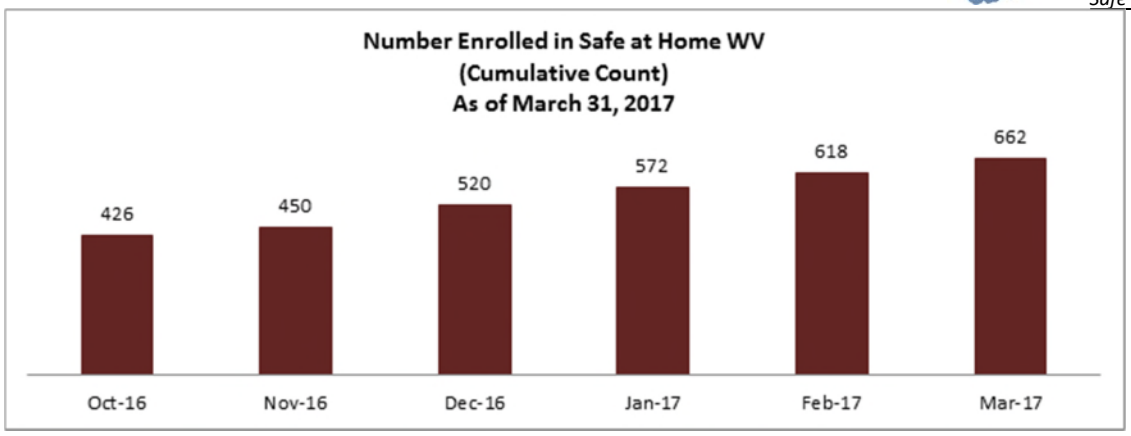

Number of Safe at Home WV Participants by Outcome
(Cumulative Count)
Prevented from Entering Residential Care
760
818
879
954
1025
1120
1193
1284
1326
1399
1489
1535
Return to Community from Out of State Residential
58
63
65
66
69
73
73
73
77
78
82
82
Return to Community from In State Residential
174
197
198
209
218
223
225
226
233
234
244
245
Return to Community from Shelter Placement
16
19
20
25
25
26
28
29
29
29
35
36
Oct-17
Nov-17
Dec-18
Jan-18
Feb-18
Mar-18
April-18
May-18
June-18
July-18
Aug-18
Sept-18

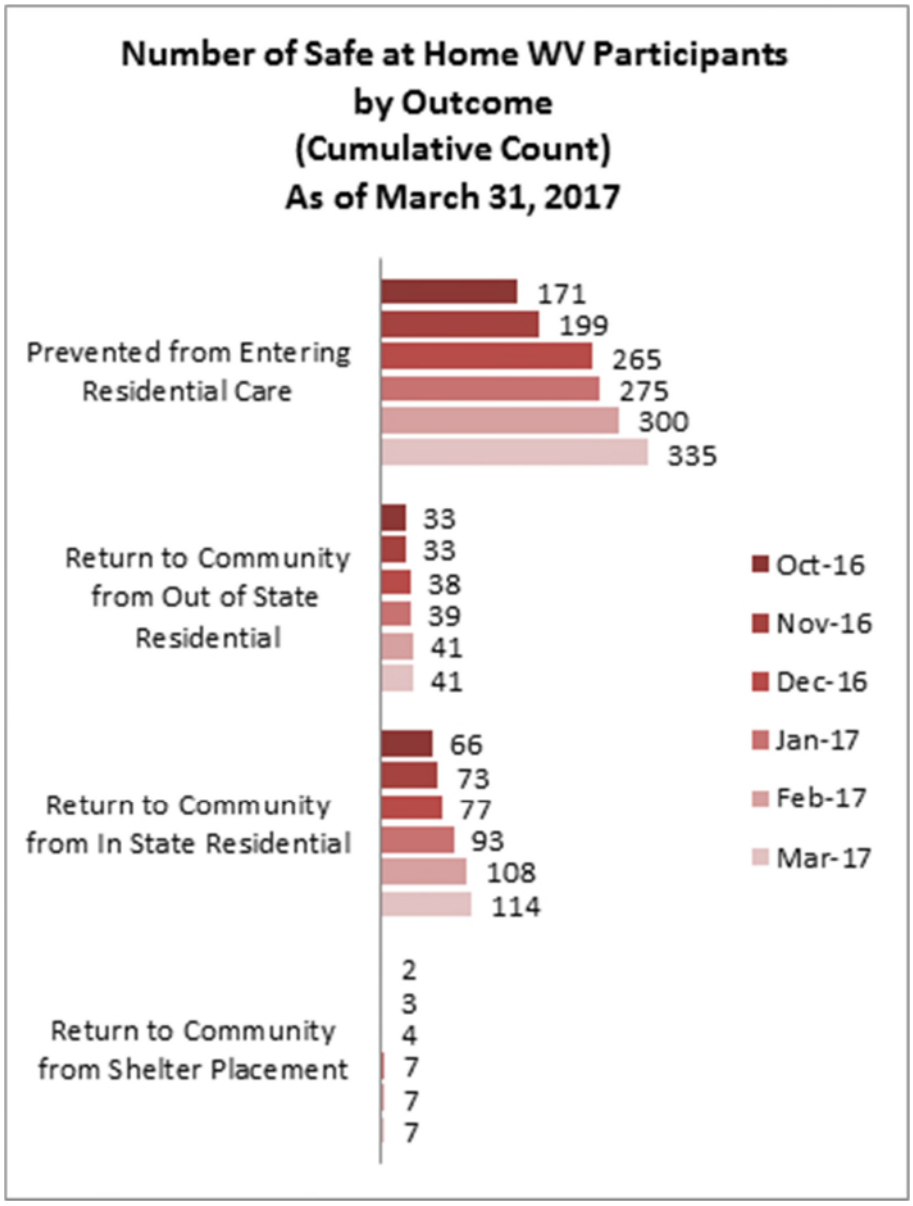

Number Enrolled in Safe at Home WV
(Cumulative Count)
426
450
520
572
618
662
766
837
924
1009
1,114
1,172
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
June-17
July-17
Aug-17
Sept- 17


Number of Safe at Home WV Participants by Outcome
(Cumulative Count)
as of 9-30-17
Prevented from Entering Residential Care
265
275
300
335
402
453
525
582
669
713
Return to Community from Out of State Residential
38
39
41
41
45
48
48
49
55
58
Return to Community from In State Residential
77
93
108
114
118
125
125
129
157
171
Return to Community from Shelter Placement
4
7
7
7
8
8
11
13
15
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
June-17
July- 17
17-Aug
17-Sep


Safe at Home WV Enrollment
(Cumulative Count)
as of 9-30-16
42
58
77
92
104
115
132
180
210
266
324
384
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar
16-Apr
16-May
Jun-16
16-Jul
16-Aug
16-Sep


Safe at Home Participants
by Outcome
(as of 9-30-16)
Prevented from Entering Residential Care
160
125
84
59
52
41
37
31
31
23
8
Return to Community from Out of State Residential
33
24
21
19
18
17
16
14
11
4
Return to Community from In-State Residential
64
61
46
29
25
23
19
14
11
6
Return to Community from Shelter Placement
2
2
2


Number Enrolled in Safe at Home WV
(Cumulative Count)
As of March 31, 2017
426
450
520
572
618
662
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17


Number of Safe at Home WV Participants
by Outcome
(Cumulative Count)
As of March 31, 2017
Prevented from Entering Residential Care
171
199
265
275
300
335
Return to Community from Out of State Residential
33
33
38
39
41
41
Return to Community from In State Residential
66
73
77
93
108
114
Return to Community from Shelter Placement
2
3
4
7
7
7
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17

During the current reporting period,

West Virginia continues to work to improve the previous recommendations of our evaluator.

April 2018 Evaluator Recommendations

- Recommendation 1: Increase DHHR staff survey response rate.
- Recommendation 2: Further Explore how to help youth/families build their natural support systems.
- Recommendation 3: Work with LCAs unable to meet the required timeframes for assessments and plans

During this reporting period, West Virginia has continued our work through the Local Coordinating Agencies to continue to build capacity to meet the needs of Safe at Home WV youth. The Local Coordinating Agencies continue to work with their respective counties to build more external supports and services, especially volunteer services that will continue to partner with and support our families and youth as their cases transition to closure.

West Virginia continues to work with the Capacity Building Center, partners at Casey Family Programs, and other partnerships to support the wavier as well as other BCF initiatives and needs.

West Virginia is also continuing work on IVE Candidacy claiming which will assist with sustainability.

The work and efforts of the Demonstration project align with the larger initiative of WVDHHR of the WV Child Welfare Reform. As we move toward the completion of the demonstration project, WV continues to work on sustaining Safe at Home WV by incorporating the successful efforts of the project into current initiatives and work throughout out child welfare system.

FFPSA

As part of our ongoing sustainability efforts WV continues to work with the upcoming changes through FFPSA to incorporate appropriate utilization of wraparound moving forward.
WV will also continue efforts Foster Care Candidacy Claiming to assist potentially in financial support for sustainability of wraparound.

SED Waiver Application

Bureau of Medical Services, one of our sister agencies, has been working on a SED 1915C Waiver for wraparound of children with severe emotional disorders. The application is currently under public comment period. WV believes that approval of this waiver will provide the opportunity for the portion SAH WV wraparound children that meet the criteria continued coverage.

Behavioral Health Wrap Around Pilot Expansion

Bureau of Behavioral Health previously ran a pilot for children in parental custody that meet the criteria for wraparound. After the successful pilot they have been granted some funding to expand the service statewide. WV believes this too will serve a portion of children in parental custody that need wraparound.

Wraparound Continuum of Care Post Waiver

The entire DHHR and the involved agencies have begun working together to align all WV Wraparound into a single continuum of wraparound service for the children and families of WV. As the work continues we will provide more updates.

Licensed Coordinating Agencies

LCA meeting have been increased during the reporting period to provide the opportunity for better communication in our monthly conference calls and our face to face LCA meetings. In the next review period LCA face to face meetings and sub workgroup meeting will continue to collaboratively work on enhancements to improve our practice as we move into post waiver SAH work.

Marshall University

Collaborative work began with Marshall University to continue the expansion of the CANS Automated System to gather data and continue work post waiver. Marshall will begin oversight of the CANS Training and hopes to become a center of excellence to carry on the valuable work and utilization during our Demonstration Project.

Prior Reporting Periods
Status, Activities, and Accomplishments

Implementation of Safe at Home West Virginia officially launched on October 1, 2015 in the 11 counties of Berkley, Boone, Cabell, Jefferson, Kanawha, Lincoln, Logan, Mason, Morgan, Putnam, and Wayne with the first 21 youth being referred for Wraparound Facilitation. West Virginia also began the process of universalizing the CANS across child serving systems.

On August 1, 2016, West Virginia began Phase 2 of implementation by expanding to the 24 counties of Barbour, Brooke, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Lewis, Marion, Mineral, Mercer, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Pocahontas, Preston, Randolph, Summers, Taylor, Tucker, and Upshur. This phase of implementation brought in counties from each of the 4 BCF regions.

On April 1, 2017, West Virginia began Phase 3 of implementation by expanding to the remaining 20 counties of; Braxton, Clay, Jackson, Roane, Ritchie, Doddridge, Pleasants, Wood, Marshall, Tyler, Wetzel, Calhoun, Gilmer, Wirt, Fayette, Raleigh, McDowell, Wyoming, Mingo, and Webster. This phase brought the entire state into full implementation.

As part of our ongoing tracking and monitoring the Local Coordinating Agencies and the BCF Regional Social Service Program Managers turn in tracking logs that provide status updates on all cases. This also allows the identification of barriers to cases progressing. Currently HZA is working on programming to enhance the current system functionality to automate the reporting in the CANS in the data base system to assist both DHHR staff and provider staff. The automation will reduce the time it currently takes staff to track and count the data collected. It is anticipated that it will also reduce tracking errors. The programming and testing are scheduled to be completed by January 2019.

Leading up to our first Safe at Home West Virginia referrals West Virginia developed a program manual and family guide as well as DHHR/BCF policies, desk guides and trainings. All staff and providers were provided with Wraparound 101 training, an overview of the wraparound process, Family and Youth engagement training that is part of our Family Centered Practice Curriculum, and CANS training. The West Virginia Department of Health and Human Resources (DHHR) instituted weekly email blasts that go out to all DHHR staff and our external partners. These email blasts focused on educating us on the 10 principles

of Wraparound, family and youth engagement, and ongoing information regarding Safe at Home West Virginia. We also implemented a quarterly newsletter that reaches all of our staff and external partners, conducted presentations across the state as well as media interviews and private meetings with partners. These activities continue as specific to each phase of implementation and sustaining. Our newsletters now reach over 1,000 partners. All program materials, newsletters, as well as other pertinent information are posted on our website for public viewing and use.

In July 2015, in preparation for Phase 1 implementation, the Bureau for Children and Families released a request for applications for Local Coordinating Agencies to hire and provide Wraparound Facilitators. The grant awards were announced on August 25th. The grants provided startup funds for the hiring of wraparound facilitators and to assure a daily case rate for facilitation and flexible funds for providing the necessary wraparound services.

The Local Coordinating Agencies could hire their allotted wraparound facilitators in 3 cohorts. West Virginia believed this would be the best process to use to assure their ability to hire and train their staff as referrals began to flow.

For Phase 2 implementation the Bureau for Children and Families released a request for application for Local Coordinating Agencies to hire and provide Wraparound Facilitators on February 26, 2016. The grant awards were announced on March 28, 2016. West Virginia adjusted the grant awards based on lessons learned from Phase 1 implementation and required the Local Coordinating Agencies to hire their allotted positions prior to the implementation date. More time was allowed between the grant award date and the actual implementation of referrals to assure facilitators could receive required training.

This same process was followed in preparation of Phase 3 implementation. The same communication plan was implemented with staff and community partners. Case reviews and selection have followed the same process and referrals were prepared for implementation.

West Virginia held an “onboarding” meeting with the Phase 1 Local Coordinating Agencies on September 16, 2015, for the Phase 2 Local Coordinating Agencies on June 7, 2016, and for the Phase 3 Local Coordinating Agencies March 29, 2017 to assure consistency as we move forward. We then hold monthly meetings for the first 4 months and move to

semi-monthly or quarterly. These meetings allow for open discussion and planning regarding our processes and outcomes as well providing peer support and technical assistance among the agencies. Activities of this group include the updating of the wraparound plan form, updating the monthly progress summary, developing advanced training specific to the wraparound facilitation, working with our Grants division to update the monthly grant report to simplify reflecting performance measures and outcomes, and implementation of evaluation recommendations.

In preparation for Phase 1 implementation the local DHHR staff began pulling possible cases for referral for review and staffing during the months of August and September so that the referral process could go smoothly, and the first referrals sent to the Local Coordinating Agencies on October 1, 2015. For Phase 2 implementation this same process was used during the months of June and July to prepare for the first referrals that were sent on August 1, 2016. For Phase 3 implementation this same process was used during the months of February and March for the first referrals to be sent on April 1, 2017. We found this process to work well and it has been used in preparation for all implementation phases.

The Phase 1 initial startup grant period of 1 year expired on August 30, 2016 and the Phase 2 initial startup grant period of 1 year expired on April 30, 2017. In preparation for this the Bureau for Children and Families prepared a provider agreement that includes all of the activities and requirements of the newest statement of work for Local Coordinating Agencies and Wraparound Facilitation as well as the Results Based Accountability outcomes and performance measures that are outlined in the grants. All original provider agencies have signed the provider agreements to continue serving as Local Coordinating Agencies in their respective Counties.

All provider agreements have been updated and signed by February 28, 2018 for renewal on March 1, 2018. This brings all the provider agreements into the same renewal cycle.

CANS training and certification as well as Wraparound 101 training continue across the state to assure new staff hires have the required trainings. Both Wraparound 101 and CANS are now integrated into DHHR/BCF new worker training.

CANS training continues throughout the state for both new DHHR staff and providers. West Virginia also continues with the identification and certification of WV CANS Advanced CANS Experts (ACES) to provide ongoing training and technical assistance.

In the previous reporting period West Virginia found that staff were having difficulty accessing advanced CANS experts to provide technical assistance. To address this Dr. Lyons came to West Virginia and spent a week with staff identified to go through the advanced CANS experts process. He also provides ongoing technical assistance calls with the experts to continue the development process. The goal has always been to have the internal capacity within West Virginia to continue this process and the transferring of learning. We believe that with the assistance of the current experts and Dr. Lyons we will have no difficulty proceeding as planned. At present, we have 10 ACES and 42 CANS Experts providing certification training and technical assistance throughout the state.

West Virginia has also developed a plan for identifying all staff trained and certified, development of a training schedule based on identified need, technical assistance plan development based on identified need. Attached is the CANS Logic Model.

There are no significant changes in the design of our interventions to date but there have been innovations throughout the waiver period. Previously, a group of Local Coordinating Agency Directors and Clinical Supervisors with extensive experience with Wraparound have worked to develop an advanced training for wraparound facilitators. We are referring to this training as “Applied Wraparound”. The training was developed, piloted, and updated to expand to all facilitators. This training addresses better engagement with families, how to problem solve and move a team forward, how to better write wraparound plans with measurable outcomes, as well as other identified needs. It is more focused on the actual application and practice of wraparound facilitation. Lead Coordinating Agencies report that this training beneficial to the facilitators and assists them in how to appropriately work with the families they serve through Safe at Home.

During this reporting period, West Virginia has continued to follow the judiciary communication plan as developed. The plan calls for continued communication with our judiciary by combined teams of WV BCF management and LCA representation.

West Virginia also worked with our Evaluator, Hornby Zeller Associates, to create automated WV CANS. All appropriate DHHR staff and Local Coordinating Agency staff have been trained in the use of the automated WV CANS and have begun entering WV CANS and subsequent updates. West Virginia has been using the CANS since 2003. It has been updated

to the WV CANS 2.0. WV CANS 2.0 is a revision that fully incorporates the National Child Traumatic Stress Network Trauma CANS. It adds several modules to strengthen our current version of the WVCANS which are: juvenile delinquency sub-module; expectant and parenting sub-module; commercial sexual exploitation youth sub-module; GLBTQ sub-module; intellectual and developmental disabilities sub-module; 0-5 population sub-module; substance abuse sub-module; fire setting sub-module; transition to adulthood sub-module; and sexually abusive behavior sub-module. Staff continues to use the automated CANS and Local Coordinating Agencies continue to partner with the project director to assure that initial and subsequent CANS are complete on every youth enrolled in Safe at Home West Virginia.

During the current period of review HZA is working on programming to enhance the current system functionality to automate the reporting in the CANS in the data base system to assist both DHHR staff and provider staff. The automation will reduce the time it currently takes staff to track and count the data collected. It is anticipated that it will also reduce tracking errors. The programming and testing are scheduled to be completed by January 2019.

Safe at Home West Virginia began implementation with the first referrals on October 1, 2015. The automated CANS data base did not become operational until February 12, 2016. During that time, there would have been cases that already transitioned to closure for various reasons. There has been a learning curve with the wraparound facilitators navigating the system and remembering to save changes to the document. This explains any discrepancy regarding the number of youth enrolled and the number of initial CANS completed in the system. The Safe at home West Virginia project director continues to work with the Local Coordinating Agencies to monitor and assure CANS are completed on each child being served.

At present 5,235 CANS have been completed and entered into the automated system. This number represents initial and subsequent CANS. CANS are to be updated at minimum every 90 days.

The system has proven to be very useful for the use of the CANS across systems. The ability for staff to quickly locate and use existing CANS is very helpful in treatment planning and the ability for administrative staff to access needed reports has proven to be very useful. We foresee this becoming even more valuable as West Virginia moves forward with the use of CANS in treatment plan development.

During the previous reporting period West Virginia worked with our evaluators who

developed an algorithm report in our automated CANS data base. Dr. John Lyon's had worked with West Virginia on this algorithm which was then provided to the evaluators for build in the system. The algorithm report went live on March 2018.

