WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia

Strengthening families & children within their home communities

Semi-Annual Progress Report

April 1, 2017 – September 30, 2017

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

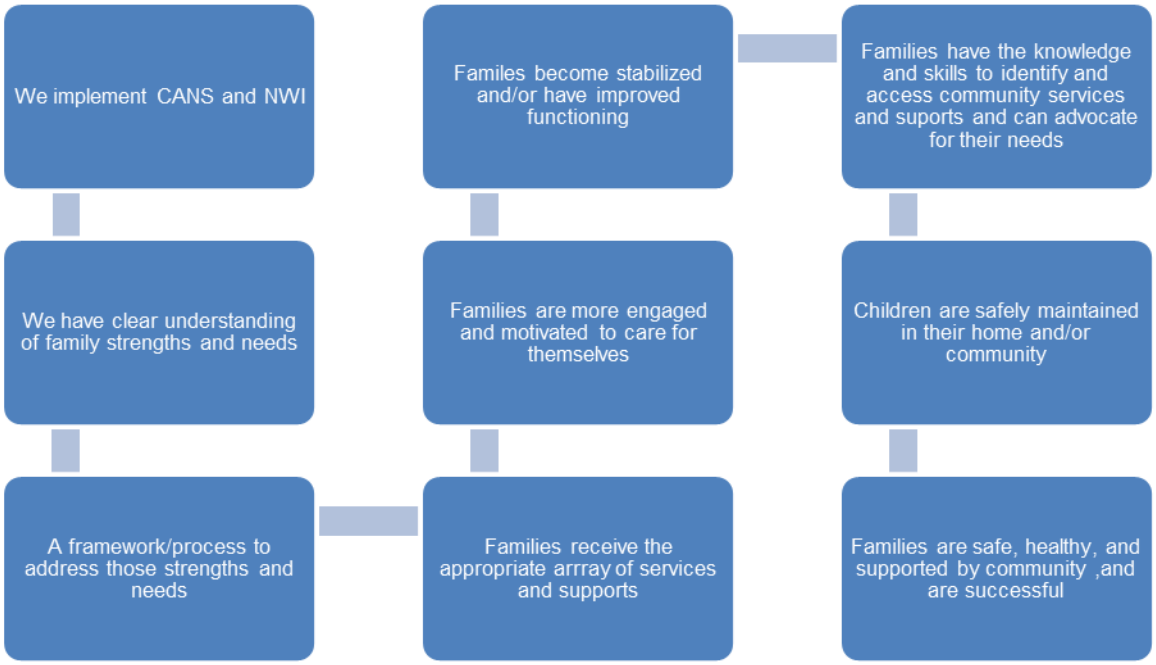
So that

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

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.

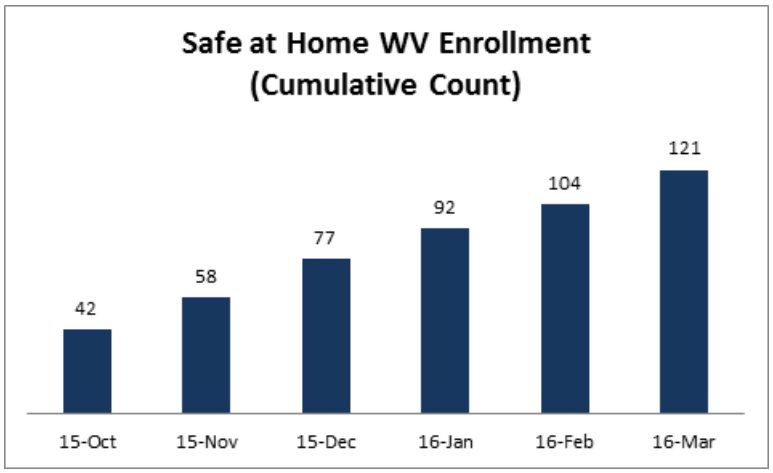
On August 1, 2016, West Virginia began Phase 2 of implementation by expanding to the 24 counties of Barbour, Brooke, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Lewis, Marion, Mineral, Mercer, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Pocahontas, Preston, Randolph, Summers, Taylor, Tucker,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

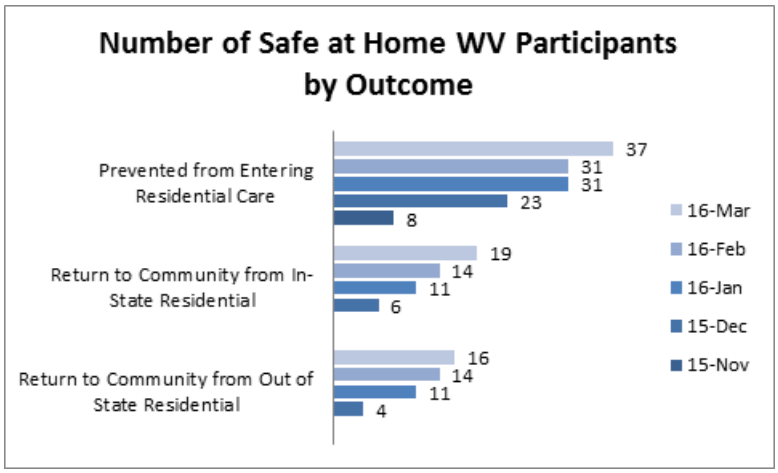
On April 1, 2017, West Virginia began Phase 3 of implementation by expanding to the remaining 20 counties of; Braxton, Clay, Jackson, Roane, Ritchie, Doddridge, Pleasants, Wood, Marshall, Tyler, Wetzel, Calhoun, Gilmer, Wirt, Fayette, Raleigh, McDowell, Wyoming, Mingo, and Webster. This phase brought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