Mentioned within West Virginia's Initial Design and Implementation reports is Senate Bill 393. This bill set forth very specific requirements regarding work with status offenders and diversion. West Virginia identified Evidence Based Functional Family Therapy (FFT) as a valuable service to the youth service population and their families as a diversion or treatment option. FFT is a short term (approximately four (4) months), high-intensity therapeutic family intervention. FFT focuses on the relationships and dynamics within the family unit. Therapists work with families to assess family behaviors that maintain delinquent behavior, modify dysfunctional family communication, teach family members to negotiate effectively, set clear rules about privileges and responsibilities, and generalize changes to community contexts and relationships. It is limited to youth 11-18 who have been charged or are at risk of beingcharged with either a status offense or a delinquent act.

West Virginia awarded a grant to a lead agency to facilitate service coverage and training throughout our state. Clinicians were trained and provide this valuable therapeutic service. FFT fits well within the wraparound process and has been identified as a very useful service for many of our families being served within Safe at Home West Virginia due to target population for FFT.

FFT is a well-established, evidence-based intervention model utilized in twelve (12) countries, including the United States. FFT has shown to reduce recidivism as much as 50%. It is one of the many therapeutic options that are available to youth and a family that may be served by the juvenile justice system, child welfare, and Safe at Home West Virginia.

Regarding analyses; the evaluator will separate cases with FFT if the SACWIS system shows us whether the family got that service. If it does not, we can only obtain the information through our case readings and the prevalence of FFT will determine whether we get any meaningful information out of it.

To further assist us with moving forward with Results Based Accountability, the outcomes included within the Local Coordinating Agency grant agreement statements of work are connected to the outcomes for Safe at Home West Virginia. All contracts and Provider agreements include provisions for training other wraparound team members with specialized roles, such as Peer Support Specialist, Parent or Youth Advocates, Mentors, and all wraparound team members outside of the Local Coordinating Agencies, and adherence to clear performance measures for families utilizing Safe at Home Wraparound. These performance

measure outcomes will be linked to continuation of yearly contractual relationships between the Bureau and each Local Coordinating Agency. Responsibility for executing the duties of the contractual relationship with the Bureau rests with the Local Coordinating Agency, as well as development of an inclusive network of community providers in order to ensure youth and families receive services that are needed, when they are needed, and where they are needed. We continue to work with our Local Coordinating Agencies to assure that their workforce development meets West Virginia's needs.

West Virginia continues to provide Trauma-informed Care training to individuals representing all child serving systems and the community at large. This training provides an overview of the incidence and prevalence of childhood traumatic experiences and describes the impact that trauma can have on a child's physical, social, emotional, cognitive and behavioral development. Also discussed are trauma and the brain, the definition of trauma-informed care as a systemic framework around which services are developed and provided, and the six core components of a trauma informed system of care. Currently, Trauma-informed care is being redesigned to be required core training for all providers and BCF staff. Ms. Yost has also been conducting train the trainer sessions throughout the state to assist with expanding West Virginia's internal capacity to continue with this valuable training.

From the beginning of the program through this reporting period, BHHF continued with its Children's Behavioral Health Wraparound. In March 2016, the Bureau for Behavioral Health and Health Facilities (BHHF) released a Request for Applications for Grants for Local Coordinating Agencies to hire Wraparound Facilitators to serve 6 pilot areas of West Virginia. The BHHF pilot project is to provide high fidelity wraparound modeled after Safe at Home West Virginia, to children in parental custody and they may or may not be involved with the child welfare system just not in custody nor eligible for safe at home. BHHF has worked closely with BCF to assure that the two programs are as similar as possible without overlap. Several of the pilot areas are part of the Phase 1 of Safe at Home West Virginia and all but 1 of the grant awards were to Local Coordinating Agencies that are also serving Safe at Home West Virginia. BHHF received 220 referrals and 88 of those were accepted and served through wraparound.

- Total received # of referrals 220
- 9/220 were duplicate referrals
- 90/220 referrals were accepted (this total includes the 3 waitlist kids because they were technically accepted for wraparound); 3 out of 90 experienced wait list; only 1/3 wait list kids actually entered the program when a slot became available;
- 88/90 total accepted referrals were served through wraparound

As discussed in West Virginia's Initial Design and Implementation Report we have worked with our out-of-home partners to make changes to our continuum of care. All provider agreements are being written to include performance measures. West Virginia continues to work with our partners to improve the continuum of care as well as our agreements.

We continue working with our partners in Positive Behavioral Support Program. They are assisting us with engagement and trainings in using the MAPs process. MAPs refer to Making Action Plans. The training helps facilitators understand the MAPs process and details and how to conduct a MAP and integrate it into a Wraparound Plan.

As part of West Virginia's ongoing work to improve our continuum of care we have created a Treatment Foster Care model. As part of that process West Virginia has developed a Three-Tier Foster Family Care Continuum. This continuum includes Traditional Foster Care homes, Treatment Foster Care homes, and Intensive Treatment Foster Care homes. This was developed in partnership with the Licensed Child Placing Providers who currently hold the Treatment Foster Care grants. When we can appropriately match children with families we utilize the opportunity.

Sustainability planning continues as it has always been included within West Virginia's workplan. As we move forward, efforts for sustaining SAH are focused to plan for transition out of the waiver and into other DHHR initiatives to improve child welfare in WV.

During this reporting period, a Finance workgroup comprised of the Project Director, BCF Deputy Commissioner of Operations, BCF CFO, DHHR CFO and staff continue to work on financial information that will be needed and used by other workgroups to inform any program adjustments. This group is scheduled to receive additional Technical Assistance through Casey Family Programs in December 2018. Financial planning also affords West Virginia the needed information to determine level of service and commitment needed to continue with this valuable program and to assist with the development of any needed improvement packages determined to be appropriate.

West Virginia continues joint work between the Bureau for Children and Families and our sister Bureau for Medical Services to discuss ways Medicaid could support wraparound as we move forward.

West Virginia wants to extend the availability of wraparound to all children we serve as appropriate. At present we are gaining all information available regarding the Family First Act in order to understand the implications of the Act and how it will support our sustainability and expansion of wraparound.

West Virginia's evaluator has conducted the first full cost analysis that is included within the previous report. Our evaluator is a valuable contributor to this group and financial sustainability planning as well as informing program adjustments. During this evaluation and reporting period our evaluator is digging deeper into our outcome data to assist us with better identification of youth who benefit most from wraparound.

III. Evaluation Status

Data Collection Activities:

Between October 2018 and April 2019, Public Consulting Group (PCG) completed a number of data collection activities as part of the ongoing evaluation of Safe at Home West Virginia. For the process evaluation, data sources included stakeholder interviews completed by phone and on-site, as well as data from the Statewide Automated Child Welfare Information System (SACWIS), FACTS. FACTS also informed the outcome evaluation component, along with the automated Child and Adolescent Needs and Strengths (CANS) assessment tool. For the cost evaluation, FACTS data was used again along with provider invoice data.

Stakeholder Interviews

Staff from PCG returned to West Virginia during the first and second weeks of February 2019 to conduct annual on-site stakeholder interviews with Department of Health and Human Resources' (DHHR) central and regional office staff, community services managers, supervisors, and caseworkers. Local coordinating agency (LCA) program managers, wraparound supervisors, and wraparound facilitators were also interviewed during that same time frame. Phone interviews were completed with circuit court judges and juvenile probation officers throughout January and February 2019. The purpose of the interviews was to reach a wide range of professionals who work directly with the program to learn about any process changes, to gauge their level of buy-in and perceptions of overall program effectiveness, and to understand any successes and challenges associated with ongoing implementation. The interviews were also used to obtain input on program sustainability following the Waiver's end.

As shown in Table 1, a total of 104 stakeholders were interviewed this year. Interviewees spanned all four of the State's regions and included professionals working in the following 28 counties: Barbour, Berkeley, Boone, Cabell, Calhoun, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Jefferson, Kanawha, Lincoln, Mercer, Mineral, Monroe, Morgan, Pleasants, Pocahontas, Preston, Putnam, Randolph, Ritchie, Summers, Taylor, Tucker, Wayne, and Wirt.

Table 1. Stakeholders Interviewed

Stakeholder Group	Number Interviewed
DHHR Central Office Staff	7
DHHR Regional Office Staff	8

Table 1. Stakeholders Interviewed	
Stakeholder Group	**Number Interviewed**
DHHR Community Services Managers	8
DHHR Supervisors	10
DHHR Caseworkers	19
LCA Program Managers	7
LCA Wraparound Supervisors	7
LCA Wraparound Facilitators	13
Circuit Court Judges	8
Juvenile Probation Officers	16
Other[1]	1
Total	**104**

FACTS

PCG uses data from West Virginia's FACTS to measure the extent to which Safe at Home's goals are achieved (e.g., reduced placement in congregate care, fewer initial entries into congregate care, shorter lengths of stay in congregate care, etc.). Outcomes for youth involved in Safe at Home are compared to an historical comparison group of youth. The comparison groups (which are selected separately for each six-month treatment cohort since the program was implemented) were selected from youth known to DHHR between State Fiscal Years (SFYs) 2010 to 2015. Characteristics, including demographic data, case history and program qualifying characteristics, such as age and placement, were used to match comparison youth to the treatment group cohorts. Youth in the treatment group were partitioned into five subgroups according to referral and placement type: out-of-state congregate care facilities and group care, in-state congregate care facilities and group care, emergency shelter, family foster care placements and youth at home. The characteristics of youth in each comparison group are statistically similar to the youth in each of the seven[2] treatment cohorts (see Appendix A for the statistical comparisons).

Regression analyses have been conducted as part of the outcome analysis, applying a number of population-based factors (e.g., youth region, youth age, type of placement at referral, etc.) to identify the specific youth population(s) for whom Safe at Home works best. FACTS data are also used in the process evaluation to describe the characteristics of the Safe at Home youth population.

[1] A school staff person who had experience working with youth and families in Safe at Home voluntarily requested to be interviewed.
[2] PCG has not created the comparison pool for the most recent cohort because not enough time has elapsed to measure outcomes for these youth. Therefore, six-month outcomes will not be available for the seventh cohort until the October 2019 semi-annual evaluation report.

CANS

During the first few months of program implementation, the evaluator developed an online CANS tool for LCA and DHHR staff to use. The online CANS tool allows for ease of access and information sharing of the assessment results across participating agencies, as well as ready access to assessment data for the evaluation team, which are used to measure progress on well-being measures. Each youth who enters Safe at Home is required to have an initial CANS assessment completed by the wraparound facilitator within 30 days of referral to the program, and subsequent CANS assessments are to be completed every 90 days thereafter.

IV. Significant Evaluation Findings to Date

Process Evaluation Results:

Youth Population Description

Table 2 describes Safe at Home's youth population at referral. In the most recent six-month cohort, the number of youth referred to Safe at Home is fairly consistent with the number of youth referred in the previous three cohorts. As of March 31, 2019, there were 1,044 active participants.

Overall, 72 percent of the 2,526 youth were referred while living at home. Referrals for youth living at home made up 37 percent of the first cohort's population, but 81 percent of the most recent cohort. This shift in referrals for youth living at home was most dramatically seen between Cohorts 1 and 3, though each cohort continues to show an increased percentage of youth referred at home compared to the previous cohorts.

Table 2. Safe at Home Youth at Referral

	C[3] 1	C 2	C 3	C 4	C 5	C 6	C 7	All
Total Referred	**124**	**221**	**297**	**445**	**512**	**463**	**464**	**2,526**
Placement								
Out-of-State Congregate Care	31 (25%)	18 (8%)	12 (4%)	12 (3%)	17 (3%)	12 (3%)	10 (2%)	112 (4%)
In-State Congregate Care	39 (31%)	73 (33%)	61 (21%)	60 (13%)	52 (10%)	35 (8%)	18 (4%)	338 (13%)
Emergency Shelter	6 (5%)	18 (8%)	6 (2%)	13 (3%)	22 (4%)	15 (3%)	9 (2%)	89 (4%)
Family Foster Care	2 (2%)	11 (5%)	13 (4%)	27 (6%)	34 (7%)	34 (7%)	52 (11%)	173 (7%)

[3] Cohort has been abbreviated to "C" due to the size of the table.

Table 2. Safe at Home Youth at Referral								
	C[3] 1	C 2	C 3	C 4	C 5	C 6	C 7	All
Total Referred	**124**	**221**	**297**	**445**	**512**	**463**	**464**	**2,526**
Home	46 (37%)	101 (46%)	205 (69%)	333 (75%)	387 (76%)	367 (79%)	375 (81%)	1,814 (72%)
Region								
Region 1	0 (0%)	30 (14%)	68 (23%)	95 (21%)	117 (23%)	128 (28%)	151 (33%)	589 (23%)
Region 2	72 (58%)	110 (50%)	117 (39%)	162 (36%)	196 (38%)	196 (42%)	190 (41%)	1,043 (41%)
Region 3	50 (40%)	54 (24%)	72 (24%)	82 (18%)	100 (20%)	68 (15%)	73 (16%)	499 (20%)
Region 4	2 (2%)	25 (11%)	40 (13%)	103 (23%)	88 (17%)	65 (14%)	46 (10%)	369 (15%)
Age								
12	10 (8%)	19 (9%)	25 (8%)	37 (8%)	63 (12%)	41 (9%)	47 (10%)	242 (10%)
13	20 (16%)	26 (12%)	35 (12%)	64 (14%)	80 (16%)	68 (15%)	72 (16%)	365 (14%)
14	30 (24%)	48 (22%)	67 (23%)	87 (20%)	98 (19%)	104 (22%)	82 (18%)	516 (20%)
15	28 (23%)	58 (26%)	65 (22%)	135 (30%)	120 (23%)	119 (26%)	99 (21%)	624 (25%)
16	32 (26%)	63 (29%)	92 (31%)	103 (23%)	120 (23%)	98 (21%)	132 (28%)	640 (25%)
17	4 (3%)	7 (3%)	13 (4%)	19 (4%)	31 (6%)	33 (7%)	32 (7%)	139 (6%)
Gender								
Male	75 (60%)	116 (52%)	186 (63%)	274 (62%)	303 (59%)	259 (56%)	259 (56%)	1,472 (58%)
Female	49 (40%)	105 (48%)	111 (37%)	171 (38%)	209 (41%)	204 (44%)	205 (44%)	1,054 (42%)
Race								
White	96 (77%)	181 (82%)	245 (82%)	405 (91%)	435 (85%)	396 (86%)	397 (86%)	2,155 (85%)
Black	8 (6%)	19 (9%)	15 (5%)	14 (3%)	25 (5%)	27 (6%)	19 (4%)	127 (5%)
Black/White Biracial	16 (13%)	18 (8%)	32 (11%)	20 (4%)	43 (8%)	31 (7%)	0 (0%)	160 (6%)
Other	4 (3%)	3 (1%)	5 (2%)	6 (1%)	9 (2%)	9 (2%)	48 (10%)	84 (3%)
Case Type								
CPS	12 (10%)	57 (26%)	36 (12%)	89 (20%)	107 (21%)	87 (19%)	102 (22%)	490 (19%)

Table 2. Safe at Home Youth at Referral								
	C[3] 1	C 2	C 3	C 4	C 5	C 6	C 7	All
Total Referred	**124**	**221**	**297**	**445**	**512**	**463**	**464**	**2,526**
Youth Services	112 (90%)	164 (74%)	263 (89%)	361 (81%)	405 (79%)	376 (81%)	364 (78%)	2,045 (81%)
Length of DHHR Case Prior to Safe at Home Referral								
0 up to 6 months	39 (31%)	68 (31%)	105 (35%)	197 (44%)	266 (52%)	245 (53%)	267 (58%)	1,187 (47%)
6 up to 12 months	24 (19%)	34 (15%)	60 (20%)	83 (19%)	84 (16%)	88 (19%)	94 (20%)	467 (18%)
12 up to 18 months	20 (16%)	47 (21%)	32 (11%)	55 (12%)	45 (9%)	47 (10%)	29 (6%)	275 (11%)
18 up to 24 months	9 (7%)	22 (10%)	30 (10%)	28 (6%)	37 (7%)	23 (5%)	37 (8%)	186 (7%)
24 plus months	32 (26%)	50 (23%)	70 (24%)	82 (18%)	80 (16%)	60 (13%)	37 (8%)	411 (16%)

Youth age at referral has remained consistent across cohorts, with most youth receiving a referral between the ages of 14 and 16. Seventeen-year-olds have made up the smallest percentage of Safe at Home youth in all seven cohorts. Males also make up more than half of the Safe at Home population (58%), which is a trend that has remained consistent across cohorts. White youth make up the majority of Safe at Home's population (85% overall) and have also consistently been represented across cohorts.

The majority of youth (81%) in Safe at Home have a Youth Services case. According to West Virginia, "The primary purposes of Youth Services interventions are to provide services which alter the conditions contributing to unacceptable behavior by youth involved with the Department system, and to protect the community by controlling the behavior of youth involved with the Department." The State's definition of Youth Services cases demonstrates how unique these cases are from Child Protective Services (CPS) cases, which are primarily focused on child maltreatment.

The median length of time between the DHHR case opening and Safe at Home referral has decreased significantly from 300 days in the first two reporting periods to 135 days in the three most recent reporting periods. This change is certainly due to the program's shift in focus towards prevention as cases open longer are more likely to be removed from the home.

Training

Training was provided by the State to both DHHR and LCA staff when Safe at Home was first implemented. The initial Safe at Home training, designed and developed by the inter-disciplinary service delivery workgroup, was collaboratively updated by DHHR and LCA staff based on the feedback they received from staff early on in the program's implementation. The updates primarily focused on clarifying the differences between caseworker and wraparound facilitator roles and responsibilities. Since that early update, the training materials for DHHR staff working with Safe at Home have remained relatively consistent, with minor adjustments made over time.

Currently, Safe at Home training for DHHR staff is incorporated as part of the pre-service training for new caseworkers. Child protective services caseworkers reported that they receive a half-day of Safe at Home training while youth service workers (who were more likely to carry a caseload with a higher ratio of youth in Safe at Home) reported receiving a two-day training for Safe at Home as part of their pre-service training. Of the DHHR staff who received training, 69 percent of them agreed that the training adequately prepared them and/or their staff for their role(s) in the program.

DHHR staff reported that there has not been any recent follow-up training and DHHR central and regional administrative staff reported that there are currently no plans to provide additional formal training. Almost a quarter (23%) of county-level DHHR staff said that there is a need for refresher Safe at Home training. Some of the training topics staff suggested include case studies/scenarios to learn best practices when working with the Safe at Home youth and their families, information about the types of services that LCAs can provide clients, strategies for family engagement to increase family buy-in, and information on how to coordinate efforts in creating DHHR case plans and LCA Wraparound plans and DHHR crisis safety plans and LCA Wraparound crisis plans.

Nearly three-quarters (74%) of the LCA staff interviewed reported that they and/or their staff received Wraparound 101 training from either the State or their own agency. Most LCA staff who had received training (88%) agreed that the training was adequate in preparing them and/or their staff for their role(s) in the program. DHHR provided Advanced Wraparound to LCA program managers and other LCA staff as part of a "train-the-trainer" effort. These efforts have enabled the LCAs to certify their own trainers and develop internal training programs for their Safe at Home staff. Often, LCAs will also collaborate when they have trainings coming up so that they can plan for cross-LCA participation.

Safe at Home training for LCA staff is more extensive than that of DHHR staff, which was not surprising since LCA staff are responsible for providing Wraparound services directly to the program's clients. All LCAs provide the State required trainings, which include the following topics: Wraparound, CANS, CPR, and first aid. Additionally, LCAs provide a mix of program-specific and clinical trainings for their Safe at Home staff. Some

examples of program-specific training include Applied Wraparound and Wraparound Case Management. Additional clinical training includes a wide range of topics from trauma, to youth and family engagement, de-escalation techniques, and crisis intervention. Some LCA staff also reported their agencies provide training for working with special populations, such as LGBTQ youth and youth with developmental disabilities and/or autism.