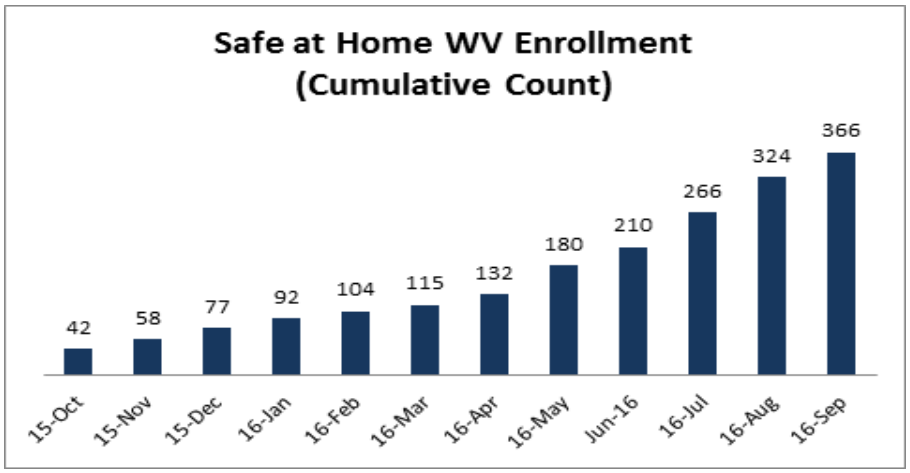
As of September 30, 2017, 1,172 youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 58 youth from out-of-state residential placement back to West Virginia, 171 Youth have stepped down from in-state residential placement to their communities, and 15 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 713 at risk youth.

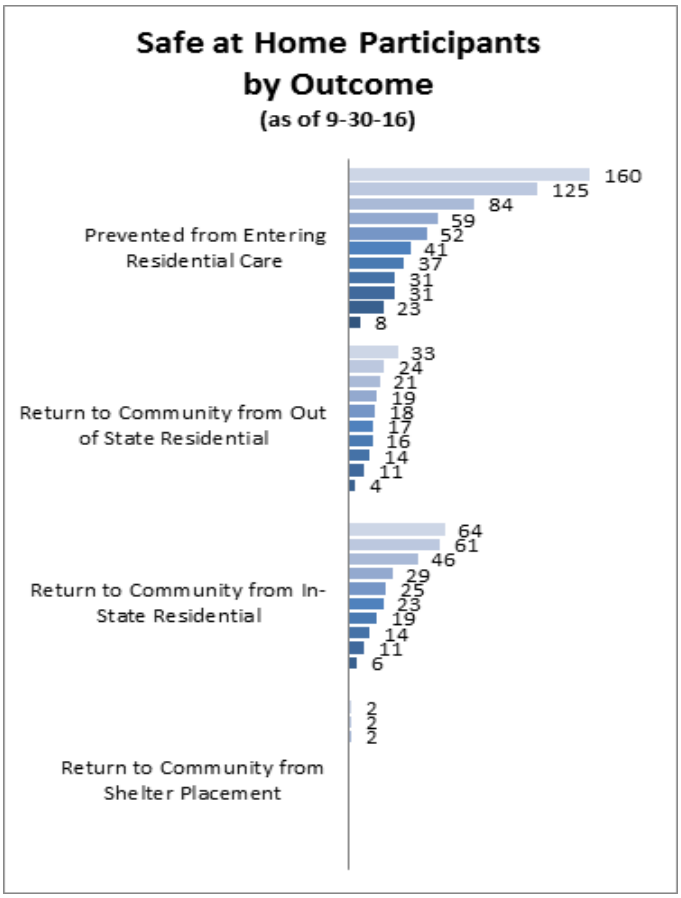
The breakdown of placement type at time of enrollment is as follows:

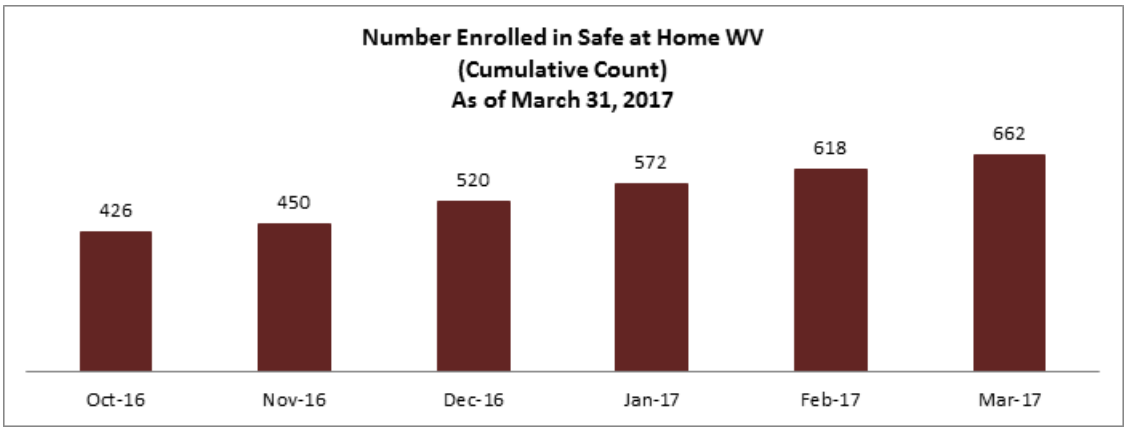
- 83 were or are in out-of-state residential placement at time of enrollment with 58 returning to WV
- 264 were or are in in-state residential placement at time of enrollment with 171 returning to community
- 789 were or are prevention cases at time of enrollment with only 76 entering residential placement
- 36 were or are in an emergency shelter placement at time of enrollment with 15 returning to their community

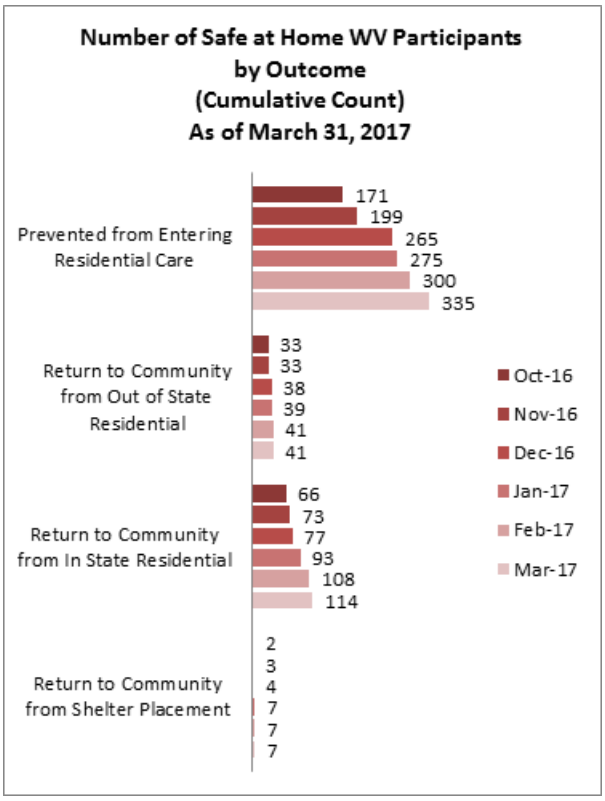

Safe at Home WV Enrollment
(Cumulative Count)
42
58
77
92
104
121
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar

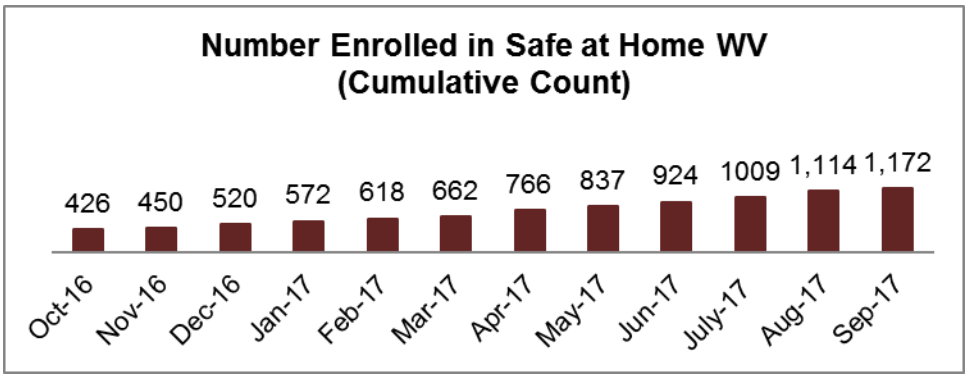

Number of Safe at Home WV Participants
by Outcome
Prevented from Entering Residential Care
37
31
31
23
8
Return to Community from In-State Residential
19
14
11
6
Return to Community from Out of State Residential
16
14
11
4
16-Mar
16-Feb
16-Jan
15-Dec
15-Nov

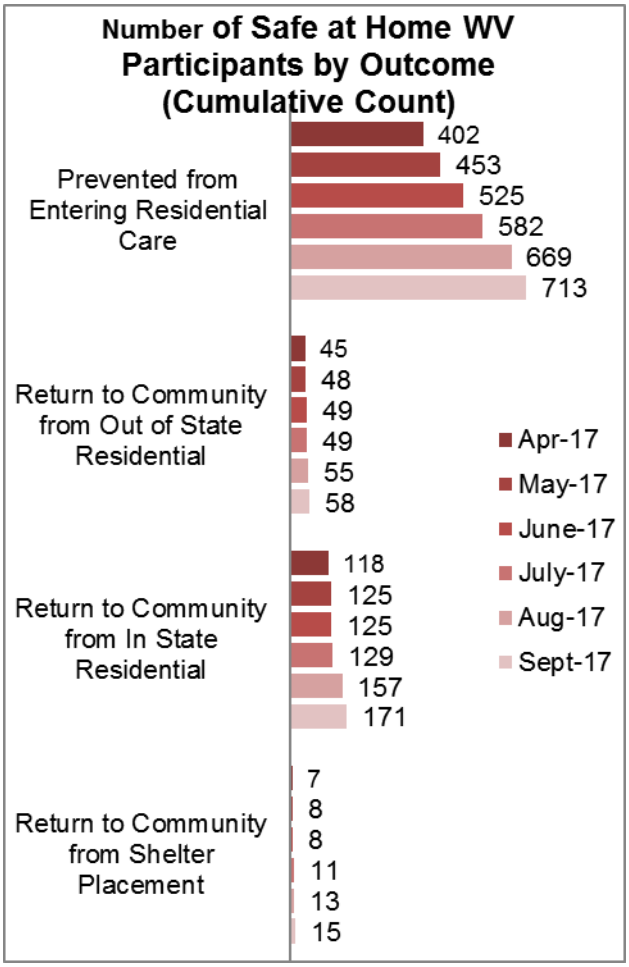

Safe at Home WV Enrollment
(Cumulative Count)
42
58
77
92
104
115
132
180
210
266
324
366
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar
16-Apr
16-May
Jun-16
16-Jul
16-Aug
16-Sep


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


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
Jun-17
July-17
Aug-17
Sep-17


Number of Safe at Home WV
Participants by Outcome
(Cumulative Count)
Prevented from Entering Residential Care
402
453
525
582
669
713
Return to Community from Out of State Residential
45
48
49
49
55
58
Return to Community from In State Residential
118
125
125
129
157
171
Return to Community from Shelter Placement
7
8
8
11
13
15
Apr-17
May-17
June-17
July-17
Aug-17
Sept-17

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.

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 bi-monthly 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 across the state. Our weekly email blasts and 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.

During the previous reporting period, West Virginia implemented the recommendations of our evaluator. This included the development of a professional white paper guiding the Local Coordinating Agency Clinical Supervisors in further professional development of the wraparound facilitators regarding engagement. BCF developed a similar transfer of learning process for use by Child Protective Service Supervisors and Youth Service Supervisors to assist the professional development of BCF staff regarding engagement. Our evaluator provided West Virginia with 4 case examples from the fidelity reviews they conducted during the previous reporting period. The 4 cases provided examples of successful case progression and outcomes that could be directly correlated to engagement. Those cases were used with staff during transfer of learning discussions. West Virginia continues with this recommendation to further develop and strengthen engagement skills.

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. LCA's have added mentors, therapists, and transportation aides in response to the service needs of clients. 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. This is often a challenge in rural communities but it is also exciting to see creative responses. One community organization came together to right a grant for public transportation to serve the larger community in their small rural area.

West Virginia has worked with the Capacity Building Center for States to develop a strategic plan to support the wavier as well as other BCF initiatives and needs. The Capacity Building Center for States provided a marketing consultant to assist with the development of a 1 page informational document about Safe at Home West Virginia. The document is written in layman terms and is being utilized by the department as well as any of our partners to inform and solicit community level support for the youth and families being served through Safe at Home West Virginia. This document is available for public use and may be accessed and printed from the Safe at Home West Virginia Website, safe.wvdhhr.org. West Virginia took this learned skill and updated the one page flyer to be more current and also developed a one page flyer for use to guide the community on identifying youth in the target population and who to contact for possible referral to Safe at Home West Virginia.

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 with regard to 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.

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.

728 DHHR staff have been trained in CANS. 44 new Youth Service Workers have been trained. This ongoing training continues as planned.

During this reporting period 114 people have been certified or re-certified in the administering of the CANS.

West Virginia also continues with the identification and certification of WV CANS Advanced CANS Experts (ACES) to provide ongoing training and technical assistance. West Virginia is finding that staff are having difficulty accessing advanced CANS experts to provide technical assistance. In order to address this Dr. Lyons came to West Virginia and spent a week with another 13 staff identified to go through the advanced CANS experts process. He will also be providing ongoing technical assistance calls with the experts in order 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 13 CANS experts with 7 providing certification training and the other 6 providing technical assistance.

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. During this reporting period, 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". At present the training is developed and has been piloted and is being

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 to be more focused on the actual application and practice of wraparound facilitation.

We continue working with our partners in Positive Behavioral Support Program. They are assisting us with engagement and possible trainings in using the MAPs process. MAPs refers 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.

During this reporting period, West Virginia has continued to follow the judiciary communication plan as developed last year. The plan simply 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.

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 3,258 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 this reporting period, the timeframe for completion of the initial CANS was changed from 14 days to 30 days. This change was made after comment by the Local Coordinating Agencies and staff during process evaluation interviews. BCF had already made this change to other provider agreement affecting programs in which CANS are administered so the change also brought consistency across all provider agreements and program structures. This change also required that all program manuals, matrix, and forms be updated.

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 being charged 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.

Prestera Center's Chief Executive Officer Karen Yost 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.

During this reporting period BHHF has fully implemented 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 4 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 no involvement with the child welfare system. 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. During the last reporting period, they had expanded to consider referrals from counties surrounding the original pilot areas. They have received a total of 112 referrals, 51 of those were accepted.

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.

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.

During the previous reporting period, West Virginia developed a request for applications for lead agencies to develop Treatment Foster Care homes throughout the state. These grants were awarded to lead agencies in all 4 of the BCF Regions. During this reporting period, the three-tiered foster family care continuum was fully implemented.

Possibly most important is West Virginia's sustainability planning. Although sustainability has always been included within West Virginia's workplan the more focused activities to plan for transition out of the waiver began this reporting period. During this reporting period, a Finance workgroup comprised of the Project Director, BCF Deputy

Commissioner of Operations, BCF CFO, DHHR CFO and staff began meeting to determine necessary financial information that will be needed and used by other workgroups to inform any program adjustments. The 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.

This group has requested Technical Assistance through Casey Family Programs which is scheduled during the next reporting period.

During this reporting period, West Virginia's evaluator has conducted the first full cost analysis that is included within this report. Our evaluator will be a valuable contributor to this group and financial sustainability planning as well as informing program adjustments.

III. Evaluation Status

Data Collection Activities:

During the most recent six-month evaluation period following implementation of Safe at Home West Virginia, the evaluator, Hornby Zeller Associates, Inc. (HZA), conducted the second annual fidelity assessment of local coordinating agencies (LCAs). HZA also re-administered the fidelity survey to Department of Health and Human Resources (DHHR) caseworkers, supervisors and county managers from Phase I implementation counties, and re-administered a separate fidelity survey geared toward LCA wraparound facilitators, supervisors and program managers. All of these data collection efforts were used to inform the process evaluation. Each is described in greater detail below.

Data from DHHR's Statewide Automated Child Welfare Information System (SACWIS), FACTS, were used to inform the outcome evaluation, along with data from the automated Child and Adolescent Needs and Strengths (CANS) tool and interview data regarding youth educational functioning. CANS and interview data were used to measure progress on well-being measures while data from FACTS were used to measure safety and permanency outcomes. All data collection activities are discussed in greater detail below.

Case Reviews and Interviews

As part of the fidelity assessment of Safe at Home, staff from HZA returned to West Virginia during the week of July 17, 2017 to conduct the second annual fidelity assessment. HZA completed case record reviews (Appendix B) for 40 cases across nine contracted agencies and conducted interviews with 79 key stakeholders (Appendix C). The count of cases reviewed at each agency was proportional to the number of youth served by the agency. The youth, a parent/caregiver, the LCA wraparound facilitator and the DHHR caseworker from each case were asked to participate in interviews. Some of the wraparound facilitators and caseworkers were interviewed about more than one case in the sample. Both the record reviews and the interviews were designed to provide information on the extent to which the program is being implemented in the way it was intended through the Safe at Home model. In addition to learning about fidelity, interviews were also

used as an opportunity to explore one aspect of child well-being, specifically, youth educational functioning. Table 1 displays the number of stakeholders interviewed during the summer of 2017.

Table 1. Stakeholders Interviewed by Group	
Youth	14
Parents/Caregivers	16
LCA Wraparound Facilitators	24
DHHR Caseworkers	25
Total	**79**

Surveys

A second round of fidelity surveys was administered to DHHR community service managers, supervisors and caseworkers from Phase I[2] implementation counties. Results from Phase II DHHR staff surveys were reported in the April 2017 semi-annual evaluation report. HZA staggers the administration of the DHHR staff survey to account for differences in staff training and time/experience working with the program. In addition to the DHHR staff survey, HZA administered a second annual fidelity survey to LCA Safe at Home program managers, supervisors and wraparound facilitators. Respondents provided their perceptions of the quality and effectiveness of services, what can be done to enhance them, the frequency with which they complete associated program responsibilities and the functionality of multi-agency collaboration.

On August 16, 2017, the survey link for the LCA staff survey was sent to the emails of all applicable LCA staff, using the online CANS database to identify applicable staff and their email addresses. HZA sent surveys to 155 staff persons. At least one LCA staff person from all but one agency participated in the survey.