Communication and Oversight

DHHR central office staff reported that they have continued to produce communications for public audiences, such as a quarterly newsletter and program flyers. Semi-annual evaluation reports are also openly available on the Safe at Home website. Additionally, an email address is available on the program website for anyone who wishes to contact DHHR with questions or to find out more about the program; all emails are auto sent to the DHHR Safe at Home program director.

Generally, DHHR staff reported that internal communication regarding Safe at Home has been adequate. Communication regarding Safe at Home for DHHR staff typically adheres to the existing DHHR bi-directional communication structure. The same process is used to communicate policy changes.

When DHHR caseworkers have an issue or question about the program, they approach their supervisor first, who will bring the issue to the regional level if it cannot be resolved locally. Region 3 DHHR staff also reported having child welfare consultants who are resources to clarify policy and respond to caseworker questions about the program. Staff from Regions 1 and 3 reported Safe at Home is a standing-agenda item for unit meetings.

Communication between DHHR and LCA staff was also reported to be working well, with some staff claiming that minor improvement is necessary. DHHR central and regional administrative staff reported attending quarterly in-person meetings and monthly conference calls with LCA staff. Regional DHHR staff reported working with LCA staff to resolve issues that are brought to their attention.

Judges and juvenile probation officers overall reported frequent communication with DHHR staff. These communications took place through multiple mediums, such as email, phone calls, and in-person meetings. Regular communication between juvenile probation officers and DHHR and LCA staff ranged from once per month to daily with communication increasing when needed (e.g., for youth in crisis).

Judges also reported that communication with LCA staff is adequate. All but one of the judges reported direct communication with LCA staff, usually at court. Wraparound facilitators reported attending hearings for youth who are court-involved. Some wraparound facilitators interviewed shared that they provide written case summaries to the court and approximately half of the judges reported that it has been useful to them when LCA

staff report on case progress during hearings.

DHHR oversight for Safe at Home is provided at every staffing level. DHHR central office staff provide high-level oversight and guidance for the program. DHHR regional office staff maintain and monitor a log of all open Safe at Home cases, review all referrals, and provide support at the county-level when issues cannot be resolved locally. Safe at Home cases are often staffed regularly among DHHR supervisors and their caseworkers in all four regions.

Program Buy-In

DHHR staff in all regions reported that judges now better understand and support Safe at Home than they did when Safe at Home was first implemented. Staff claimed that judge buy-in has increased through their witnessing success with Safe at Home cases in their courts. DHHR and LCA staff have met with judges independently and together to educate them on the program. Multiple central office staff reported participation in the Court Improvement Project, where updates on Safe at Home are often shared. A DHHR staff member noted that, "some judges are strong proponents of the program and often mitigate issues with fellow judges regarding the benefits of Safe at Home*".*

DHHR staff, in one particular Region, reported that their local judges had been initially court ordering youth and families to participate in the program and that this practice has diminished now that the judges understand participation in Safe at Home is voluntary and why that is an important element of the program.

A majority of DHHR caseworkers and their supervisors, as well as wraparound facilitators and their supervisors, reported that family engagement and compliance with the program is high. One DHHR caseworker said that, "the families that buy-in to it get quality out of it". Family schedules and lack of transportation have made engagement difficult for some families while wraparound facilitators reported that some families only comply with the program because they are forced due to court involvement.

Referrals

Youth are referred to Safe at Home by DHHR caseworkers, although a request for a referral to the program may be made by judges or probation officers as well as the rarer occurrence of self-referrals by youth or their caregivers. All DHHR caseworkers reported that they consider the specifics of a case against the eligibility requirements when determining which youth to refer to the program. DHHR supervisors in Regions 1 and 4 reported discussing Safe at Home referrals with their staff before approving referrals while those in Region 3 reported frequently discussing potential referrals at multidisciplinary team meetings.

Overall, most DHHR and LCA staff reported that the referral process was working well. Some issues

continue, however, which mostly result from a lack of adequate information being transmitted from DHHR to the LCAs. LCA staff reported receiving referrals that are missing contact information or incorrect information regarding who has legal custody of youth. Supporting documentation, such as psychological evaluations or information from the school, was often reported to be missing. A couple of wraparound facilitators noted that the caseworker provides these documents when requested; however, this represents a duplication of effort because the supporting documents, which are included with the referral, somehow are not passed along through the approval process. DHHR staff noted that the referral is lengthy and time-consuming to complete, with one staff member stating that there are redundancies that could be removed to streamline the referral. While they are not involved in the referral process, juvenile probation officers reported that the process to refer a youth to Safe at Home takes too long and delays the start of service provision, where immediate services are needed for these youth to remain in their homes.

Forty-two percent of DHHR caseworkers reported that they spend less time on Safe at Home cases than they do their others. The main reason for this was due to the increased involvement of the wraparound facilitator. Thirty-six percent of DHHR caseworkers reported that they spend the same amount of time on Safe at Home as they do on non-Safe at Home cases. Twenty-four percent reported that they spend more time on Safe at Home cases, and this was largely attributed to an increase in communication, meeting, and documentation requirements associated with the program.

Youth and Family Characteristics

In addition to the information gathered from FACTS to describe Safe at Home youth and families, the interviews were used to gain the perspectives of individuals who are involved with the clients. The most common issues that juvenile probation officers reported facing with youth ages 12-17 on their caseload were a lack of caregiver supervision, truancy, and drug use by either the youth or their caregiver(s). Education and school issues, such as poor grades and disruptive behavior, were also mentioned for the youth.

All of the judges interviewed reported drug use by either the youth or their caregiver(s) as the most major issue facing youth ages 12-17 in their courts. Two judges noted that they have few placement options for these youth even when the issue is the caregiver's drug use because family-wide drug use prevents placement with relatives and there is a general lack of foster homes willing to take youth. One judge noted that intergenerational drug use is a difficult cycle to break while another said that "Safe at Home has not really alleviated the drug problem, but it gives kids a fighting chance to have an adult to guide them"

Juvenile probation officers reported that Safe at Home has helped alleviate some of these issues by helping the family access resources and reminding them about appointments. One juvenile probation officer explained how Safe at Home has addressed the lack of caregiver supervision, noting that, "Safe at Home is oriented to what the family needs for things to work. They are not just pointing at the juvenile as the problem. It

has been a very effective approach." Another noted that Safe at Home has been an effective "communication bridge" between caregivers and youth.

Youth with truancy and other educational issues also have been helped through Safe at Home, according to juvenile probation officers. Wraparound facilitators have made sure youth get to school, have linked youth to tutors, and in one case, provided a bicycle so a youth could attend an alternative school for which there is no bus service. One juvenile probation officer stated that, "The chances of a kid going to school and staying in long enough to graduate increases greatly with Safe at Home." Other successes that juvenile probation officers reported included finding a place to live for a youth whose caregiver died and transitioning a youth successfully into adulthood.

During the interviews, DHHR and LCA staff often noted the program has been more successful for younger youth. The reasons given for this observation were that younger youth have less severe issues, were easier to find activities for, and were more willing to engage with the wraparound facilitator. For those staff who saw older youth as more successful with the program, the primary reasons given were that older youth were more mature, had an enhanced ability to set their own goals, and had a better recognition of their need for skills to transition to adulthood. Other factors that increased youth success in the program included: higher levels of caregiver buy-in, youth who were not yet court-involved, youth who had status offenses rather than delinquency issues, and youth who were in the prevention category.

DHHR and LCA staff inversely reported that youth faced greater hurdles to success if there was court-involvement, a lack of caregiver or youth buy-in, intergenerational drug use, a single caregiver or divorced caregivers, developmental disabilities present, families with very low-income, and families with a history of violence or where there were domestic violence issues present in the home.

LCA Service Provision

Wraparound facilitators link youth and their families to a variety of services available in their communities. These include tutoring and mentoring, parenting skills education, counseling and therapy, legal assistance, and community resources such as food banks. Additionally, flexible funding available through Safe at Home has been used to provide memberships for youth to the YMCA and to pay for expenses to participate in youth-oriented community activities such as a community playhouse and local sports as well as to purchase essentials like a stove, a bicycle, and repairs for the family vehicle.

LCA staff from every region reported services that were unavailable or more challenging to provide. Transportation was a reported issue throughout the State, which is mostly rural and lacking in public transportation, and LCA staff often reported that their agency developed a transportation resource so that families without reliable transportation could get to appointments and youth to school. Other services with

limited availability include those for mental health, autism and developmental disabilities, mentoring and caregiver respite services. Staff from four LCA agencies reported that their agency is able to provide some services in-house, such as clinical assessments, counseling and/or therapy, tutoring and/or mentorship, crisis support, anger management and medication management. LCA staff from one agency that provides mentoring services to youth involved with Safe at Home said that they attempt to transition youth to a mentor in the community prior to the youth completing the program. Wraparound facilitators reported providing some direct services such as adult life skills and parenting skills education, in addition to educating the youth and family about goal setting which is central to Safe at Home.

Wraparound facilitators provided examples of creative approaches they have used to engage youth and families as well as to help youth and families to succeed. One example is that Safe at Home was able to provide a dress for a youth to attend prom. Another example is providing boxing gloves to an aggressive youth and education in the nonviolent philosophy of boxing through a community boxing club. Another example is that an older youth with a low IQ was linked to Youth Build, which is providing him job training and the supports he will need to successfully transition to adulthood and enter the workforce.

Sustainability

With the conclusion of the Title IV-E Waiver demonstration period quickly approaching, several questions concerning the sustainability of Safe at Home were included in this round of stakeholder interviews. Central office staff, regional office staff, community service managers, LCA program managers, and wraparound supervisors were asked if they have been involved in the sustainability planning process for Safe at Home. Most interviewees reported being involved in the sustainability planning process in some capacity, primarily as participants in quarterly meetings and workgroups devoted to the topic. All stakeholders who were asked agreed they would like to see Safe at Home be sustained beyond the Waiver demonstration period. As one LCA program manager stated, “Safe at Home has been a valuable asset to our community, and we would hate to lose it.”

Central and regional office staff agreed that the State hopes to be able to leverage the Family First Prevention Services Act (FFPSA) to sustain Safe at Home. When asked about other potential funding sources being considered in planning for the sustainability of Safe at Home, several staff identified the Medicaid Serious Emotional Disturbance Waiver as a potential source.

Stakeholders were asked if they were aware of any programs being used in West Virginia or elsewhere which were similar to Safe at Home or could benefit the same youth and families; by far the most commonly cited program was West Virginia’s Children’s Mental Health Wraparound, a pilot project of the Bureau for Behavioral Health and Health Facilities.

Interviewees were asked if they had any concerns about the sustainability of Safe at Home. Table 3 shows the most common responses.

Table 3. Sustainability Interview Responses	
Sentiment	**Number in Agreement**
Funding in light of FFPSA	31
No concerns	23
Loss of flexible funding	4
State leadership will evaluate the program's effectiveness solely on success rates and statistics	4

Successes, Challenges, and Hopes

Eighty-five percent of interviewed stakeholders agreed Safe at Home has been mostly effective in achieving its goals. All interviewees were asked about both the successes and challenges they have experienced in working with Safe at Home. Table 4 provides a summation of the most common responses.

Table 4. Successes and Challenges Interview Responses	
Sentiment	**Number in Agreement**
Successes	
The wholistic, family-centered approach (engaging the whole family as a unit and involving the family in the decision-making process)	28
Frequency of contact and level of involvement of the wraparound facilitators, including the amount of time facilitators have available to work directly with youth/families	20
Preventing removals/use of congregate care and keeping youth with their families (and in-state)	11
Team effort (LCA and DHHR collaboration)	10
Connecting youth/families to the services they need	10
Helping troubled youth/families achieve positive outcomes	6
Individualized, needs-based approach / customized plan for each family	6
Providing transportation to help clients access services in the community	4
Accessing mentoring services for youth	4
Flexible funding	4

Table 4. Successes and Challenges Interview Responses	
Sentiment	**Number in Agreement**
Challenges	
Lack of resources and services available in rural areas	22
Lack of family or youth buy-in/commitment to the program	11
DHHR challenges working with specific LCAs	10
Accuracy, timeliness and volume of referrals / Difficulty obtaining required documentation/information in a timely manner	9
Difficulties finding community resources to help youth who have severe mental or behavioral health needs or other special needs	7
Cases being referred when it is too late to truly help the youth and family	6
Buy-in and support from judges / court staff	5
Program's age restrictions	4
Staff turnover, especially among wraparound facilitators	3
Difficulties with crisis intervention	3

As Table 4 reveals, Safe at Home's wholistic, family-centered approach was the most frequently cited strength of the program during this round of stakeholder interviews. Stakeholders mentioned that engaging the family as a unit and involving them in the decision-making and planning processes makes them more likely to engage in the program and remain committed in the long run.

Another program strength mentioned by many stakeholders was the frequency of the wraparound facilitators' contact (particularly face-to-face contact) with the clients. Interviewees pointed out that the facilitators' smaller caseloads allow them to devote more time and attention to each youth and family, which is important because it takes time for the facilitator to cultivate a relationship with the youth and family and earn their trust.

Certainly, one of the more central themes present throughout the stakeholder interviews was the tremendous importance of the wraparound facilitators and the role they play in Safe at Home. Numerous interviewees expressed that the program's effectiveness is largely dependent on the individual facilitator in each case, essentially stating that each Safe at Home case will be as successful (or inversely, unsuccessful) as the facilitator makes it. With a select few exceptions, stakeholders' opinions of the wraparound facilitators were overwhelmingly positive. As one interviewee stated, "A large part of Safe at Home's success is the personalities of the individual workers." Another said, "Safe at Home is a breath of fresh air. The facilitators care about the families and about the kids."

Challenges associated with Safe at Home were also identified, chief among them, the overall lack of service availability throughout much of the State, particularly in the more rural communities. Stakeholders explained it is extremely difficult to provide services consistently across the State because certain types of services simply are not available in certain areas. Other commonly reported challenges include noncompliant youth and difficulties getting families to buy in and commit to the program; challenges working with certain LCAs, some of which keep too much in-house and do not partner enough with outside/community providers; challenges related to the accuracy, timeliness and volume of referrals and difficulties obtaining required documentation; and difficulties finding appropriate services for youth with severe mental or behavioral health needs or other special needs (examples provided include a youth with an autism diagnosis and another youth with special dietary needs).

Numerous interviewees expressed frustration with the timing of when youth are referred to Safe at Home, with the referral coming after the situation bringing them to the attention of the agency has escalated too far for the program to come in and have a positive effect. When asked what could be done to address this issue, one interviewee suggested that if Safe at Home worked with pre-petition probation, getting involved in cases before behavior escalates and before the youth is on the verge of being incarcerated, the program could be much more beneficial. According to one juvenile probation officer, "The time lapse between the recommendation being made by the court, probation officer or school and the case being picked up by the facilitator is a very big issue. It needs to be more immediate. These kids cannot wait two months for Safe at Home to start. Probation in West Virginia is very hands on. That only DHHR can make referrals to Safe at Home is a handicap." Several stakeholders echoed the sentiment that the sooner the LCA receives the referral, the better the family's chance for success.

While several stakeholders reported encountering issues during the early implementation phase of Safe at Home with certain judges' apprehensiveness about the program, data from this round of interviews indicate that a vast majority of judges have since come around and now vocally support Safe at Home. Interviewees acknowledged that while there still are a small number of judges who do not support the program's efforts, they are most certainly the outliers. All judges agreed they would like to see Safe at Home sustained beyond the Title IV-E Waiver demonstration period.

Interviewees also were asked to identify any social, political or economic factors in West Virginia which have impacted the potential success of Safe at Home. Across all regions and stakeholder types, the most commonly mentioned contextual factor was the opioid/drug epidemic which is currently devastating West Virginia and other states.

Another contextual factor which was commonly identified by stakeholders as having impacted Safe at Home was the poor state of West Virginia's economy. Some stakeholders expressed that the State does not have the resources to properly support the Safe at Home model. The overall lack of money and resources has

been a challenge with many Safe at Home cases. As one facilitator put it, "It's hard to get people to engage [in Safe at Home] when they are worried about where their next meal is coming from." Another facilitator pointed out that when a parent is worried about being able to provide basic necessities, like food and shelter, for his or her family, it is difficult to see the youth's behavior as a priority issue.

All stakeholders interviewed shared hope that the program would be sustained beyond the end of the Waiver demonstration period in October 2019. In addition, numerous stakeholders expressed that they would like to see the program's target population expanded to include younger children (i.e., children under the age of 12). This hope was shared by various stakeholders from DHHR supervisors and caseworkers to judges and juvenile probation officers.

Summary of Process Evaluation Results

Overall, there were no substantial changes noted to Safe at Home's youth population. The program continues to be prevention focused based on the referrals received. The vast majority of youth in Safe at Home have Youth Services cases and a minority have CPS cases.

Between half and three-quarters of DHHR staff and the overwhelming majority of LCA staff agreed that their training adequately prepared them and/or their staff for their role(s) in the program. However, almost a quarter of county-level DHHR staff said that there is a need for refresher Safe at Home training.

DHHR staff across all regions agreed that judges better understand and support Safe at Home now than they had earlier in implementation periods, attributing the increased buy-in of judges to witnessing success with Safe at Home cases in their own courts.

Many DHHR and LCA staff observed greater success with the program in younger youth. The reasons given for this observation were that younger youth have less severe issues, were easier to find activities for, and were more willing to engage with the wraparound facilitator. For the few staff who saw older youth as being more successful with the program, the primary reasons given were that older youth were more mature, had an enhanced ability to set their own goals, and a better recognition of their need for skills to transition to adulthood. Other factors that increased youth success in the program included: higher levels of caregiver buy-in, youth who were not yet court-involved, youth who had status offenses rather than delinquency issues, and youth who were in the prevention category.

DHHR and LCA staff inversely reported that youth faced greater hurdles to success if there was court-involvement, a lack of caregiver or youth buy-in, intergenerational drug use, a single caregiver or divorced caregivers, developmental disabilities present, families with very low-income, and families with a history of violence or where there were domestic violence issues present in the home.

Wraparound facilitators reported linking youth and their families to a variety of services available in their communities. Some examples include tutoring and mentoring, parenting skills education, counseling and therapy, legal assistance, and community resources such as food banks. Additionally, flexible funding available through Safe at Home has been used to provide memberships for youth to the YMCA and expenses to participate in youth-oriented community activities such as a community playhouse and local sports as well as to purchase essentials for families, like a stove, a bicycle, and repairs for the family vehicle.

All stakeholders who were asked agreed they would like to see Safe at Home be sustained beyond the Waiver demonstration period. The greatest concern regarding sustainability was a possible inability to fund Safe at Home once the Waiver ends or uncertainty regarding how Safe at Home will or will not fit into FFPSA requirements. Inversely, a high number of stakeholders had no concerns regarding sustainability.

The overwhelming majority of stakeholders agreed that Safe at Home has been mostly effective in achieving its goals. The wholistic, family-centered approach was regarded as the most successful component of the program. The greatest challenge reported was a lack of resources and services available in rural communities. Stakeholders shared additional concerns about the State's opioid epidemic and how it has negatively impacted the potential for programmatic success.

Outcome Evaluation Results:

Youth Cohort Analysis

Since implementation of Safe at Home in October 1, 2015, a total of 2,526 youth has been referred to the program as of March 31, 2019. For the analysis of outcomes, youth are divided into six-month cohorts based on the date they were referred to Safe at Home (Table 5); the six-month cohorts make it possible to measure changes in outcomes over time. Outcomes are measured for youth when enough time has passed to allow for six or twelve-month measurements; for this reason, data available for youth in the most recent cohort (i.e., Cohort 7) are limited to only descriptive information about the youth population because a full six months in the program has not passed for youth in this cohort.[4]

The matched comparison groups were selected by using Propensity Score Matching (PSM), which relies on data from FACTS. The comparison pools are comprised of youth who meet the Safe at Home referral criteria during SFYs 2010 through 2015. Propensity scores were calculated using age at referral, gender, race, ethnicity, initial placement setting, report allegation, number of prior placements, evidence of an axis one diagnosis, juvenile justice involvement and if the youth were ever in a psychiatric hospital or group home. These scores were matched using a nearest neighbor algorithm to select a comparison group that is statistically similar to the

[4] For descriptive data on the most recent cohort, please see the process evaluation section, Page 3.

treatment group (see Appendix A). For each cohort, there are an equal number of youth in the treatment and comparison groups.

Table 5. Youth Cohorts			
Cohort	**Group**	**Referral Period**	**Number of Youth**
1	Treatment	October 1, 2015 — March 31, 2016	124
	Comparison	SFY 2010 — 2015	124
2	Treatment	April 1, 2016 — September 30, 2016	221
	Comparison	SFY 2010 — 2015	221
3	Treatment	October 1, 2016 — March 31, 2017	297
	Comparison	SFY 2010 — 2015	297
4	Treatment	April 1, 2017 — September 30, 2017	445
	Comparison	SFY 2010 — 2015	445
5	Treatment	October 1, 2017 — March 31, 2018	512
	Comparison	SFY 2010 — 2015	512
6	Treatment	April 1, 2018 — September 30, 2018	463
	Comparison	SFY 2010 — 2015	463
7	Treatment	October 1, 2018 — March 31, 2019	464
	Comparison	SFY 2010 — 2015	-
Total	**Treatment**	**October 1, 2015 — March 31, 2019**	**2,526**
	Comparison	**SFY 2010 — 2015**	**2,526**

Population Analysis

In order to identify populations for which Safe at Home works best, a combination of random forest and logistic regression analyses were performed for several of the outcome measures. The population factors which were tested to determine their influence on outcomes include county, gender, race, placement at referral, length of time out-of-state prior to referral, age, length of DHHR case activity prior to referral, presence of a mental health diagnosis, juvenile justice involvement, substance use, whether formal services have been received, and number of actionable items in the CANS' domains. Each of these factors have been run against the following outcome measures: initial congregate care entries; congregate care re-entries; length of stay in congregate care; county movement (e.g., home-county to out-of-county and out-of-county to home-county); initial foster care entries; and foster care re-entries.

The first step in the population analysis is to run a random forest using the complete list of factors above against the various outcome measures. Random forests generate 500 unique population samples equal in size to the original population (i.e., all applicable treatment group members for each outcome). The population samples are made by randomly sampling the original population with replacement. These 500 samples are used to make unique decision trees. Each tree creates a flowchart-type structure of factors that best split the population into

those who have a given outcome vs. those who do not. Trees stop splitting when there is no benefit to dividing the population. After all 500 trees are made, the importance of each factor is determined by its effectiveness to split the population and isolate those with and without each outcome, also referred to as the mean decrease in Gini. Typically, factors that are the most commonly seen in the decision trees are classified as the most important.

While random forests are able to intuitively split the data and determine variable importance, this technique does not allow for correlation direction (i.e., positive or negative) or significance determination; therefore, the second step of this analysis is to run a regression analysis. The regression used the same inputs as the random forest to determine which variables were positively or negatively correlated as well as their respective p-values, i.e., to measure the significance of the factor in having an influence. Whenever any of the factors from the analysis are found to have a substantial impact (which can be either statistically significant or not) on any of the outcome measures, they are described in detail while discussing each specific outcome measure.

Figures showing the results of this analysis (e.g., Figure 17) can be found after the discussion of each respective outcomes. The figures are color coded green to show protective (i.e., positive) factors and red to show risk (i.e., negative) factors. If the factor was found to be significant the bar is completely shaded while non-significant finds are lightly shaded.

Youth Placement Changes

Table 6 identifies where Safe at Home youth in Cohorts 1 through 6 were placed when they were referred to the program and then again six months following referral. A small subset of youth was placed in detention, transitional placement, or on runaway status at six months; however, since these placement types impact only a small number of youth (23 across all cohorts), they are included in a footnote due to space constrictions.

Table 6. Safe at Home Youth Placements at Referral and 6 Months						
Cohort 1						
Placement at Referral	**Placement at 6 Months**					
	OOS CC[5]	IS CC[6]	ES[7]	FFC[8]	Home	**Total at Referral**
OOS CC	11	4	1	2	13	31
IS CC	1	11	3	2	20	37
ES	1	2	0	0	1	4
FFC	0	2	0	0	0	2

[5] "Out-of-State Congregate Care" has been abbreviated to "OOS CC" due to space constrictions.
[6] "In-State Congregate Care" has been abbreviated to "IS CC" due to space constrictions.
[7] "Emergency Shelter" has been abbreviated to "ES" due to space constrictions.
[8] "Family Foster Care" has been abbreviated to "FFC" due to space constrictions.

Table 6. Safe at Home Youth Placements at Referral and 6 Months						
Home	3	6	3	0	33	45
Total at 6 Months[9]	16	25	7	4	67	119
Cohort 2						
Placement at Referral	**Placement at 6 Months**					
	OOS CC	IS CC	ES	FFC	Home	**Total at Referral**
OOS CC	3	2	1	0	12	18
IS CC	3	25	4	3	37	72
ES	0	6	4	3	4	17
FFC	0	2	2	4	3	11
Home	0	11	2	1	84	98
Total at 6 Months[10]	6	46	13	11	140	216
Cohort 3						
Placement at Referral	**Placement at 6 Months**					
	OOS CC	IS CC	ES	FFC	Home	**Total at Referral**
OOS CC	3	0	0	1	8	12
IS CC	0	9	2	6	42	59
ES	0	0	1	0	5	6
FFC	1	1	2	8	1	13
Home	4	30	6	6	158	204
Total at 6 Months[11]	8	40	11	21	214	294
Cohort 4						
Placement at Referral	**Placement at 6 Months**					
	OOS CC	IS CC	ES	FFC	Home	**Total at Referral**
OOS CC	2	0	0	0	10	12
IS CC	1	11	3	5	40	60

[9] At six months, three youth from Cohort 1 were placed in detention and two youth had a "runaway" status. Of those youth in detention at six months, one began in in-state congregate care, one began in an emergency shelter and the third began at home. Of the two youth with a runaway status at six months, one began in in-state congregate care and the other began in an emergency shelter.

[10] At six months, there was one youth from Cohort 2 in detention and four youth with a status of runaway. For the youth in detention at six months, s/he started the program at home. Of the four youth on runaway status, two were referred while placed at home, one was referred while in in-state congregate care and the fourth was referred from an emergency shelter placement.

[11] From Cohort 3, there were two youth placed in detention at six months post-referral; both of them were referred from in-state congregate care. One youth had run away from home at six months.

Table 6. Safe at Home Youth Placements at Referral and 6 Months						
ES	2	2	1	1	7	13
FFC	0	2	1	14	10	27
Home	6	49	7	1	268	331
Total at 6 Months[12]	11	64	12	21	335	443
Cohort 5						
Placement at Referral	**Placement at 6 Months**					
	OOS CC	IS CC	ES	FFC	Home	**Total at Referral**
OOS CC	2	2	0	0	13	17
IS CC	1	12	2	2	34	51
ES	3	6	0	2	11	22
FFC	1	4	2	20	7	34
Home	5	49	9	12	307	382
Total at 6 Months[13]	12	73	13	36	372	506
Cohort 6						
Placement at Referral	**Placement at 6 Months**					
	OOS CC	IS CC	ES	FFC	Home	**Total at Referral**
OOS CC	0	0	0	2	10	12
IS CC	0	6	0	4	25	35
ES	0	4	0	1	10	15
FFC	0	5	1	21	7	34
Home	5	33	11	6	310	365
Total at 6 Months[14]	5	48	12	34	362	461

In more recent cohorts there has been an increase in the number of youth who are placed in an in state congregate care setting by the end of six months. For example, in the first cohort there was a 40 percent decrease in the number of youth in an in state congregate care facility at six months, but in the most recent reportable time frame (Cohort 6) there is nearly no change in the number of youth in those facilities. The majority of youth in an in state congregate care facility at six months in Cohorts 3, 4, 5, and 6 were referred in home.

Youth across cohorts who were referred from congregate care (either in state or out of state) are

[12] At six months, two youth from Cohort 4 were placed in detention; both youth were at home at the time of referral.

[13] Six youth from Cohort 5 were placed in detention at six months; five of them were referred while living at home and one was referred from in-state congregate care.

[14] At six months, two youth from Cohort 6 were placed in detention; both youth were at home at the time of referral.

consistently being stepped down into lower level placements at six months (on average, 75 percent of the youth are placed in a lower level of care within six months of referral). However, the overall number of youth living at home at six months has been decreasing over time. On average, 70 percent of the youth who were referred from congregate care were placed in their homes at six months across all six cohorts.

Eighty-one percent of the youth who started the program while living at home were still there at six months across all six cohorts. The impact was lowest for youth in Cohort 1, with only 73 percent remaining at home, and highest for youth in Cohorts 2 and 6 with roughly 85 percent still at home. There was less variation among Cohorts 3 through 5, with 77 to 81 percent of youth still living at home at six months.

Similar to Table 6, Table 7 displays the placements of Safe at Home youth at referral and then again at twelve months following referral. Placements of detention, runaway status, or transitional living continued to impact a minimal number of youth, and are thus shared, again, in footnotes. Table 7 only includes youth from Cohorts 1 through 5 since not enough time has passed to examine twelve-month outcomes for youth in Cohort 6.

Table 7. Safe at Home Youth Placements at Referral and 12 Months

Cohort 1						
Placement at Referral	**Placement at 12 Months**					
	OOS CC[15]	IS CC[16]	ES[17]	FFC[18]	Home	**Total at Referral**
OOS CC	5	4	3	2	16	30
IS CC	3	8	3	2	21	37
ES	1	2	0	0	2	5
FFC	0	0	1	0	1	2
Home	4	8	2	1	31	46
Total at 12 Months[19]	13	22	9	5	71	120
Cohort 2						
Placement at Referral	**Placement at 12 Months**					
	OOS CC	IS CC	ES	FFC	Home	**Total at Referral**
OOS CC	4	1	0	1	12	18
IS CC	6	16	4	7	37	70
ES	1	5	2	5	4	17

[15] "Out-of-State Congregate Care" has been abbreviated to "OOS CC" due to space constrictions.
[16] "In-State Congregate Care" has been abbreviated to "IS CC" due to space constrictions.
[17] "Emergency Shelter" has been abbreviated to "ES" due to space constrictions.
[18] "Family Foster Care" has been abbreviated to "FFC" due to space constrictions.
[19] For youth in Cohort 1, three youth had runaway at twelve months and one was placed in detention. The youth in detention was living in out-of-state congregate care when s/he was referred. Of the three youth who ran away, two were referred from in-state congregate care and one was from an emergency shelter.

Table 7. Safe at Home Youth Placements at Referral and 12 Months						
FFC	1	2	0	4	4	11
Home	7	23	0	1	68	99
Total at 12 Months[20]	19	47	6	18	125	215
Cohort 3						
Placement at Referral	**Placement at 12 Months**					
	OOS CC	IS CC	ES	FFC	Home	**Total at Referral**
OOS CC	3	0	0	1	8	12
IS CC	2	17	0	5	36	60
ES	0	0	1	2	3	6
FFC	0	3	0	4	6	13
Home	5	34	2	4	158	203
Total at 12 Months[21]	10	54	3	16	211	294
Cohort 4						
Placement at Referral	**Placement at 12 Months**					
	OOS CC	IS CC	ES	FFC	Home	**Total at Referral**
OOS CC	4	1	0	0	6	11
IS CC	3	10	2	6	39	60
ES	1	3	2	1	6	13
FFC	0	1	1	9	16	27
Home	12	42	8	7	261	330
Total at 12 Months[22]	20	57	13	23	328	441
Cohort 5						
Placement at Referral	**Placement at 12 Months**					
	OOS CC	IS CC	ES	FFC	Home	**Total at Referral**
OOS CC	0	3	1	0	13	17
IS CC	5	9	0	0	37	51

[20] At twelve months, two youth were in detention, three had run away and one was in transitional living from Cohort 2. Both youth in detention at twelve months were in in-state congregate care at referral. The one youth in transitional living was referred while at home. Of the three youth with a status of runaway, one was in in-state congregate care, the second was in an emergency shelter and the third was at home at the time of referral.

[21] From Cohort 3, one youth referred from in-state congregate care was in detention at twelve months and one youth referred from home had run away.

[22] At twelve months, four youth from Cohort 4 were placed in detention; three were referred while living at home and one was referred from out-of-state congregate care.

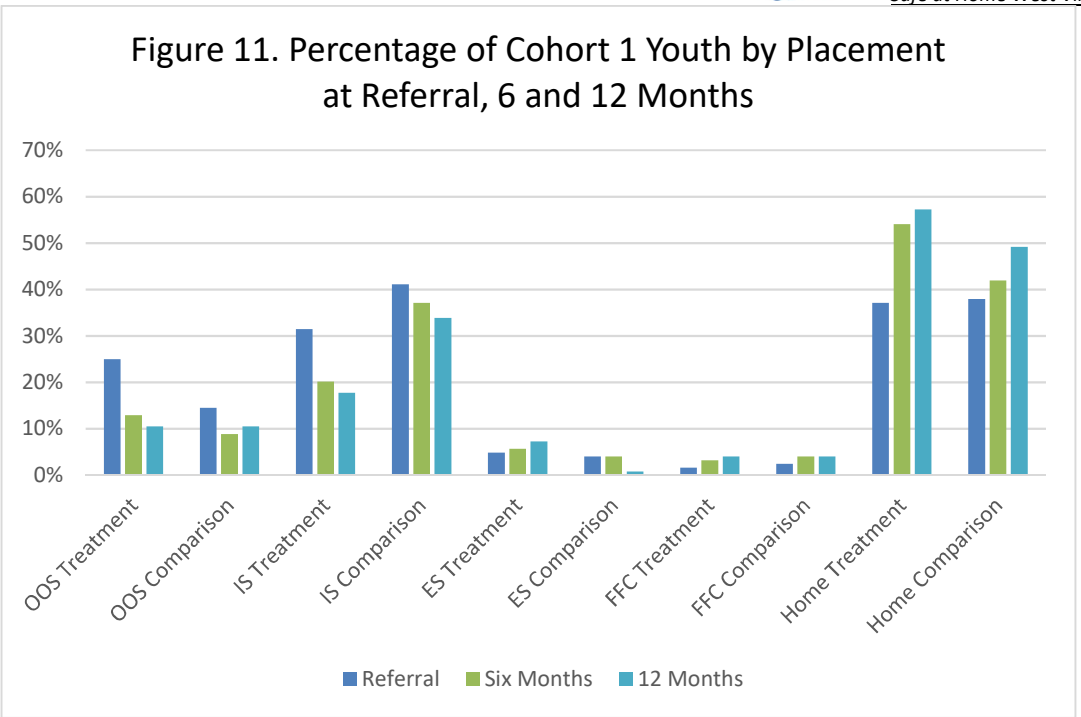
Table 7. Safe at Home Youth Placements at Referral and 12 Months						
ES	2	2	1	2	15	22
FFC	1	5	0	14	14	34
Home	10	49	9	15	302	385
Total at 12 Months[23]	18	68	11	31	381	509

The trend of increasing in state congregate care placements found at six months is more pronounced at twelve months. A similar trend is also observed for out of state congregate care. In Cohort 1 there was a 50 percent decrease in the number of youth in congregate care (both in and out of state) at twelve months, but by Cohort 5 there is a 26 percent increase. This shift in 12-month congregate care usage over time likely caused by the population shift of youth in Safe at Home since the program's implementation. More youth are referred from their homes who are already at risk to be removed. With more people involved in the case (e.g., Wraparound Facilitators), it could lead to higher rates of identifying issues that wouldn't have been seen previously.

The percentage of youth who were referred in congregate care and returned home has improved drastically over time (see Figure 11). This outcome has consistently improved across the lifetime of Safe at Home where 55 percent of youth in Cohort 1 who began Safe at Home in congregate care were living in their homes at twelve months compared to 74 percent of youth in Cohort 5.

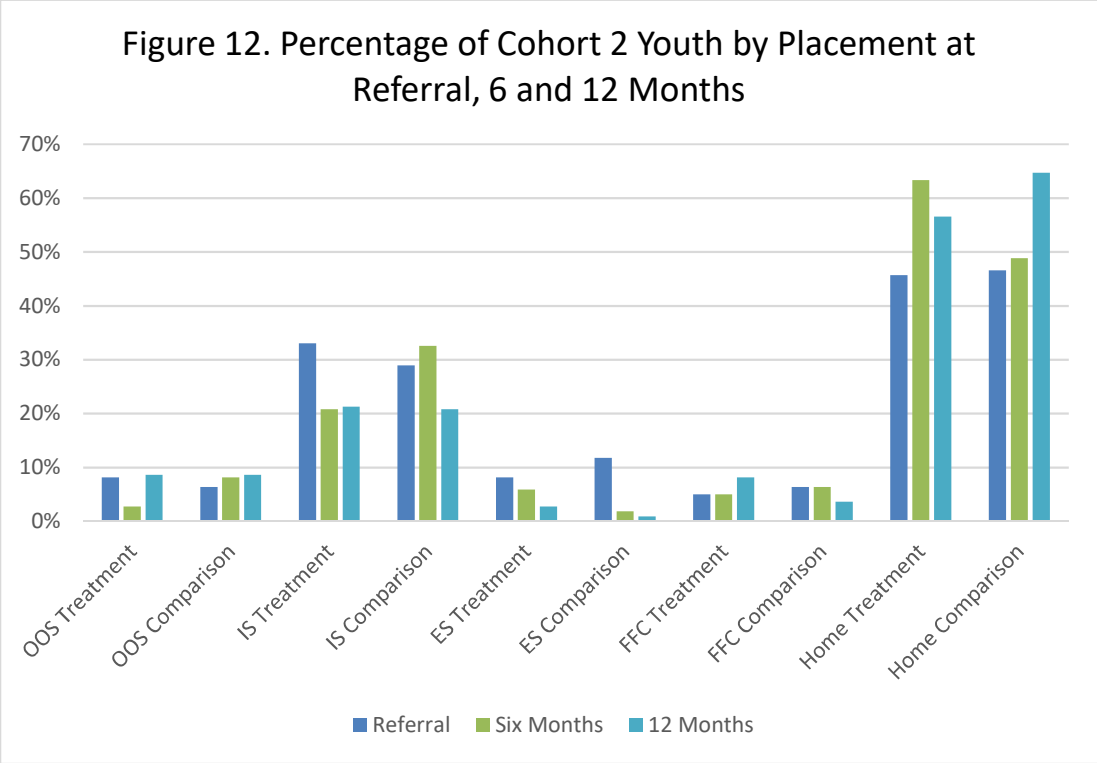
Contrasting the placement changes of youth in the comparison groups to those in Safe at Home (i.e., the treatment groups) provides an opportunity to assess the general impact Safe at Home is having on youth placements. Figure 11 compares the placements of Safe at Home youth along with their corresponding comparison youth for Cohort 1 at referral and at six- and twelve-months following referral.

[23] At twelve months, three youth from Cohort 5 were placed in detention; two were referred while living at home and one was referred from congregate care.