On the same day, the survey link for the DHHR staff survey was sent to community services managers from all of the Phase I implementation counties, where all nine community services managers were asked to complete the survey and also to forward the

[2] Safe at Home's implementation rolled out in three phases. Phase I began October 1, 2015 and involved eleven counties, Phase II began August 1, 2016 and added 24 new counties and Phase III completed the statewide implementation on April 1, 2017 by bringing in the remaining 20 counties.

survey to their casework and supervisory staff involved with Safe at Home. The deadline to complete the surveys was September 1, 2017. Due to low participation rates, HZA extended the original survey deadline to September 15, 2017 and sent an updated message to stakeholders urging their participation. A total of seven DHHR staff and 51 LCA staff responded to the respective surveys.

FACTS Data

HZA uses data from West Virginia's FACTS to measure the impact on achieving the initiative's goals, e.g., reduced placement in congregate care. Outcomes for Safe at Home involved youth are compared to an historical comparison group of youth. The comparison groups, which are selected for each six-month reporting timeframe since the program was implemented, were selected from youth known to DHHR between State Fiscal Years (SFYs) 2010 to 2015. The characteristics of youth in each comparison group are similar to the youth in each of the three[3] treatment cohorts. A total of 1,058 youth have been referred to Safe at Home as of September 30, 2017.

Characteristics, including demographic data, case history, and program qualifying characteristics, such as involvement in mental health and juvenile justice systems, were used to match 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 the youth selected into the comparison groups are statistically similar to those in the corresponding treatment groups (Appendix D).

CANS Data

During the first few months of program implementation, HZA developed an online CANS tool for LCA and DHHR staff to use. The online CANS tool allows for ease of access and information sharing across participating agencies. Each youth who enters Safe at Home was originally expected to have an initial CANS assessment completed within 14 days of referral,

[3] HZA has not created the comparison pool for the most recent cohort but will do so for the next semi-annual evaluation period because not enough time has elapsed to measure outcomes for these youth. Therefore, six month outcomes will be available for the fourth cohort for the April 2018 semi-annual evaluation report.

and subsequent CANS assessments every 90 days. However, a policy change, which went into effect in June 2017, moved the 14 day initial assessment deadline out to 30 days, with subsequent CANS still to be completed every 90 days thereafter. This policy change was a direct result of process evaluation findings illustrating that LCA wraparound facilitators were struggling to conform to the 14 day initial CANS assessment deadline. The online CANS tool provides the evaluation team with ready access to assessment data which are used to measure progress on well-being measures.

IV. Significant Evaluation Findings to Date

Process Evaluation Results:

Youth Population Description

Table 2 provides a description of Safe at Home youth at the time of referral. Overall, 62 percent of the youth referred to Safe at Home were living in their own homes at the time of referral. Since Safe at Home was implemented, the percentage of youth in congregate care at the time of referral has continually decreased, giving rise to a more prevention based population. Youth placed in a congregate care setting at the time of referral comprised 56 percent of Cohort I youth and only 17 percent of those in Cohort IV.

Table 2. Safe at Home Youth Population Description				
	Cohort I	**Cohort II**	**Cohort III**	**Cohort IV**
Placement at Referral				
Total	**124**	**226**	**299**	**409**
Out-of-state Congregate Care	30	18	11	12
In-state Congregate Care	39	74	62	56
Emergency Shelter	5	18	6	13
Family Foster Care	2	11	13	27
Home	48	105	207	301
Age at Referral				
12 or less	10	20	26	35
13	20	26	35	60
14	30	51	66	75
15	28	59	66	121
16	32	64	93	100
17	4	6	13	18
Gender				
Male	77	116	189	250
Female	47	110	110	159

Table 2. Safe at Home Youth Population Description				
	Cohort I	**Cohort II**	**Cohort III**	**Cohort IV**
Race/Ethnicity				
White	96	184	250	364
Black	9	20	17	15
Mixed	15	19	26	14
Other	4	3	6	16

More males than females were referred to Safe at Home in each cohort; on average across all four cohorts, 63 percent of youth were males. However, fewer youth were male in Cohort II (51%). Additionally, gender disproportionality was highest among youth referred when placed in out-of-state congregate care, where males made up at least 75 percent of the population in each cohort. The majority of youth were white in all four cohorts (over 75%). The percentage of white youth increased slightly with each cohort.

Fidelity Assessment

As described above, the fidelity assessment was conducted during the summer of 2017 and HZA staff completed a total of 40 case record reviews on-site at the LCAs. The cases were selected randomly, in proportion to the number of youth served by each LCA. Ultimately, the case sample included cases from all four of the State's regions, and more specifically, the following 18 counties: Berkeley, Boone, Brooke, Cabell, Grant, Hardy, Jefferson, Kanawha, Lincoln, Mason, Mercer, Monongalia, Morgan, Nicholas, Ohio, Putnam, Randolph and Wayne. At the time of review, 26 of the 40 cases were open, eight had successfully graduated the program, and six were discharged before program completion. On average, the open cases had been open for 371 days as of the date the reviews were completed, while cases closed due to graduation were open 382 days and 223 days for discharged closed cases.

LCA Wraparound Facilitator Qualifications

LCAs are the contracted agencies with primary responsibility for delivering wraparound services to youth in Safe at Home, with one wraparound facilitator assigned to each youth in the program. Per the State's LCA funding announcements, wraparound

facilitators are supposed to have a Bachelor's Degree in social work, sociology, psychology or another human service related field and two years of work experience serving a youth population similar to that of Safe at Home's (i.e., ages 12-17 with a mental health diagnosis in congregate care or at risk of congregate care entry). Facilitators are also supposed to have a general knowledge of mental illness diagnoses and behavioral disorders in children, and personal family experience with mental illness is considered helpful. In some cases, the State will make an exception to one or more of these requirements if the applicant has extensive knowledge and/or experience in the field.

All 35 facilitators who responded to the survey reported having at least a Bachelor's Degree in one of the preferred human services fields, with the most common being in the field of psychology. Five of the facilitators also had a Master's Degree. Ninety-one percent reported having two plus years of experience in the behavioral health field. Seventy-one percent of facilitators had a prior knowledge base of mental illness diagnoses and behavioral disorders in children and 60 percent had personal family experience with mental illness.

LCA staff working with Safe at Home are also required to complete training, wraparound certification and CANS certification. According to the latest (Phase III) Safe at Home funding announcement, all LCA staff are required to have training which, at minimum, includes the following content:

- System of Care "Ladder of Learning" for Core Competencies,
- Child and Family Team Building,
- Family Centered Practice,
- Family and Youth Engagement,
- Effects of Trauma on Children and Youth,
- The 10 Wraparound Key Principles,
- Safe at Home West Virginia Model and
- BCF Policy Cross Training.