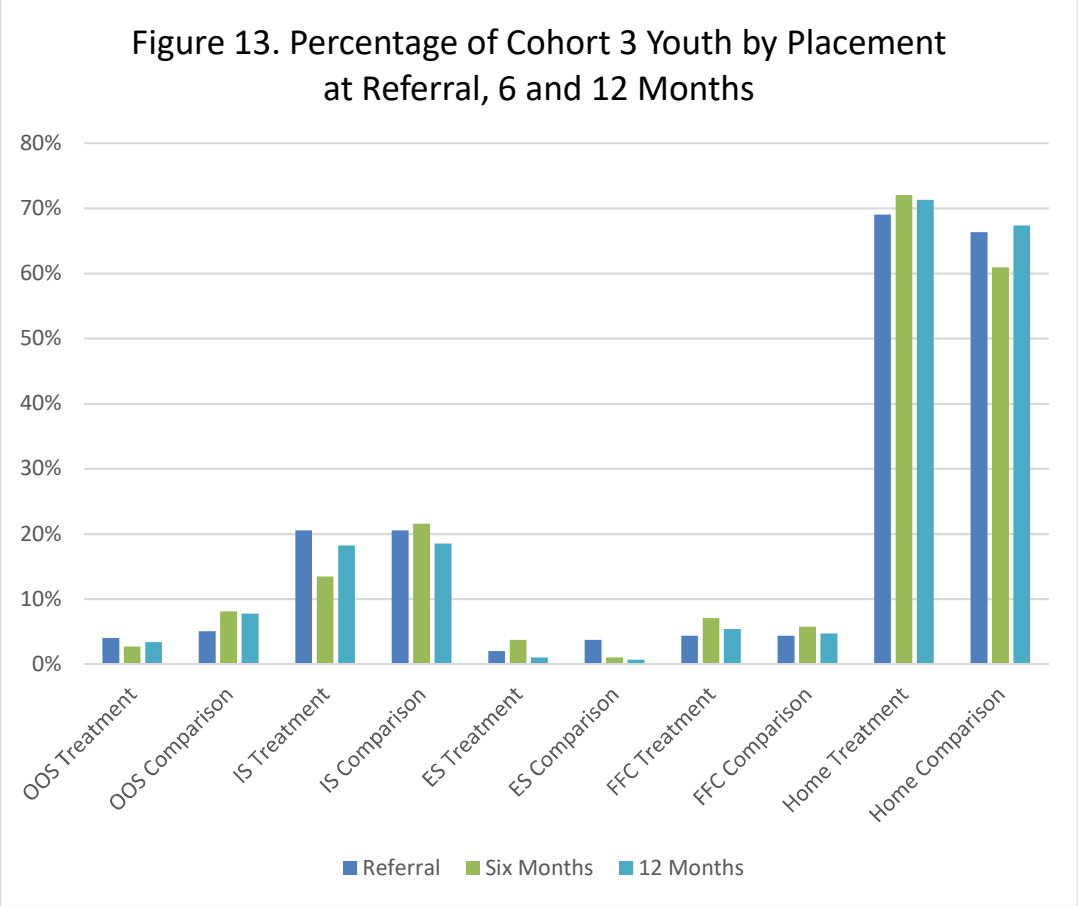
Overall, placements were better for Safe at Home youth in Cohort 1 than were the case for comparison youth. Both the treatment and comparison groups experienced reductions in congregate care placements six- and twelve-months following referral. The reduction of youth in both in and out-of-state congregate care is more apparent for youth in Safe at Home than it is for youth in the comparison group. An increased percentage of youth are living at home at six- and twelve-months post-referral for youth in both groups, but again, the positive difference is more pronounced for youth in Safe at Home.

Figure 12 replicates the analysis presented in Figure 11 for youth in Cohort 2.



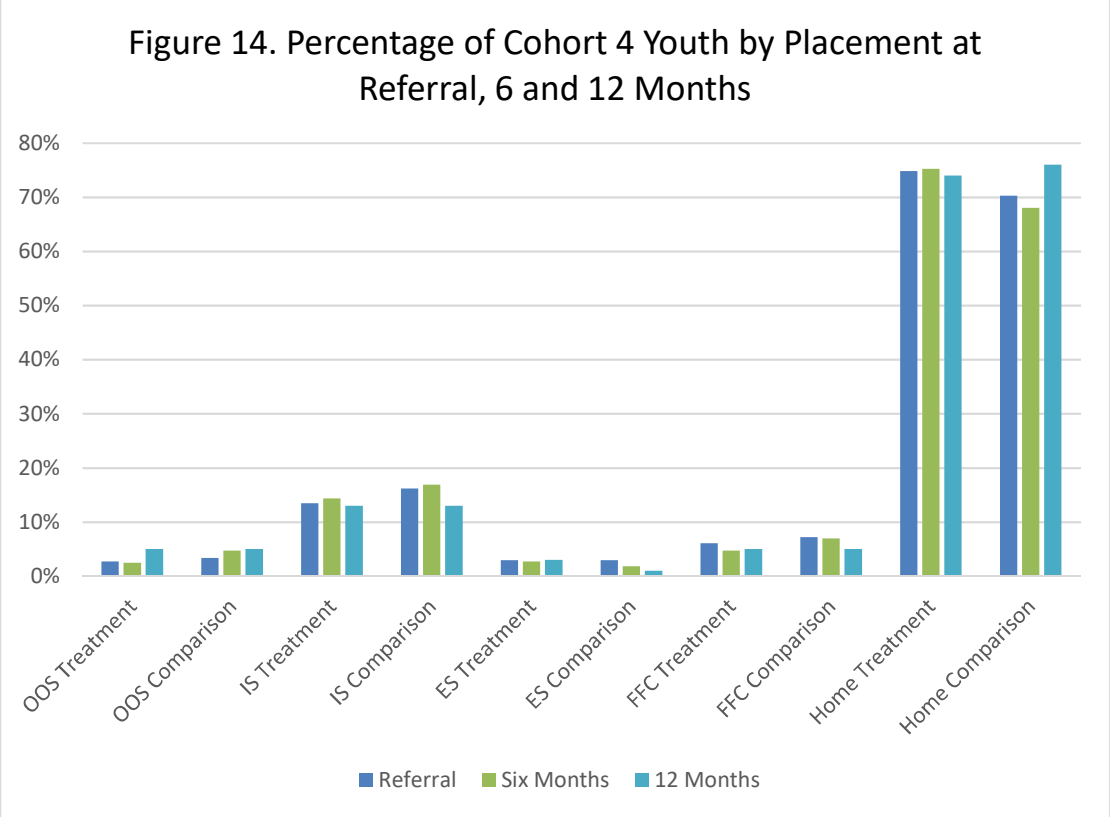
Although a small percentage of Cohort 2's treatment and comparison youth were referred while in an out-of-state congregate care placement, the comparison group experienced a slight increase in youth placed outside of West Virginia at both the six and twelve months. Interestingly, the percentage of Safe at Home youth living in out-of-state congregate care decreased by five percentage points six months after referral but increased by the same amount at twelve months. Safe at Home youth demonstrated reduced percentages of youth living in in-state congregate care at six and twelve months while the comparison group had increased percentages at six months but decreased percentages at twelve months. The percentage of youth in Safe at Home who were living at home increased from referral to six-months by 17 percentage points, then decreased by six percentage points from six-months to twelve-months. Comparison youth fared slightly better than treatment youth regarding at-home placement twelve months post-referral.

Figure 13 compares the treatment and comparison group placements for Cohort 3 at referral and six and twelve months after referral.



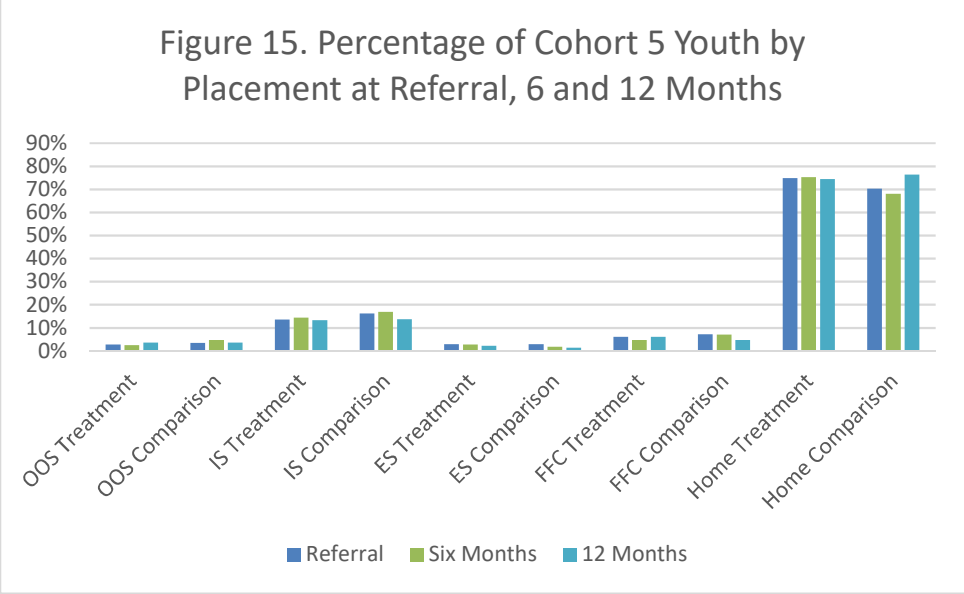
Overall, Safe at Home youth from Cohort 3 demonstrated more positive placement changes at six months than comparison youth. A smaller proportion of Safe at Home youth are in out-of-state or in-state congregate care facilities and more youth are in their homes when compared to youth in the comparison group. Each of these results is significant at the $p < 0.05$ level. By twelve months however, the treatment and comparison groups have similar proportions of youth in all placement settings, excluding out-of-state congregate care. A significantly lower percentage of Safe at Home youth were in out-of-state congregate care than those in the comparison group.

Figure 14 compares the placements of Cohort 4's Safe at Home youth to their corresponding comparison youth at referral and six months and twelve months following referral.



Overall, the differences between Safe at Home youth and comparison youth are minimal between six and twelve months. Regarding congregate care, there is a smaller percentage of Safe at Home youth in these settings at six months, but by twelve months there are no differences between Safe at Home and comparison youth. There is a higher proportion of Safe at Home youth living at home at six months, but by twelve months the difference is minimal, with a slightly higher percentage of youth in the comparison group in their homes than those in the treatment group. The six-month results for youth living at home at six months was statistically significant ($p<.05$).

Finally, Figure 15 displays the placements of Cohort 5's Safe at Home youth as well as the corresponding comparison youth at referral and six months and twelve months following referral.



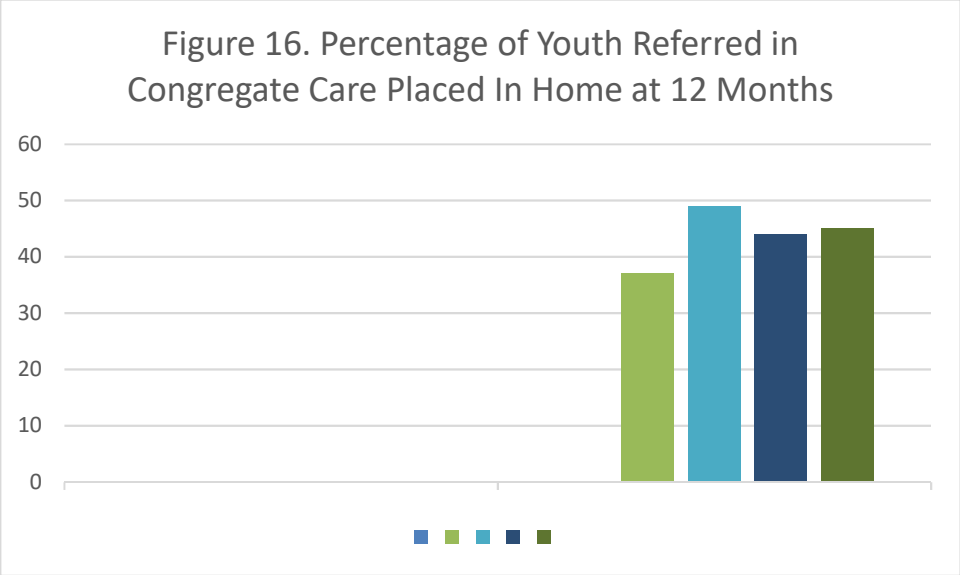
Similar to Cohort 4, the differences between Cohort 5 Safe at Home youth and comparison youth are minimal between six and twelve months. Roughly three-quarters of Safe at Home youth are placed in their own home at referral and at six and twelve months following the referral. A similar trend is shown in the comparison group. There are minor shifts in the percentages of youth in congregate care; however, none of those shifts are significant.

Overall, since the implementation of Safe at Home, the percentage of youth referred while in congregate care were placed in their home 12 months after referral and the percentage of youth who remained in their home has increased. Treatment group youth show a similar or decreased percentage of youth in congregate care at six and twelve months than the comparison group. In general, there are a higher percentage of treatment group youth living at home six-months after referral than comparison group youth; however, at twelve months, the trend inverts where a higher percentage of comparison group youth are at home.

Congregate Care

Safe at Home's main goal is to safely return youth to their homes and communities from congregate care and to prevent youth at risk of placement from ever entering congregate care. For those youth who do enter congregate care, the goal is to prevent prolonged placement in that setting.

To investigate the effectiveness of Safe at Home at returning youth who were referred in congregate care to their homes, Figure 16 shows the percentage of youth referred in either in state or out of state congregate care who are placed in their home 12 months after referral. In general, 61 percent of Safe at Home youth referred in congregate care are back in their homes at 12 months. Interestingly, each six-month cohort shows an increased percentage of youth returning home, likely due to an increase in staff experience. Furthermore, each Safe at Home cohort has a significantly higher percentage of youth in their home at 12 months than comparison group cohorts ($p < 0.01$).



One way to evaluate the impact of preventing placement into congregate care is to compare the results for youth in the treatment cohorts with those in the comparison cohorts who were in a lower level of care at the time of referral to see the extent to which they did (or did not) enter congregate care at six- and twelve-months following referral.

Youth placed initially in lower levels of care, i.e., their own homes, family foster care, or an emergency shelter, were examined at six- and twelve-months following referral (Table 8) to determine the extent to which those youth were placed in congregate care. The most recent measurable reporting period (i.e., Cohort 6) shows a similar trend at six months to the previous two reporting periods, with slightly more Safe at Home youth from lower levels entering congregate care than comparison group youth. Safe at Home youth in Cohort 5 also show similar trends to previous cohorts with a larger percentage of youth in congregate care at 12 months than comparison group youth.

Table 8. Percentages of Youth Moved from Lower Levels of Care to Congregate Care

Cohort	Group	N Referred at Lower Level	% in CC at 6 Months	% in CC at 12 Months
1	Treatment	54	26%	28%
	Comparison	55	24%	27%
2	Treatment	130	15%	30%
	Comparison	143	28%	17%
3	Treatment	224	16%	18%
	Comparison	221	20%	17%
4	Treatment	373	16%	16%
	Comparison	358	12%	11%

Table 8. Percentages of Youth Moved from Lower Levels of Care to Congregate Care				
Cohort	**Group**	**N Referred at Lower Level**	**% in CC at 6 Months**	**% in CC at 12 Months**
5	Treatment	443	15%	16%
	Comparison	448	14%	12%
6	Treatment	416	11%	-
	Comparison	418	10%	-

The random forest and regression results (described in the Populations Analysis section) are shown in Figure 17. The colors in the figure are green for protective (i.e., positive) factors and red for risk (i.e., negative) factors. Those factors which are significant are boldly shaded while non-significant factors are lightly shaded. The Figure below shows that youth who received clothing assistance and those who received one or more other services (e.g., counseling, education) had more actionable Risk Behavior domain CANS items were significantly more likely to be in congregate care at 12 months than youth without those factors. A similar finding is found for youth with an Axis 1 diagnosis. Interestingly, youth with a larger number of prior placements were significantly less likely to enter congregate care than those with fewer prior placements. Additionally, youth in Region 2 were slightly more likely to enter congregate care than youth from other regions.

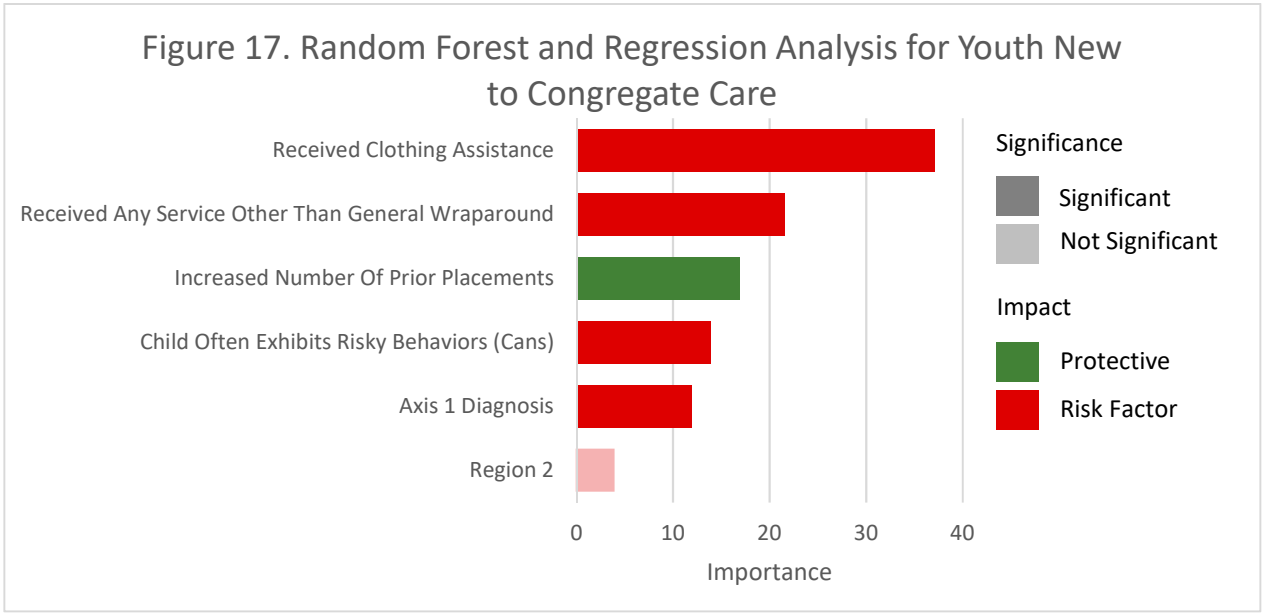
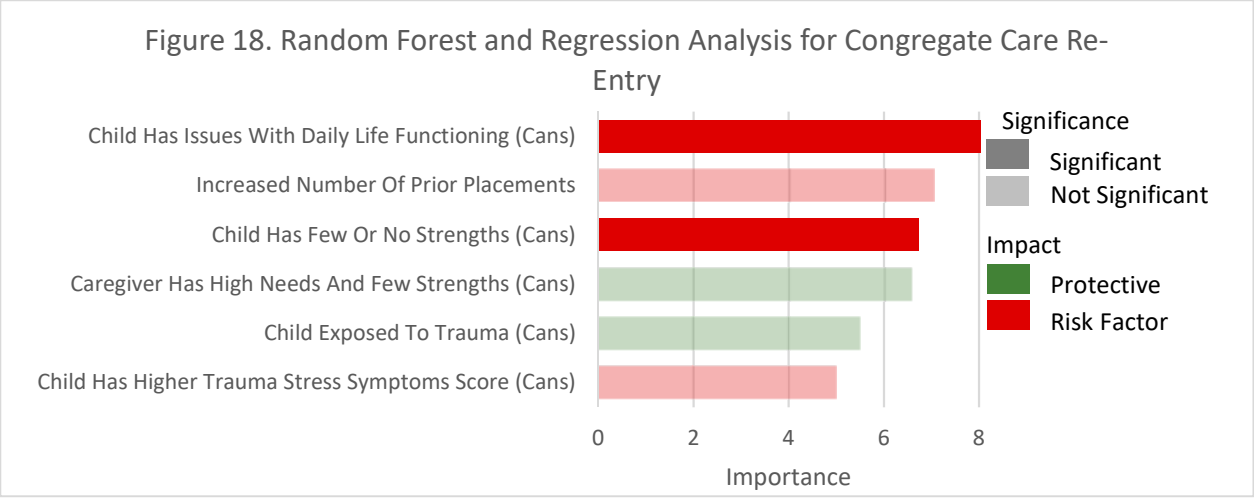


Table 9 displays the results for youth who left congregate care and moved to a lower level of care within twelve months of referral, but ultimately re-entered congregate care at either six or twelve months following their initial congregate care discharge date. Results are only included for youth younger than 17 and where sufficient time has passed to measure outcomes; thus, Cohort 6 has been excluded and only six-month outcomes are available for Cohort 5. A larger volume of Safe at Home youth are discharged from congregate care to a lower level of care within 12 months than comparison group youth; however, the percentages of those

youth who return to congregate care six and twelve months later are roughly similar among treatment and comparison youth. In general, one-quarter of the youth who were discharged from congregate care to a lower placement level in both the treatment and comparison groups re-enter congregate care within six and twelve months.

Table 9. Rate of Congregate Care Re-Entry				
Cohort	Group	N Discharged from CC within 12 Months	% Re-Entered within 6 Months	% Re-Entered within 12 Months
1	Treatment	60	23%	27%
	Comparison	44	32%	30%
2	Treatment	108	28%	26%
	Comparison	68	29%	26%
3	Treatment	92	16%	24%
	Comparison	64	27%	22%
4	Treatment	127	20%	19%
	Comparison	79	23%	24%
5	Treatment	124	24%	-
	Comparison	85	21%	-

Figure 18, displaying the random forest and regression analysis for re-entry into congregate care, shows that if a youth has more actionable items in the Life Functioning and Strengths CANS domains, they are more likely to re-enter congregate care within 12 months than youth with fewer actionable items. Youth with more actionable items in the Caregiver and Trauma CANS domains are slightly less likely to re-enter congregate care.

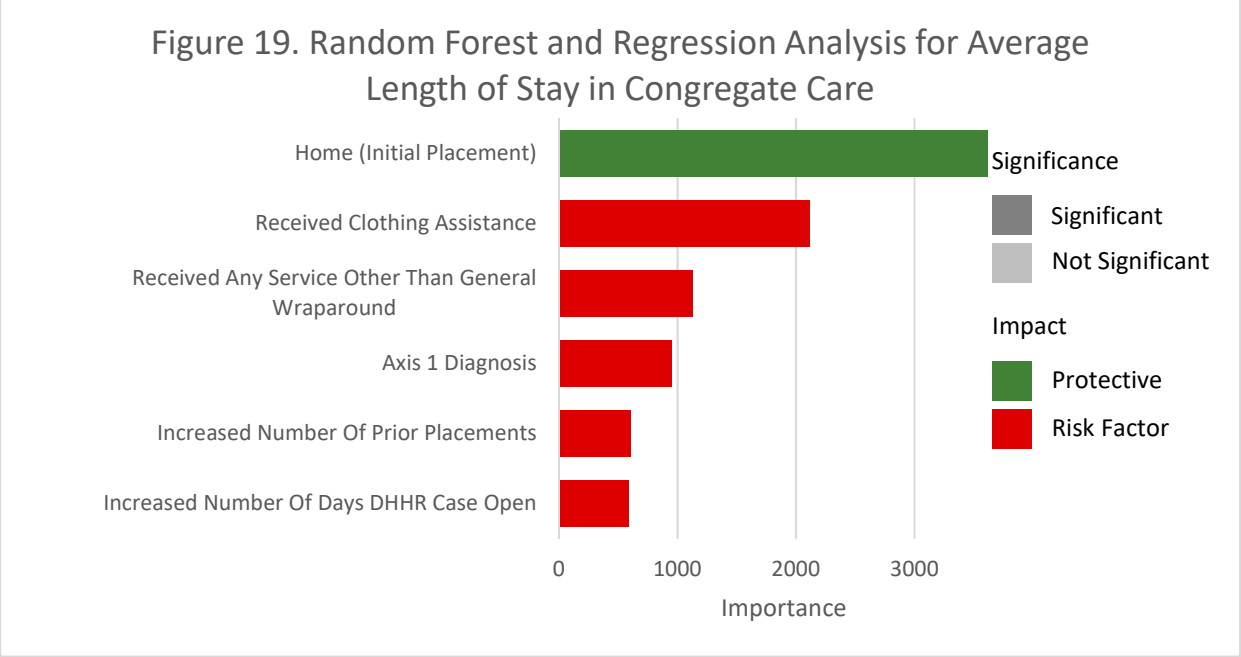


To assess the length of time youth are in congregate care, Table 10 shows the average number of days youth spent in congregate care within six and twelve-months or referral. While congregate care initial entry and re-entry rates show a mix of positive and negative outcomes for Safe at Home youth, the average length of stay in congregate care results are clearly positive. Safe at Home youth from all cohorts are spending substantially less time in congregate care. Safe at Home youth spend an average of 50 fewer days in congregate care within six months of referral and 84 fewer days within twelve months than comparison youth. All results were statistically significant at ($p<.01$). In the most recent reporting period, Safe at Home youth spent less than half the number of nights in congregate care as comparison group youth.

Table 10. Average Length of Stay in Congregate Care

Cohort	Group	Average Days in CC within 6 Months	Average Days in CC within 12 Months
1	Treatment	101	167
	Comparison	137	239
2	Treatment	84	144
	Comparison	131	237
3	Treatment	61	126
	Comparison	122	219
4	Treatment	70	139
	Comparison	127	217
5	Treatment	63	133
	Comparison	115	206
6	Treatment	53	-
	Comparison	113	-

Not surprisingly, Figure 19 shows youth referred in home are significantly less likely to spend more nights in congregate care than other placements. Those youth who received services, have an Axis 1 diagnosis, have a higher number of prior placements or a longer case length are significantly more likely to spend more days in congregate care.



In general, Safe at Home is preventing youth from spending more nights in congregate care when compared to youth in the comparison group. Youth in Safe at Home are also slightly less likely to re-enter congregate care after leaving the placement than comparison group youth. However, Safe at Home youth referred at a level below congregate care are slightly more likely to enter congregate care than comparison group youth.

Detention

Eighty-one percent of Safe at Home youth have a Youth Services case, meaning that many of these youth likely have, or are at serious risk for, further court and/or juvenile justice involvement. Therefore, initial detention entries and re-entries have been examined (Table 11). Per policy, youth cannot be referred to Safe at Home from a juvenile detention facility so none of the youth start the program while in this placement setting. Conversely, once youth enter a juvenile detention facility they are no longer eligible for Safe at Home services and are subsequently discharged from the program (though they may be re-referred following their exit from detention).

While the overall numbers of youth in detention at six and twelve months are small, six-month results generally appear to be more positive for Safe at Home youth than comparison group youth (Table 10). This result flips at 12 months with slightly more Safe at Home youth in detention than comparison group youth. Of those youth who entered detention, five Safe at Home youth re-entered a detention facility within 12 months of discharge from the placement while none of the comparison group re-entered in the same timeframe.

Table 11. Initial Detention Entries			
Cohort	**Group**	**N in Detention at 6 Months**	**N in Detention at 12 Months**
1	Treatment	3	1
	Comparison	4	1
2	Treatment	1	2
	Comparison	4	1
3	Treatment	2	1
	Comparison	7	1
4	Treatment	3	5
	Comparison	6	1
5	Treatment	6	3
	Comparison	3	1
6	Treatment	3	-
	Comparison	6	-

County Movement

A secondary goal of Safe at Home is to increase the number of youth living in their home communities. To measure the extent to which this goal has been achieved, the movements of youth both leaving and returning to their home counties have been examined at six- and twelve-months post-referral[24] (Table 12).

Regarding youth who moved from their home-county to another county, results were mixed at six months. While a slightly higher percentage of Safe at Home youth moved out-of-county at six months in Cohorts 1, 4, 5, and 6, the opposite was true for Cohorts 2 and 3. At twelve months, a larger proportion of Safe at Home youth across all cohorts had moved out-of-county as compared to youth in the comparison group. While none of the results were statistically significant at six months, results at twelve months were statistically significant for Cohorts 2 ($p<.05$), 4 ($p<.01$), and 5 ($p < .05$).

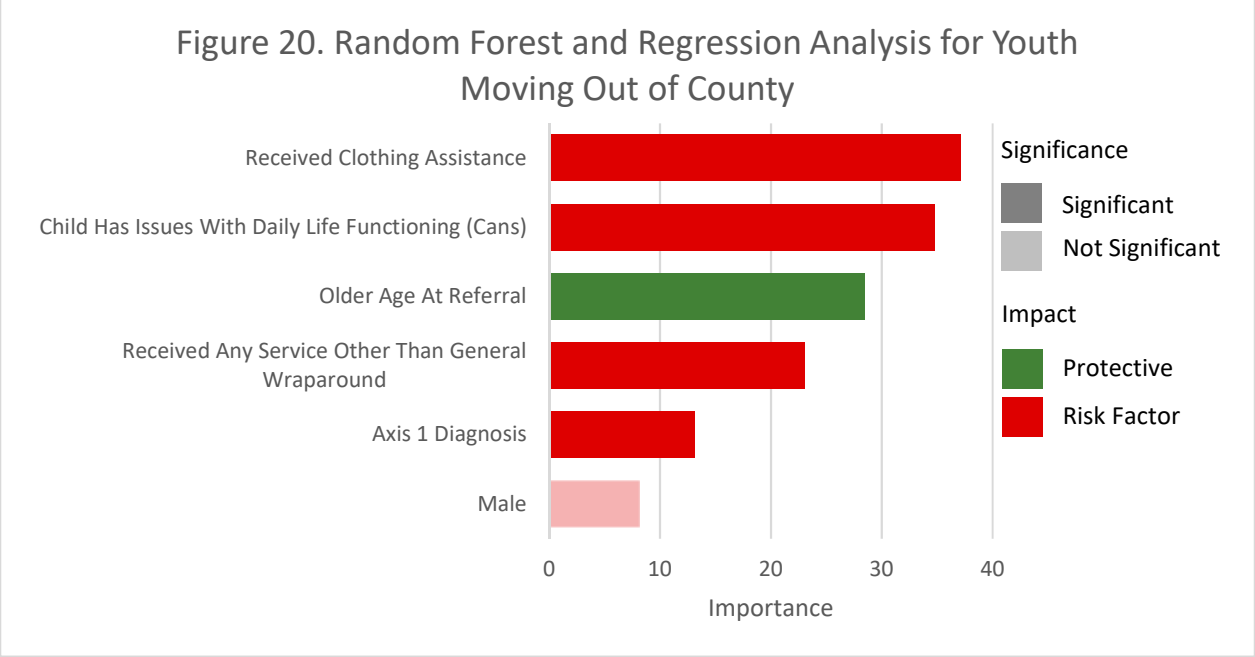
For youth moving back to their home-county, results were overwhelmingly positive for Safe at Home youth within six and twelve months across all cohorts, with a greater percentage more likely to move back to their home-county than youth in the comparison group. Six-month results were statistically significant for all cohorts ($p<.01$) and twelve-month results were significant for all but Cohort 2.

Table 12. Youth County Movements				
Cohort	**Group**	**Denominator**	**% at 6 Months**	**% at 12 Months**
From Home-County to Out-of-County				
1	Treatment	59	27%	27%

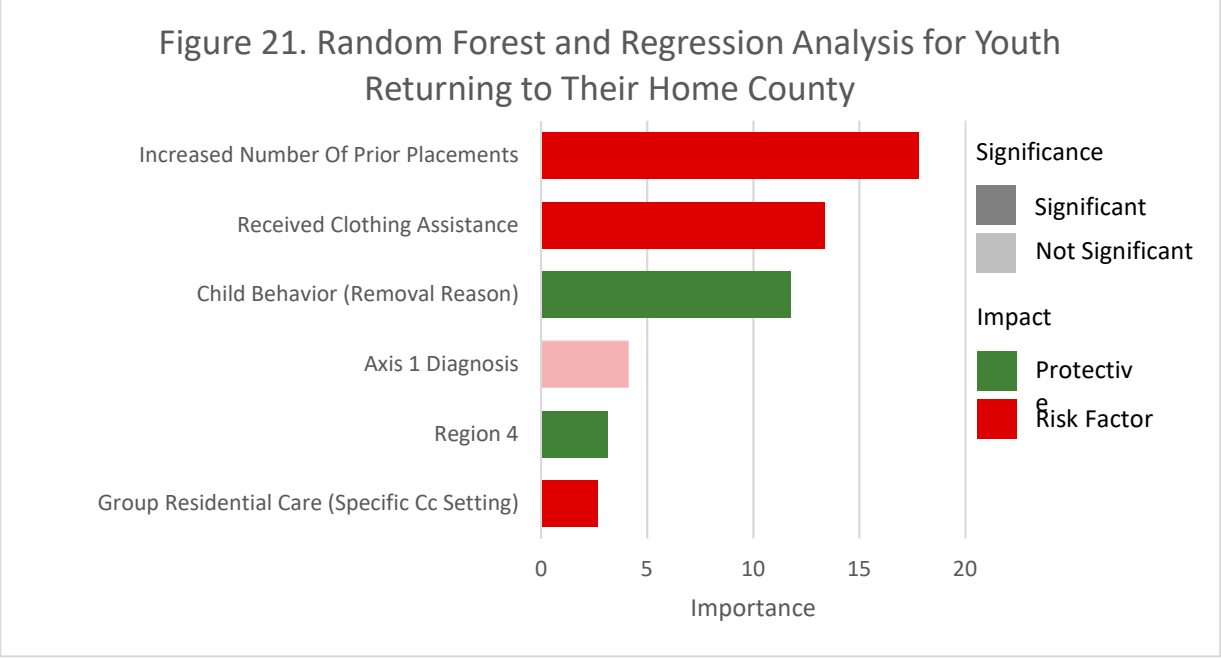
[24] Instances where youth move out-of-county because of placement with a parent or relative foster placement are not included in the analysis, as these are more ideal placement settings for youth to achieve permanency than merely living within their home-counties.

Table 12. Youth County Movements				
Cohort	**Group**	**Denominator**	**% at 6 Months**	**% at 12 Months**
	Comparison	55	24%	24%
2	Treatment	132	18%	27%
	Comparison	118	23%	14%
3	Treatment	226	17%	19%
	Comparison	213	20%	18%
4	Treatment	364	15%	17%
	Comparison	337	12%	10%
5	Treatment	423	17%	18%
	Comparison	416	14%	12%
6	Treatment	400	13%	-
	Comparison	394	11%	-
From Out-of-County to Home-County				
1	Treatment	66	59%	64%
	Comparison	69	28%	39%
2	Treatment	96	61%	59%
	Comparison	103	29%	48%
3	Treatment	74	81%	72%
	Comparison	85	33%	45%
4	Treatment	88	74%	68%
	Comparison	107	28%	50%
5	Treatment	92	65%	75%
	Comparison	97	35%	49%
6	Treatment	68	79%	-
	Comparison	70	44%	-

Figure 20 highlights the random forest and regression analysis for youth moving out of county. Youth who were older at the time of referral were less likely to be moved out of county, likely implying that Safe at Home was able to find the right services for those youth. Alternatively, youth receiving services, having an Axis 1 diagnosis or having a higher number of actionable Life Functioning Domain CANS items were significantly more likely to be moved out of their home county.



When the random forest and regression analysis was run on the youth returning to their home county (Figure 21), it was found that youth removed due to their own behavior problems were significantly more likely to return to their home county. Additionally, those youth in Region 4 were significantly more likely to return to their county. Youth with a larger number of prior placements, who received clothing assistance, or were in a group residential setting were significantly less likely to return to their home county.



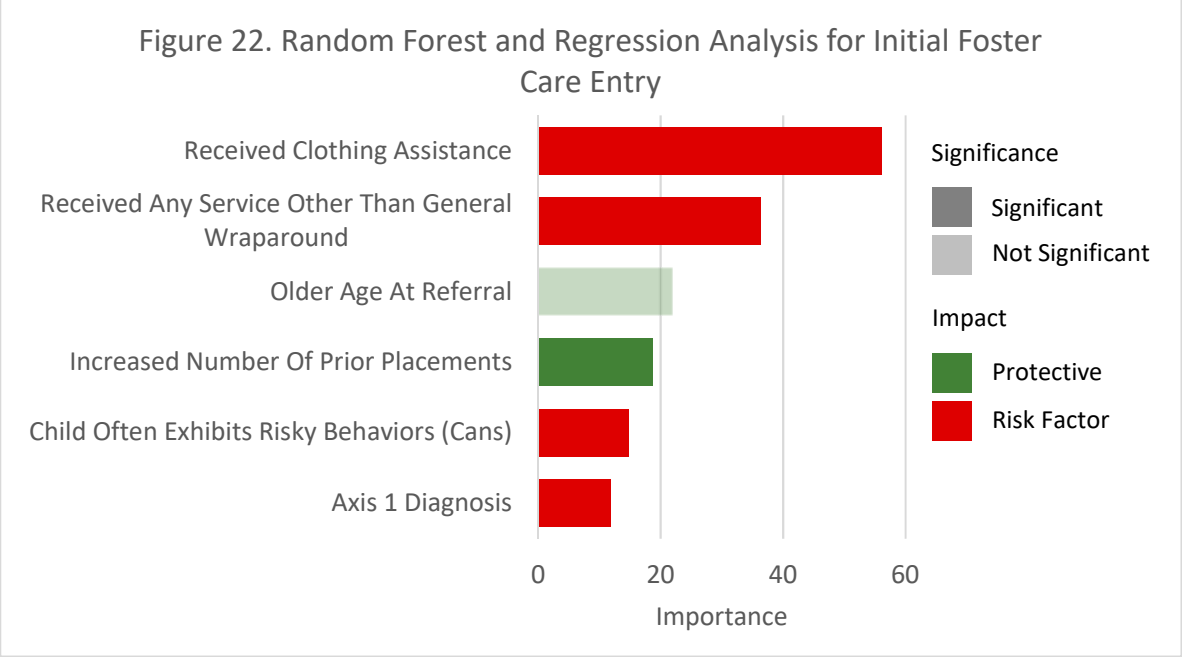
Foster Care

Safe at Home aims to reduce the need for any type of placement outside the home. Table 13 examines initial entry into foster care for those youth who were referred while living in their own homes. Results for youth in the treatment and comparison groups, at both six- and twelve-months following referral, are similar for Cohorts 1, 3, and 6. Cohorts 4 and 5's Safe at Home youth are significantly ($p<.05$) more likely to enter foster care than comparison youth at both six and twelve months. There are two possible explanations for these results. First, it is possible the comparison group population is different from the treatment group population due to a lack of information regarding mental health diagnoses for the treatment group due to the discontinued use of axis level diagnoses and insufficient FACTS data. Alternatively, the increased intensity of services and oversight of the families are leading to more frequent identification of issues.

Table 13. Initial Foster Care Entries

Cohort	Group	Denominator	% Entry at 6 Months	% Entry at 12 Months
1	Treatment	46	28%	33%
	Comparison	47	28%	30%
2	Treatment	101	15%	32%
	Comparison	103	23%	16%
3	Treatment	205	23%	22%
	Comparison	197	22%	20%
4	Treatment	333	20%	22%
	Comparison	312	14%	13%
5	Treatment	387	20%	22%
	Comparison	383	15%	15%
6	Treatment	367	16%	-
	Comparison	375	14%	-

The random forest and regression analysis show that youth receiving services are far more likely to be removed from their initial placements in the home. If youth had a higher number of prior placements (meaning they were removed and returned to the home prior to Safe at Home referral), they were more likely to remain in the home than youth with fewer placements. Youth who had a higher number of actionable items in the Risk Behaviors CANS domain or had an Axis 1 diagnosis were significantly more likely to be removed.