All 51 LCA staff who responded to the survey (inclusive of 35 wraparound facilitators and 16 supervisors) had received training prior to working with Safe at Home, and some had received multiple trainings. Only 14 percent of the respondents reported that the training they received did not prepare them sufficiently for the job. Eighty-nine percent of facilitators had received wraparound certification and all facilitators had received CANS certification. It

is possible that the small percentage of facilitators who had not completed the wraparound certification were new to the position and still completing the process.

Phase I: Engagement and Team Preparation

The first wraparound phase, Engagement and Team Preparation, is used to orient the family to the program and to begin engaging with the family and youth to explore their strengths, needs and goals; identify any pressing issues or concerns that the family has; and to build the wraparound team with an emphasis on family identified supports.

Interviewees reported that in most cases youth and their families initially learned about Safe at Home through their DHHR caseworkers. Typically, caseworkers provided a brief overview of the program to the families and their youth and how it may help to meet their needs. Following this introduction, wraparound facilitators provided a more in depth explanation of what Safe at Home entails. Some of the information wraparound facilitators reported sharing with youth/families include the program materials and associated paperwork, the team process of wraparound, how Safe at Home differs from DHHR, youth/family voice and choice, how assessments are used, the strengths based nature of the program, how the program benefits youth/families in general and the types of services that are available. In a few cases, youth/families first learned about the program through placement staff, the courts or the wraparound facilitator. In one case, the parent learned about the program on his/her own and requested to speak to a DHHR caseworker about Safe at Home and in a couple of cases youth already had a sibling currently in Safe at Home. One parent shared his/her takeaway of Safe at Home, stating, “Safe at Home is supposed to support us, be there for us during a crisis and provide services we can’t get regularly. It does all this and more.”

Wraparound facilitators and caseworkers were asked how well youth/families understood what the program entails. In all but three cases, facilitators and caseworkers believed that youth/families fully understood Safe at Home. One facilitator shared how s/he adapts to the youth/families learning styles to ensure they understand the program, stating, “[The youth] had to see it to understand it so I drew it out and showed [him/her] the systems on the outside and the family in the middle and how we were the linkage to all these services.” In another three cases, it took time for facilitators to see that the youth/families really did understand the program. One caseworker shared of one of his/her experiences;

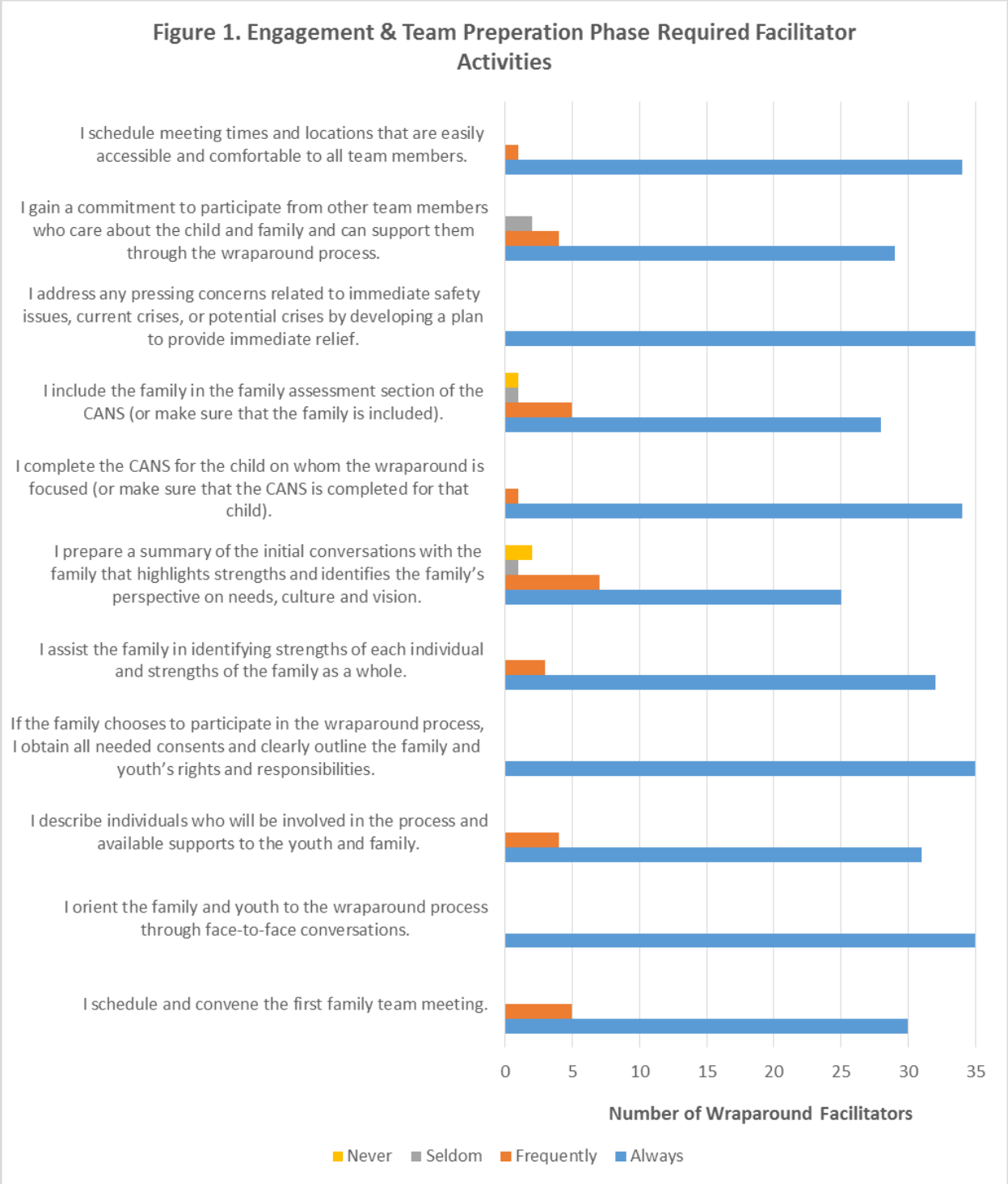
"They had a fair understanding, but I wouldn't say good. They didn't understand the level that the program could truly help. Once we began doing things, they got it."

Nearly all stakeholders interviewed reported that wraparound facilitators encouraged youth/families to share their concerns, hopes, goals or strengths in the very early stages of the case. Wraparound facilitators reported that in the majority of cases it took time to build rapport and get youth/families to fully engage with them and feel comfortable enough to share their concerns and goals. One wraparound facilitator shared a strategy for doing so, "I had the parents create a five year plan for [the youth] and [the youth] create a five year plan for [himself/herself], then we compared the plans. Together we mapped out where [s/he] is now and where we all wanted [him/her] to be." However, in some cases youth and families were able to share goals and concerns without much prompting or rapport building. A youth from one of these cases said, "When I met [the facilitator] I felt really comfortable right away and I just knew we would get along. I'm actually just going to be really sad when [s/he] has to go." In a few cases engagement continues to remain as an ongoing issue.

According to the interviewees, wraparound facilitators always asked youth/families to identify any supports they wanted to be involved with them through Safe at Home. However, most of the youth/families elected to keep Safe at Home involvement within the immediate family for a variety of reasons. In some cases, the youth/family did not have any supports they could identify and in others they did not want anyone else involved. Either way, facilitators often revisited this conversation throughout the life of the case. In eight cases, youth/families did identify supports and about half of those identified formal supports such as therapists, placement workers or school resource officers. The other half identified informal supports such as extended relatives, church members or friends. One facilitator provided an example where the youth wanted his/her aunts involved and, eventually, this opened up a placement resource for the youth.

Additionally, the LCA and DHHR fidelity surveys asked facilitators and caseworkers about the extent to which required tasks were performed during each phase of wraparound, including the Engagement and Team Preparation Phase. Due to the low response rate for caseworkers[4], only wraparound facilitator responses are included in Figure 1.

[4] Of the five caseworkers who responded, only three had any direct experience handling Safe at Home cases.



Nearly all wraparound facilitators surveyed reported completing each of the required casework activities "Always" or "Frequently" during the Engagement and Team Preparation Phase.

Phase II: Initial Plan Development

The purpose of the Initial Plan Development Phase is to create the initial wraparound and crisis safety plans through a collaborative team process. Youth/families are to play an active and integral role in planning, where their feedback is elicited and incorporated into plans wherever possible. This section of the report discusses who participates in the planning process, what resources are used and how quickly it happens. It also reviews the steps which go into making revisions to the initial plan and how frequently that is done.

Nearly all youth, parents, facilitators and caseworkers agreed that youth/family input is prioritized and incorporated into planning. Strategies employed by wraparound facilitators to involve youth in planning varied greatly. Facilitators worked with youth/families to develop long and short term goals, often through a brainstorming process. Facilitators asked youth/families to think about how they as a team can achieve these goals and what is most important to them. Sometimes the CANS was used as a discussion piece in the planning process to talk about areas of need and strength. Wraparound facilitators often laid out who is responsible for what parts of the plan. As time went on, the team would discuss progress and areas that still needed work. Facilitators would ask youth/families what they were doing well and whether they were following through with the actions necessary to achieve the goals.

Parents commonly noted that they provide feedback/input whenever necessary. They also help to make sure the youth and family members comply with the plan. Parents also reported they work to come to a consensus as a team in developing the plans and provide updates on youth progress and/or setbacks. One parent said, “We [mom and dad] did a lot with [the facilitator] to come up with a school solution that would work for [the youth] and the crisis plan.” Most parents also reported that youth make substantial contributions to wraparound planning, with one saying, “Yes, most definitely. [The youth] is there for every meeting and [s/he] always asks a lot of questions and is always very interested with the planning.” A few youth provided examples of instances where their input had actually been used in planning, such as expressing interest in particular activities, voicing their desire to consider an alternative learning environment and goal setting.

When it was difficult for wraparound facilitators to engage youth/families in the planning process, facilitators used multiple strategies to get them to participate. Examples of these strategies include adjusting planning activities to the unique learning styles of youth/families, convincing youth/families that LCAs are not DHHR or the courts, working around families' hectic schedules and finding times that are most convenient for them, looking to other supports for feedback when there is minimal participation by youth and families, offering suggestions, building rapport by showing that facilitators follow through, and figuring out what motivates each individual and offering incentives.

As a formal support/team member, caseworkers were asked to share how they assist in wraparound plan creation. Three of the 25 caseworkers interviewed reported that they have not been involved in wraparound planning at this point. For the majority who were, they stated that they provide input while allowing the facilitator to take the lead in planning. Caseworkers reported that facilitators share ideas to garner their feedback prior to the planning meetings; they also noted that their position allows them to provide thorough youth/family histories. Additionally, caseworkers stated that they help by utilizing their legal authority when necessary to sign off on service referrals for youth and follow up with providers to ensure that plans are being implemented. Nearly all caseworkers agreed that the planning process was very youth/family driven and saw their role as supportive in nature. One caseworker described the collaboration process with the facilitator, stating, “Usually [the facilitator] will contact me and let me know [s/he] is getting a new plan. We usually meet up in person and we will see what [the youth] needs, [his/her] goals, and we talk about what [the youth] needs at the time. As time goes on problems change and we work together to update plans accordingly.”

Another tool used in planning is the CANS. Wraparound facilitators are responsible for completing CANS assessments for all youth in the program. As noted earlier, initial CANS are to be completed within 30 days of referral to Safe at Home while subsequent CANS are to be conducted every 90 days thereafter. When looking at the overall average, LCAs completed the initial CANS 36 days after referral and subsequent CANS every 90 days thereafter. Therefore, LCAs as a whole fell slightly short of fulfilling the initial CANS requirement but subsequent CANS were performed within the required timeframe.

While it may appear on the surface that LCAs are not meeting the required timeframe for initial CANS assessments, only one of the nine LCAs included in the fidelity assessment stood out as falling widely short on this measure. When this one LCA is excluded from the calculation, the remaining eight LCAs completed the initial CANS within 22 days of referral; exceeding the necessary timeframe by eight days. The LCA falling far short of meeting the initial CANS measure, also had two cases which were outliers, with initial CANS not being completed until 200 plus days following referral. When just those two cases are excluded from the analysis then the statewide average becomes 26 days following referral.