Foster care re-entry was examined (Table 14) in addition to initial entry into foster care. The denominator for this measure is youth who were discharged from foster care within twelve months of referral to Safe at Home. Safe at Home youth are re-entering foster care at a higher rate than comparison youth across all cohorts at both six and twelve months. Results are statistically significant at six months for Cohort 2 ($p<.05$); the twelve-month result for Cohort 4 is statistically significant ($p<.01$).

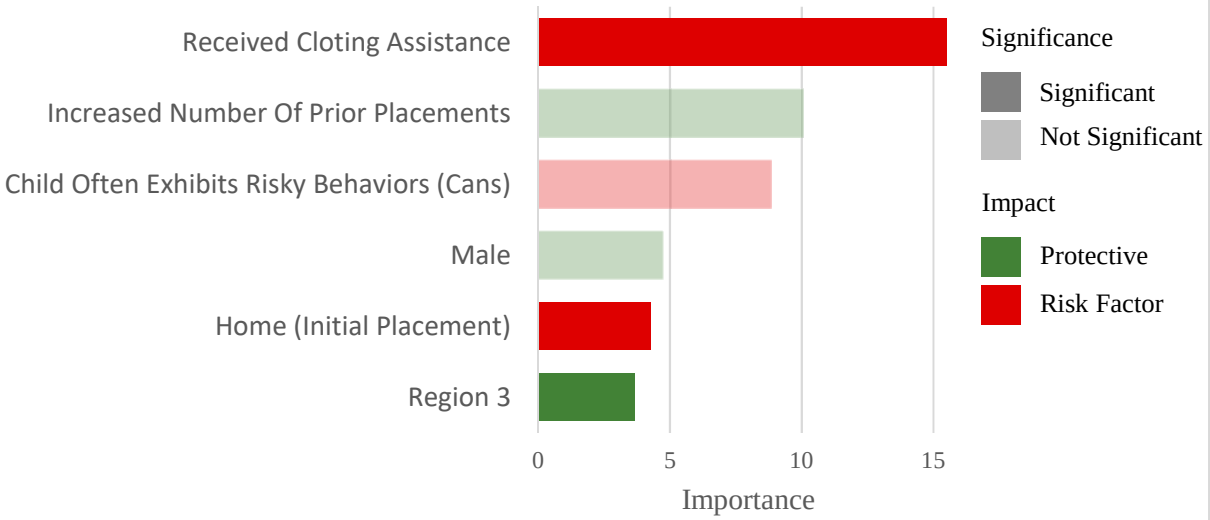
Table 14. Foster Care Re-Entry Rates

Cohort	Group	Denominator	% Re-Entered at 6 Months	% Re-Entered at 12 Months
1	Treatment	43	16%	16%
	Comparison	31	6%	6%
2	Treatment	77	26%	21%
	Comparison	60	10%	10%
3	Treatment	84	19%	23%
	Comparison	62	15%	15%
4	Treatment	123	24%	21%
	Comparison	80	10%	5%
5	Treatment	106	23%	-
	Comparison	89	7%	-

Figure 23, displaying the random forest and regression analysis, highlights that youth referred from Region 3 were significantly less likely to re-enter foster care. Additionally, those youth who had a higher number of prior placements were slightly less likely to re-enter care. This finding agrees with the results from the initial

foster care entry measure which found youth with a higher number of prior placements were less likely to have an initial placement into foster care. Youth who received clothing assistance or were referred in home were significantly more likely to re-enter care.

Figure 23. Random Forest and Regression Analysis for Foster Care Re-Entry



When youth do enter foster care, relative placements play a critical role in minimizing trauma for youth. Due to the small sample size, the results displayed in Table 15 are reported for the full population of treatment and comparison youth instead of by cohort. When youth are placed in foster homes, Safe at Home youth are significantly more likely to be placed in a relative home at both six and twelve months (both at $p<.01$) than are comparison youth.

Table 15. Percentage of Youth Placed in Relative Homes

Group	Denominator	% in Relative Home at 6 Months	% in Relative Home at 12 Months
Treatment	121	71%	68%
Comparison	135	27%	29%

Placement stability was also considered when examining outcomes related to foster care. Table 16 displays the results of that analysis for youth who were referred out-of-home. Applying the federal definition of placement stability, the proportion of youth with no more than two moves which occurred within twelve-months of referral was measured. Outcomes were calculated for Cohorts 1 through 5. Safe at Home youth in Cohorts 1 and 3 experienced more placement stability than their comparison counterparts. There was no difference in the rate of placement stability between comparison youth and Safe at Home youth in Cohort 4, and Safe at Home youth in Cohorts 2 and 5 experienced greater placement instability than comparison youth. While none of the cohorts satisfied the rate of federal compliance, the results were not statistically significant for any

of the cohorts.

Table 16. Foster Care Placement Stability			
Cohort	**Group**	**N Youth Referred Out-of-Home**	**% Youth with 3+ Moves in 12 Months**
1	Treatment	81	32%
	Comparison	78	37%
2	Treatment	124	43%
	Comparison	120	31%
3	Treatment	98	23%
	Comparison	105	27%
4	Treatment	130	28%
	Comparison	134	28%
5	Treatment	138	30%
	Comparison	133	24%

Another way in which foster care outcomes were examined was to look at the rates of reunification (Table 17) within six- and twelve-months following referral to Safe at Home. Youth in the treatment group were much more likely to reunify across all cohorts within both six and twelve months than youth in the comparison groups. This was highly significant across all cohorts within six months ($p<.01$). Within twelve months all results were significant, but the significance level varied (between $p<.05$ for Cohorts 1 and 2 and $p<.01$ for Cohorts 3, 4, and 5).

Table 17. Reunification Rates				
Cohort	**Group**	**N Out-of-Home**	**% Reunified within 6 Months**	**% Reunified within 12 Months**
1	Treatment	78	35%	47%
	Comparison	77	14%	29%
2	Treatment	120	40%	49%
	Comparison	118	16%	36%
3	Treatment	92	52%	61%
	Comparison	100	17%	32%
4	Treatment	112	53%	60%
	Comparison	133	17%	35%
5	Treatment	125	50%	58%
	Comparison	129	17%	35%
6	Treatment	96	45%	-
	Comparison	88	24%	-

In general, Safe at Home youth are more likely to have an initial entry into the foster care system or re-enter the system than comparison group youth. This is potentially due to the lack of mental health data available to produce a comparison group for these measures; it is likely that comparison group are less likely to

have a mental health diagnosis or elevated behavioral health issue. The result is also potentially due to the increased intensity of the services provided to treatment youth, with wraparound facilitators working more closely with youth and their families and providing greater opportunity to identify family issues. Once in foster care, Safe at Home youth are significantly more likely to be placed with a relative and be reunified with their biological family or relatives than comparison group youth.

Maltreatment

Safe at Home also strives to increase the safety of youth by demonstrating decreased rates of maltreatment/repeat maltreatment. Table 18 displays the number of youth with a maltreatment referral subsequent to their referral to Safe at Home and the number for which that referral led to a substantiation of maltreatment. It is likely that the sample sizes which are incredibly low for this measure are because most youth in Safe at Home have a Youth Services case rather than a CPS case.

For Cohorts 1 through 4, Safe at Home youth experienced fewer maltreatment referrals within six and twelve months of their referral to the program than comparison youth. Slightly more maltreatment referrals were made for Safe at Home youth than comparison youth in Cohorts 5 and 6 within six months of referral to the program. The numbers of substantiated maltreatment referrals were minimal, but when they did occur, it was only Safe at Home youth who received a substantiation. At six months, one Safe at Home youth from Cohort 4 experienced a substantiation and the same was true within twelve months for an additional Safe at Home youth in Cohort 3.

Table 18. Youth with New Referrals and/or Substantiations

Cohort	Group	Referral within 6 Months	Substantiation within 6 Months	Referral within 12 Months	Substantiation within 12 Months
1	Treatment	3	0	3	0
	Comparison	15	0	22	0
2	Treatment	24	0	30	0
	Comparison	32	0	42	0
3	Treatment	29	0	46	1
	Comparison	33	0	48	0
4	Treatment	43	1	71	1
	Comparison	49	0	70	0
5	Treatment	63	0	83	0
	Comparison	57	0	80	0
6	Treatment	49	0	-	-
	Comparison	46	0	-	-

Well-Being

The CANS tool provides an assessment of youth's strengths and needs which is used to support decision making, facilitate service referrals and monitor progress toward goals. By utilizing a four-level rating system (with scores ranging from 0 to 3) on a series of items used to assess specific domains, such as Child Risk Behaviors or Life Domain Functioning, the assessment helps LCA wraparound facilitators to identify needs/actionable items (i.e., those with a score of 2 or 3). Where needs are discovered, the facilitators then gain a better understanding regarding where attention and focus should be placed when planning with the youth and their families, and where services might be warranted. Some items in the CANS will trigger further modules for additional questioning if a need is discovered in a specific area, such as substance use and LGBTQ (Lesbian, Gay, Bi-Sexual, Transgender and/or Queer).

Wraparound facilitators from the LCAs administer CANS assessments to youth in Safe at Home. Once the assessments are completed, they are entered into the online WV CANS database. Per policy, youth in the program receive an initial CANS assessment within 30 days of referral and subsequent CANS are completed every 90 days thereafter. There are no CANS available for youth in the comparison groups, thus limiting the analysis to pre/post comparisons of Safe at Home youth only.

The results of the initial CANS assessments for youth from Cohorts 1 through 5 are compared to those completed at six and twelve months post-initial CANS to measure progress while in the program, with the results limited to six months for youth in Cohort 6. Progress is measured by the extent to which scores have improved, meaning the number of needs/actionable items have been reduced over time.

As shown in Table 19, the count of CANS assessments available for analysis becomes more limited as more time elapses after the youth's entry into Safe at Home. This is due to a closure of the Safe at Home case prior to six months.

Table 19. Number of Youth with CANS Assessments Available for Analysis

Factors	C1	C2	C3	C4	C5	C6
Number of youth with an initial CANS assessment	88	166	211	311	355	327
Number of youth with a 6-month follow-up CANS	56	99	109	174	174	89
Number of youth discharged before a 6-month follow-up CANS could be performed	24	45	65	91	115	110
Number of youth where not enough time has passed before a 6-month CANS can be performed	0	0	0	2	4	29
Number of youth where enough time has passed, and no 6-month CANS was performed	8	22	37	44	62	99
Number of youth with a 12-month follow-up CANS	27	50	51	85	46	2

Table 19. Number of Youth with CANS Assessments Available for Analysis						
Factors	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**
Number of youth discharged before a 12-month follow-up CANS could be performed	57	94	132	178	150	155
Number of youth where not enough time has passed before a 12-month CANS can be performed	0	0	1	2	54	162
Number of youth where enough time has passed, and no 12-month CANS was performed	4	22	27	46	105	8

Table 20 provides an overview of the percentage of youth who had at least one need/actionable item selected in the CANS, by domain, during the initial assessment. Life Domain Functioning has consistently been the domain with the highest percentage of youth who have a need at the time of the initial assessment, hovering around 90 percent for all cohorts. The other three domains (i.e., Child Behavioral/Emotional Needs, Child Risk Behaviors, and Trauma Stress Symptoms) show a decreasing percentage of youth with these needs since implementation, likely due to the shift in Safe at Home's focus to prevention.

Table 20. Percentage of Youth with a Need on Initial CANS						
CANS Domain	**C1 (N=88)**	**C2 (N=166)**	**C3 (N=211)**	**C4 (N=311)**	**C5 (N=355)**	**C6 (N=327)**
Child Behavioral/Emotional Needs (13 items)	82%	78%	69%	69%	70%	63%
Child Risk Behaviors (13 items)	49%	44%	37%	38%	34%	27%
Life Domain Functioning (19 items)	91%	90%	91%	92%	90%	88%
Trauma Stress Symptoms (12 items)	48%	45%	28%	30%	35%	28%

Table 21 shows the percentage of youth who had a six or twelve-month follow-up CANS and who also reduced at least one need in a domain (i.e., at least one item in the domain had gone from actionable to non-actionable or was no longer considered a need). More than half of the youth exhibited improvement on each domain across cohorts. The only instances where this did not hold true was at six months for Cohorts 1 and 4 under Trauma Stress Symptoms. However, by twelve months more than 60 percent of the youth in both cohorts showed a reduction in their needs related to the Trauma Stress Symptoms. Improvements were evident across all domains and all cohorts between six and twelve months, showing even greater continued improvement between the two time periods.

Table 21. Percentage of Youth with Improved Scores		
CANS Domain	**% Improved at 6 Months**	**% Improved at 12 Months**
Cohort 1		
Child Behavioral/Emotional Needs	50%	78%
Child Risk Behaviors	54%	75%
Life Domain Functioning	58%	83%
Trauma Stress Symptoms	37%	64%
Cohort 2		
Child Behavioral/Emotional Needs	62%	73%
Child Risk Behaviors	63%	80%
Life Domain Functioning	67%	78%
Trauma Stress Symptoms	62%	74%
Cohort 3		
Child Behavioral/Emotional Needs	54%	58%
Child Risk Behaviors	64%	67%
Life Domain Functioning	63%	70%
Trauma Stress Symptoms	58%	61%
Cohort 4		
Child Behavioral/Emotional Needs	56%	65%
Child Risk Behaviors	53%	62%
Life Domain Functioning	70%	71%
Trauma Stress Symptoms	48%	68%
Cohort 5		
Child Behavioral/Emotional Needs	67%	72%
Child Risk Behaviors	67%	69%
Life Domain Functioning	68%	75%
Trauma Stress Symptoms	52%	75%
Cohort 6		
Child Behavioral/Emotional Needs	55%	-
Child Risk Behaviors	70%	-
Life Domain Functioning	69%	-
Trauma Stress Symptoms	61%	-

In addition to the main CANS domains, there are triggered sub-modules which delve deeper into specific questions on topics where youth have identified needs. Table 22 provides the percentage of youth who triggered a sub-module in the initial CANS assessment. The submodules which were most commonly triggered across cohorts were Delinquent Behavior followed by Substance Use. The Adolescent Suicide sub-module saw

the greatest reduction in use over time.

Table 22. Percentage of Youth with Triggered Sub-Modules						
Submodule	C1 (N=88)	C2 (N=166)	C3 (N=211)	C4 (N=311)	C5 (N=355)	C6 (N=327)
Adolescent Suicide	14%	10%	4%	7%	5%	4%
Child Suicide	0%	2%	1%	1%	1%	1%
Commercial Sexual Exploitation	0%	0%	2%	1%	1%	1%
Children's Sexual Behaviors	14%	11%	10%	10%	10%	8%
Delinquent Behavior	48%	39%	53%	52%	53%	50%
Fire Setting	1%	1%	1%	2%	1%	1%
LGBTQ	5%	2%	3%	6%	3%	6%
Sexually Abusive	19%	13%	13%	14%	11%	10%
Substance Use	30%	23%	27%	28%	33%	25%

Family Functioning

Progress in family functioning was calculated by using the Family Functioning domain of the CANS which is further broken out into the specific items within that domain (Table 23). The most common Family Functioning need on the initial assessment is Family Stress followed by Residential Stability; this finding was consistent across cohorts. Of those with a CANS assessment at six-months, 41 percent showed improved Family Stress scores as well as 51 percent on Residential Stability scores. Though the number of 12-month assessments is limited, when looking at the entire Family Functioning domain, 51 percent of youth showed an improvement from the initial CANS to the 12-month follow-up.

Table 23. Youth with Improved Family Functioning					
CANS Item	N with Need on Initial CANS	N with 6 Month CANS	N Improved at 6 Months	N with 12 Month CANS	N Improved at 12 Months
Cohort 1					
Physical Health	5	1	1	1	1
Mental Health	2	2	0	1	1
Substance Use	1	1	1	1	1
Family Stress	24	18	10	8	6
Residential Stability	7	4	3	3	2
Total	**29**	**19**	**11**	**9**	**7**
Cohort 2					
Physical Health	15	9	2	7	2

Table 23. Youth with Improved Family Functioning					
CANS Item	**N with Need on Initial CANS**	**N with 6 Month CANS**	**N Improved at 6 Months**	**N with 12 Month CANS**	**N Improved at 12 Months**
Mental Health	4	1	1	1	1
Substance Use	5	4	2	3	1
Family Stress	26	17	5	9	5
Residential Stability	10	5	1	3	2
Total	**43**	**27**	**7**	**16**	**7**
Cohort 3					
Physical Health	7	2	1	2	1
Mental Health	9	4	2	2	1
Substance Use	3	2	0	1	1
Family Stress	32	20	8	13	5
Residential Stability	16	10	4	8	5
Total	**42**	**24**	**10**	**16**	**7**
Cohort 4					
Physical Health	7	3	0	3	1
Mental Health	6	3	0	2	0
Substance Use	3	2	1	1	1
Family Stress	46	25	11	15	7
Residential Stability	15	9	5	5	2
Total	**59**	**32**	**14**	**20**	**9**
Cohort 5					
Physical Health	15	6	3	2	2
Mental Health	11	6	3	2	1
Substance Use	11	8	4	1	1
Family Stress	40	22	8	10	2
Residential Stability	16	8	6	2	2
Total	**67**	**36**	**17**	**12**	**7**
Cohort 6					
Physical Health	15	4	1	-	-
Mental Health	3	0	0	-	-
Substance Use	3	1	0	-	-
Family Stress	30	11	4	-	-
Residential Stability	16	1	0	-	-
Total	**57**	**16**	**4**	**-**	**-**

Educational Functioning

Similar to the analysis of family functioning, an analysis of educational functioning draws on the use of CANS data to identify the areas of challenge and improvement for youth in Safe at Home. Educational functioning items fall within the Life Domain Functioning and Trauma Stress Symptoms CANS domains and are inclusive of four specific items: School Achievement, School Attendance, School Behavior, and School Violence. Results for educational functioning items are displayed in Table 24. The most common educational functioning need on the initial assessment is School Achievement followed by School Behavior. School Attendance experienced the most improvement from the initial to six- and twelve-month CANS with roughly 70 percent of youth across the cohorts demonstrating improvement. Overall, school-based needs were reduced by 59 percent at six months and 65 percent at twelve months.

Table 24. Youth with Improved Educational Functioning					
CANS Item	**N with Need on Initial CANS**	**N with 6 Month CANS**	**% Improved at 6 Months**	**N with 12 Month CANS**	**% Improved at 12 Months**
Cohort 1					
School Achievement	22	12	42%	5	40%
School Attendance	14	6	100%	3	100%
School Behavior	33	24	33%	12	42%
School Violence	11	4	0%	1	0%
Total	**56**	**33**	42%	**15**	53%
Cohort 2					
School Achievement	45	32	63%	20	70%
School Attendance	31	20	70%	8	63%
School Behavior	50	32	63%	14	79%
School Violence	18	11	27%	5	20%
Total	**93**	**61**	61%	29	66%
Cohort 3					
School Achievement	73	37	49%	18	56%
School Attendance	49	27	70%	16	69%
School Behavior	53	30	60%	15	73%
School Violence	17	7	29%	3	67%
Total	**123**	**61**	62%	32	72%
Cohort 4					
School Achievement	100	60	47%	25	52%
School Attendance	82	51	75%	22	64%
School Behavior	90	55	62%	28	64%
School Violence	21	14	14%	6	33%

Table 24. Youth with Improved Educational Functioning					
CANS Item	**N with Need on Initial CANS**	**N with 6 Month CANS**	**% Improved at 6 Months**	**N with 12 Month CANS**	**% Improved at 12 Months**
Total	**180**	**111**	61%	50	66%
Cohort 5					
School Achievement	136	64	59%	15	53%
School Attendance	90	43	70%	11	64%
School Behavior	114	54	54%	16	63%
School Violence	38	20	20%	4	25%
Total	**236**	**121**	57%	29	62%
Cohort 6					
School Achievement	124	38	47%	-	-
School Attendance	97	34	59%	-	-
School Behavior	102	28	64%	-	-
School Violence	26	4	0%	-	-
Total	**211**	**57**	61%	**-**	**-**

Across the child well-being outcomes, a high percentage of youth are showing improvement at six and twelve months after the initial CANS assessment. In particular, education related items show a large improvement for school attendance, achievement, and behavior. Additionally, children are exhibiting fewer actionable items in subsequent CANS assessments across the four domains, as shown in Table 21. The items that have shown the least amount of growth are family stress and school violence.

Summary of Outcome Evaluation Results

There has been a shift in overall placements for Safe at Home youth as the program continues to be implemented across West Virginia. Where Safe at Home youth from earlier cohorts were seeing a continual decrease in congregate care placements, slight increases have been noticed in later cohorts. Conversely, where increases in home placements are noted in earlier cohorts, decreases are noted in later periods. However, one could argue that youth in earlier Safe at Home cohorts are too distinctly different to make accurate comparisons to those in latter cohorts; this is particularly apparent regarding youth placement at the time of referral where the first cohort was made up of mostly youth referred from congregate care, the later cohorts consist of mostly prevention (i.e., placed at home) cases.

Generally, Safe at Home youth were more likely than comparison youth to enter congregate care, but they were less likely to re-enter at twelve months (though variation among cohorts was noted). Most of these results were not statistically significant; the length of time youth were spending in congregate care was. Safe at Home youth spend a significantly shorter amount of time in congregate care than do their comparison counterparts. Additionally, results were overwhelmingly more positive for Safe at Home youth than comparison youth regarding movement back to their home counties within six and twelve months across all cohorts

(significant at for all at six months and for most cohorts at twelve months).

Foster care entry and re-entry results were not as positive for youth in Safe at Home, who were often more likely to enter and re-enter than comparison youth at varying levels of significance. However, when youth did enter or re-enter foster care, Safe at Home youth fared much better than did comparison youth. Safe at Home youth were significantly more likely to be placed with relatives and reunify with their families.

The random forest and regression analysis did not reveal any consistent populations for which Safe at Home is working well but did highlight that for each outcome there are groups of youth for whom the program performs better. The most common factor that resulted in poor outcomes was receipt of clothing assistance or formal services other than Wraparound. If youth are receiving those formal services, it is likely that Wraparound facilitators are more aware of the youth and their families' needs, and when out-of-home placement is needed to quickly address certain issues.

CANS assessments demonstrated that Safe at Home youth effectively reduce needs in all domains over time. Life Functioning Domain needs are the most common across cohorts at the time the initial assessment is completed and show greater promise in their reduction over time. Overall, school-based needs were reduced for over half of the youth who had one by six months, and at twelve months that percentage rose to nearly three quarters.

Cost Evaluation Results:

The cost evaluation aims to determine the extent to which Safe at Home is (or is not) more cost effective and efficient in comparison to those youth from the historical comparison group who did not receive Safe at Home services.

Four research questions guide the cost evaluation:

- Are the costs of providing Safe at Home to a youth and family less than those provided prior to Safe at Home?
- How does Safe at Home alter the use of federal funding sources as well as state and local funds?
- What is the overall cost effectiveness of the program?
- Is the project cost neutral?

The cost analysis for this reporting period focuses on the costs of out-of-home care and fee-for-services costs, comparing costs incurred for youth in Safe at Home to those in the comparison groups for Cohorts 1 through 5. It also provides a glimpse of the contracted costs for services provided by the LCAs.

When the cost evaluation first began, a daily rate for room and board expenditures was developed using costs incurred by youth in Cohort 1's comparison group (Table 25). The cost of providing out-of-home care to youth in the comparison cohort was calculated, limiting the cost to the first 365 days of substitute care for those who remained out of the home longer than one year following the date they qualified for inclusion in the comparison group. This limitation was applied to ensure that the same amount of time was applied to the

review of costs for the treatment and comparison groups. Those costs were then used to compute an average daily rate which has continued to be used for the cost evaluation. With rates subject to change year to year, it is important that a standard rate be developed and applied to eliminate the impact of rate increases and thus avoid the inappropriate appearance of Safe at Home costs being higher just because of rate increases.

Table 25. Daily Rates Calculated Using Cohort 1's Comparison Group	
Placement Setting	**Cost**
Out-of-State Residential Care	$239.91
In-State Residential Care	$161.95
Shelter Care	$150.17
Therapeutic/Specialized Foster Care	$57.29
Family Foster or Relative Care	$21.47

Those rates were first applied to the number of days youth in the first treatment cohort were in substitute care, again limiting the analysis to the first year following enrollment in Safe at Home. The rates were also applied to the number of days youth in the remaining treatment and comparison cohorts were in out-of-home placement.

As illustrated in Table 26, Safe at Home generated a cost savings of over $6.3 million in costs for room and board expenditures for youth in the first five treatment cohorts with respect to the comparison cohorts. The savings are largely the result of reducing the time youth spend in residential care, both in state and out of state. Table 26 also includes the average cost of room and board per youth removed from their home for each Cohort. The average cost for the comparison group remains fairly consistent at roughly $32,000 per youth in each of the cohort timeframes. Conversely, the treatment group consistently decreases for each subsequent cohort and averages roughly $22,000 per youth overall.

Table 26. Cost of Room and Board Payments		
Placement Setting	**Comparison Group**	**Treatment Group**
Cohort 1		
Out-of-State Residential Care	$406,891.81	$814,023.52
In-State Residential Care	$2,242,735.23	$1,127,036.00
Shelter Care	$229,310.92	$313,556.78
Therapeutic/Specialized Foster Care	$26,467.12	$77,740.00
Family Foster of Relative Care	$19,128.55	$10,133.19
Totals	**$2,924,533.63**	**$2,342,489.49**
Average Cost per Youth	**$23,584.95**	**$18,891.04**
Cohort 2		

Table 26. Cost of Room and Board Payments		
Placement Setting	**Comparison Group**	**Treatment Group**
Out-of-State Residential Care	$1,039,061.56	$349,312.78
In-State Residential Care	$3,546,138.84	$2,320,796.93
Shelter Care	$444,956.29	$698,444.72
Therapeutic/Specialized Foster Care	$106,842.38	$75,734.92
Family Foster or Relative Care	$67,368.55	$58,888.45
Totals	**$5,204,367.62**	**$3,503,177.79**
Average Cost per Youth	**$23,549.17**	**$15,851.48**
Cohort 3		
Out-of-State Residential Care	$1,167,654.73	$499,498.08
In-State Residential Care	$3,254,784.08	$1,969,618.25
Shelter Care	$361,311.11	$463,727.65
Therapeutic/Specialized Foster Care	$76,594.24	$76,365.09
Family Foster or Relative Care	$64,062.38	$73,980.89
Totals	**$4,924,406.55**	**$3,083,252.95**
Average Cost per Youth	**$16,580.49**	**$10,381.32**
Cohort 4		
Out-of-State Residential Care	$1,022,027.77	$758,363.80
In-State Residential Care	$3,914,421.62	$2,925,208.25
Shelter Care	$527,400.09	$716,915.73
Therapeutic/Specialized Foster Care	$192,144.42	$70,177.97
Family Foster or Relative Care	$110,584.90	$81,623.72
Totals	**$5,766,578.80**	**$4,522,289.47**
Average Cost per Youth	**$12,958.60**	**$10,229.86**
Cohort 5		
Out-of-State Residential Care	$1,053,216.41	$640,566.70
In-State Residential Care	$3,628,087.43	$2,978,976.88
Shelter Care	$735,837.26	$765,120.58
Therapeutic/Specialized Foster Care	$180,400.35	$147,860.69
Family Foster or Relative Care	$128,554.14	$162,174.01
Totals	**$5,726,095.59**	**$4,694,698.86**
Average Cost per Youth	**$11,183.78**	**$9,169.33**

Fee-for-services costs (e.g., case management, maintenance, services, etc.) were also examined to determine if Safe at Home was having a positive impact in reducing expenditures incurred by West Virginia to meet the needs of youth (Table 27).

In total, limiting the analysis to the amount paid for fee-for-services for Safe at Home youth as identified within FACTS, the amount expended for youth in the treatment group is nearly $1.2 million less than the comparison group. Education expenditures account for the largest percentage of fee-for-service costs followed by Other. Several service categories (e.g., assessment, case management) are not reported for Safe at Home youth since they are Administrative Services Organization (ASO) payments which are now included in the contracted Wraparound services.

Table 27. Cost of Fee-for-Service Payments		
Service Category	**Comparison Group**	**Treatment Group**
Cohort 1		
Assessment	$15,647.25	$0.00
Case Management	$11,653.50	$0.00
Clothing	$19,674.97	$9,377.26
Education	$36,874.43	$71,148.42
Independent Living	$23,224.35	$1,775.59
Legal	$529.08	$0.00
Maintenance	$22,696.75	$0.00
Other	$9,453.34	$5,497.02
Services	$18,626.80	$1,205.27
Supervised Visitation	$3,857.30	$0.00
Transportation	$22,464.14	$0.00
Total	**$184,701.91**	**$89,003.56**
Cohort 2		
Assessment	$27,713.50	$502.75
Case Management	$22,379.00	$0.00
Clothing	$22,263.16	$21,766.79
Education	$46,955.66	$32,210.19
Independent Living	$35,037.13	$11,376.92
Legal	$1,555.91	$851.34
Maintenance	$24,586.75	$0.00
Other	$6,448.34	$34,460.20
Services	$22,486.57	$3,130.60

Table 27. Cost of Fee-for-Service Payments		
Service Category	**Comparison Group**	**Treatment Group**
Supervised Visitation	$6,282.38	$0.00
Transportation	$37,641.24	$0.00
Total	**$253,349.64**	**$104,298.79**
Cohort 3		
Assessment	$37,260.00	$0.00
Case Management	$29,668.00	$0.00
Clothing	$26,999.30	$18,149.27
Education	$50,550.72	$1,360.00
Independent Living	$28,022.63	$1,850.00
Legal	$248.28	$0.00
Maintenance	$25,100.60	$373.60
Other	$22,867.51	$22,383.79
Services	$28,192.58	$3,228.98
Supervised Visitation	$4,290.00	$0.00
Transportation	$41,209.24	$0.00
Total	**$294,408.86**	**$47,345.64**
Cohort 4		
Assessment	$44,910.00	$0.00
Case Management	$43,610.00	$0.00
Clothing	$38,116.07	$29,384.36
Education	$61,177.92	$41,944.05
Independent Living	$35,429.04	$2,287.84
Legal	$492.86	$1,080.56
Maintenance	$31,683.50	$5,031.11
Other	$21,194.65	$35,611.96
Services	$48,300.28	$651.36
Supervised Visitation	$9,024.00	$0.00
Transportation	$61,990.00	$0.00
Total	**$395,928.32**	**$115,991.24**
Cohort 5		
Assessment	$74,700.00	$0.00
Case Management	$72,716.00	$0.00
Clothing	$45,989.21	$30,265.73
Education	$91,884.44	$54,534.50

Table 27. Cost of Fee-for-Service Payments		
Service Category	**Comparison Group**	**Treatment Group**
Independent Living	$43,357.72	$2,799.57
Legal	$954.16	$618.79
Maintenance	$24,086.76	$673.61
Other	$21,542.39	$43,995.42
Services	$95,585.17	$0.00
Supervised Visitation	$11,238.00	$0.00
Transportation	$78,544.47	$0.00
Total	**$560,598.32**	**$132,887.62**

Contracted costs to provide Wraparound services were also examined. A daily case rate of $136 is paid to LCAs to provide assessments, case management, and supervision, as well as to provide services that are traditionally not funded by the agency. The added per case costs to DHHR may be mitigated by the amount of time caseworkers have to work on other, non-Safe at Home cases. Using the number of days youth were enrolled in Safe at Home, roughly $49 million has been incurred to provide services to enrolled youth. The costs equate to an average cost of $30,628 per youth in Cohorts 1 through 5.

All three cost categories are shown in Table 28 which breaks out the cost per child for both Safe at Home and the comparison groups per year. In general, Safe at Home costs $42,300 per youth per year compared to $16,400 per youth per year for the comparison group, a difference of roughly $25,900 per youth per year. When only room and board and fee-for-services are considered, Safe at Home saves nearly $4,750 per youth per year. Interviewed DHHR staff suggest some of the costs of Wraparound services are likely offset by caseworkers who spend less time on Safe at Home cases since wraparound facilitators are providing such intensive services for youth/families.

Table 28. Total Cost Per Youth Per Year					
Cohort	**Number of Youth**	**Room and Board Costs**	**Fee-for-Service Costs**	**Wraparound Costs**	**Cost per Youth**
Safe at Home					
1	124	$18,891.04	$717.77	$33,271.74	$52,880.56
2	221	$15,851.48	$471.94	$32,997.54	$49,320.96
3	297	$10,381.32	$159.41	$29,995.56	$40,536.29
4	445	$10,229.86	$260.65	$29,860.71	$40,351.23
5	512	$9,169.33	$259.55	$29,999.16	$39,428.04
Total	**1,599**	**$11,367.05**	**$306.15**	**$30,628.15**	**$42,301.35**
Comparison					
1	124	$23,584.95	$1,489.53	$0.00	$25,074.48
2	221	$23,549.17	$1,146.38	$0.00	$24,695.55

Table 28. Total Cost Per Youth Per Year					
Cohort	**Number of Youth**	**Room and Board Costs**	**Fee-for-Service Costs**	**Wraparound Costs**	**Cost per Youth**
3	297	$16,580.49	$991.28	$0.00	$17,571.77
4	445	$12,958.60	$889.73	$0.00	$13,848.33
5	512	$11,183.78	$1,094.92	$0.00	$12,278.70
Total	**1,599**	**$15,350.83**	**$1,056.28**	**$0.00**	**$16,407.11**

Summary of Cost Evaluation Results

The program has generated a cost savings of $6.3 million in room and board costs and a savings of over $1.2 million for fee-for-services for treatment youth in Cohorts 1 through 5. The most significant portion of these savings can be attributed to the reduced time youth spend in congregate care placements. However, as noted above, costs to contract with Wraparound service providers averages $30,628 per youth per year. When the amounts incurred to contract for Wraparound is combined with room and board costs as well as with costs for fee-for-services, overall Safe at Home costs roughly $25,900 more per youth per year than the costs of serving youth traditionally. These costs may be partially mitigated by less DHHR caseworker time spent on these Safe at Home cases.

V. Recommendations & Activities Planned for Next Reporting Period

Next Steps:

PCG will return to West Virginia for one last round of on-site data collection in June 2019. The purpose of the trip will be to complete the final fidelity assessment, which will be inclusive of 40 case record reviews and interviews with youth, parents/caregivers, wraparound facilitators, and caseworkers. Fidelity surveys will also be administered to both LCA and DHHR staff in August 2019.

Appendices

Appendix A. Statistical Similarity of Treatment and Comparison Groups

Measure	Significance Cohort 1	Significance Cohort 2	Significance Cohort 3	Significance Cohort 4	Significance Cohort 5	Significance Cohort 6	Test
Gender	0.593	0.780	0.436	0.836	0.750	0.740	Chi-Squared
Hispanic	0.186	0.650	0.689	0.696	0.788	0.911	Chi-Squared
Black	0.583	0.708	0.630	0.466	0.160	0.254	Chi-Squared
UTD	1.000	1.000	1.000	1.000	1.000	1.000	Chi-Squared
White	0.883	0.765	0.763	0.364	0.286	0.240	Chi-Squared
NHOPI	0.969	0.156	0.317	0.316	1.000	0.203	Chi-Squared
Asian	0.956	1.000	0.317	1.000	1.000	1.000	Chi-Squared
AIAN	1.000	1.000	1.000	1.000	0.563	0.363	Chi-Squared
AsianPI	1.000	1.000	1.000	1.000	1.000	1.000	Chi-Squared
Unknown Race	0.530	1.000	0.476	1.000	0.157	0.563	Chi-Squared
Declined	1.000	1.000	1.000	1.000	1.000	1.000	Chi-Squared
Placement Type	0.999	0.814	0.326	0.608	0.872	0.658	Chi-Squared
Parent Jail	0.530	0.067	0.563	0.313	0.780	1.000	Chi-Squared
Abandonment	1.000	1.000	0.082	0.654	1.000	0.561	Chi-Squared
Child Alcohol	1.000	1.000	0.317	0.654	1.000	0.654	Chi-Squared
Parent Alcohol	0.594	0.703	1.000	0.561	0.795	0.402	Chi-Squared
Caretaker Unable to Cope	0.303	1.000	0.316	1.000	0.654	1.000	Chi-Squared
Child Behavior	0.454	0.926	0.739	0.456	0.704	0.693	Chi-Squared
Child Disability	0.340	1.000	1.000	1.000	1.000	1.000	Chi-Squared
Parent Death	1.000	1.000	0.563	1.000	1.000	0.563	Chi-Squared
Child Drugs	0.522	1.000	0.325	0.833	0.590	0.807	Chi-Squared
Parent Drugs	0.405	0.382	0.649	0.097	0.529	0.863	Chi-Squared
Housing	0.340	0.703	0.737	0.463	0.193	1.000	Chi-Squared
Neglect	0.524	0.563	0.862	0.319	0.595	0.581	Chi-Squared
Physical Abuse	0.854	0.413	1.000	0.463	0.702	1.000	Chi-Squared
Relinquishment	0.969	1.000	1.000	1.000	0.704	1.000	Chi-Squared
Sexual Abuse	0.608	0.587	1.000	0.478	0.614	0.525	Chi-Squared
Voluntary	0.340	0.154	1.000	0.129	1.000	0.157	Chi-Squared
Other	1.000	1.000	1.000	1.000	1.000	1.000	Chi-Squared
Number of Prior Placements	0.219	0.335	0.605	0.614	0.895	0.785	Chi-Squared
Axis 1 Diagnosis	0.804	0.847	0.677	0.374	0.266	0.388	Chi-Squared

Measure	Significance Cohort 1	Significance Cohort 2	Significance Cohort 3	Significance Cohort 4	Significance Cohort 5	Significance Cohort 6	Test
Juvenile Justice Involved	0.839	0.86	0.253	0.066	0.266	0.413	Chi-Squared
Psychiatric Hospital	0.408	0.568	0.157	0.676	0.563	0.330	Chi-Squared
Group Home	0.882	0.576	0.933	0.829	0.879	0.818	Chi-Squared
Age at Referral	0.823	0.085	0.534	0.214	0.724	0.735	One Way ANOVA

Measure	Significance Cohort 1	Significance Cohort 2	Significance Cohort 3	Significance Cohort 4	Significance Cohort 5	Test
Parent Drugs	0.405	0.382	0.649	0.097	0.529	Chi-Squared
Housing	0.340	0.703	0.737	0.463	0.193	Chi-Squared
Neglect	0.524	0.563	0.862	0.319	0.595	Chi-Squared
Physical Abuse	0.854	0.413	1.000	0.463	0.702	Chi-Squared
Relinquishment	0.969	1.000	1.000	1.000	0.704	Chi-Squared
Sexual Abuse	0.608	0.587	1.000	0.478	0.614	Chi-Squared
Voluntary	0.340	0.154	1.000	0.129	1.000	Chi-Squared
Other	1.000	1.000	1.000	1.000	1.000	Chi-Squared
Number of Prior Placements	0.219	0.335	0.605	0.614	0.895	Chi-Squared
Axis 1 Diagnosis	0.804	0.847	0.677	0.374	0.266	Chi-Squared
Juvenile Justice Involved	0.839	0.86	0.253	0.066	0.266	Chi-Squared
Psychiatric Hospital	0.408	0.568	0.157	0.676	0.563	Chi-Squared
Group Home	0.882	0.576	0.933	0.829	0.879	Chi-Squared
Age at Referral	0.823	0.085	0.534	0.214	0.724	One Way ANOVA