Wraparound facilitators shared how they use CANS assessments in planning, stating that CANS is used to identify areas of concern so the team can figure out how to address the youth and families' needs. Additionally, the CANS tells the facilitator how urgent each need is which helps with prioritizing. Facilitators also use the CANS to identify areas of strength on which they can continue to build and which they can use to address the areas of need. Often facilitators discussed CANS results with youth/families as a way to demonstrate progress, focus planning and develop or refine goals.

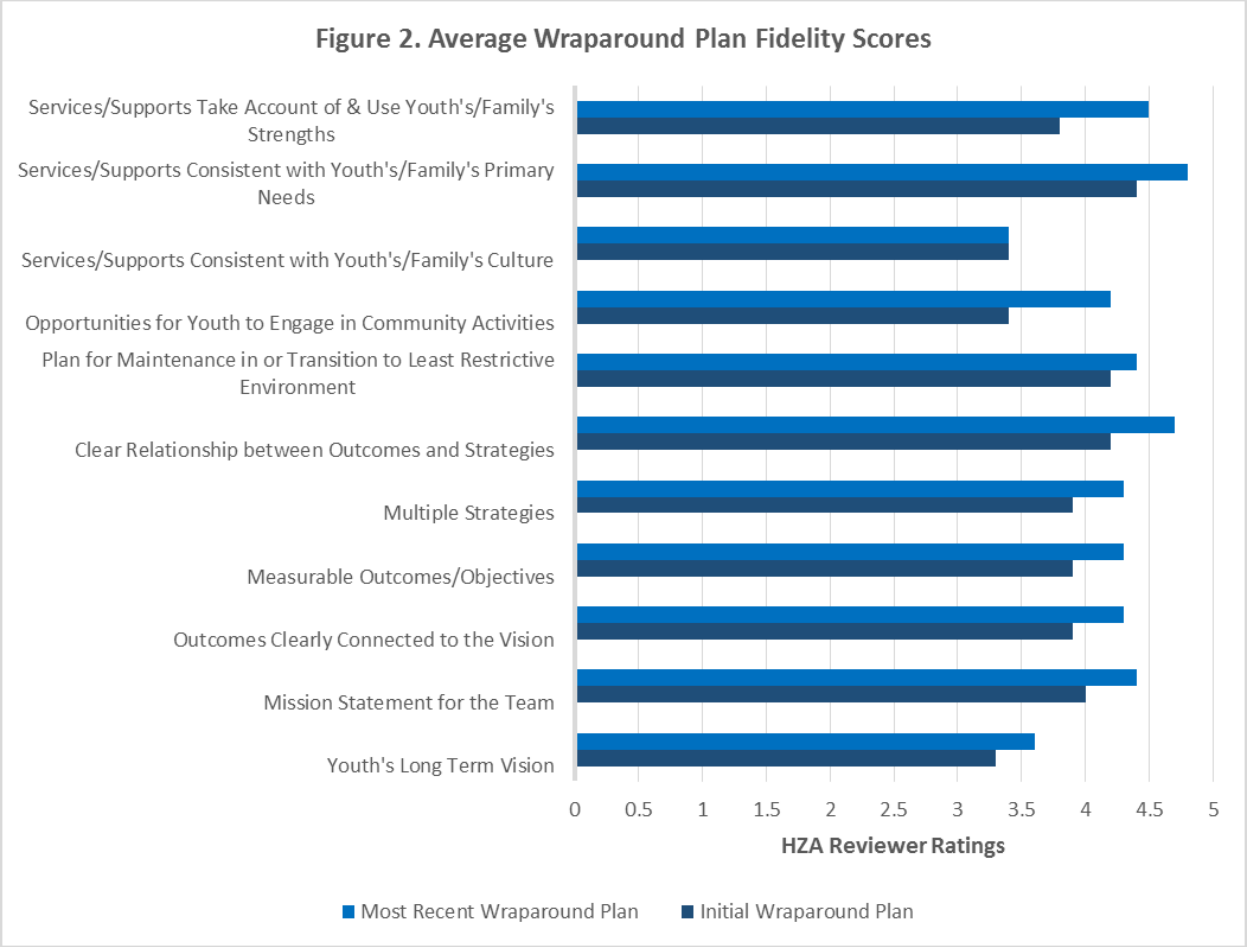
Stakeholders listed the goals that had been established through the Safe at Home planning process. While goals varied among the 40 cases, the most common responses included improvement in grades, behavior, school attendance, social skills and family relationships, and to achieve permanency when youth were placed out of the home. One youth exhibited exceptional motivation with goal planning, stating, "Once they leave, my personal goal is to do what I'm doing now, but be able to do it on my own without them."

Most youth and parents reported witnessing progress and/or goal achievement through their involvement with Safe at Home. One parent said, "If you could see how [the youth] was before and how [s/he] is now; [s/he] is a completely different person. [S/he] was always mad, anxious or depressed and [s/he] still has those moments, but we are seeing those moments less and less." One parent who did not believe his/her youth was progressing said, "[S/he] is just going to have to learn on [his/her] own that we're trying to help [him/her]."

Youth and parents also discussed what is currently being done to overcome challenges. Two youth reported that upcoming plans to change the school environment would help them in overcoming the challenges they continue to face in meeting some of their goals. Parents shared a variety of strategies that have been employed to help get youth back on track, such as collaborating as a team to come up with solutions, ensuring that placements are stable, making sure counseling attendance is high and medications are appropriate, and keeping on top of youth when it comes to school work and attendance.

Initial wraparound plans are to be completed within 30 days of program referral. On average, LCAs completed initial wraparound plans within 45 days of referral, falling short of this timeframe by 15 days. Subsequent wraparound plans are to be updated and refined as necessary, and on average they were revised every 50 days.

HZA reviewed the initial and most recent wraparound plans and rated the content for the extent to which required items were included in the plan. Reviewers used a five point Likert scale, with one meaning the item was "Not at All" a part of the plan and five meaning the item was "Thoroughly" included in the plan. Figure 2 displays the average scores for each fidelity item, showing comparisons between the initial and most recently completed wraparound plans.

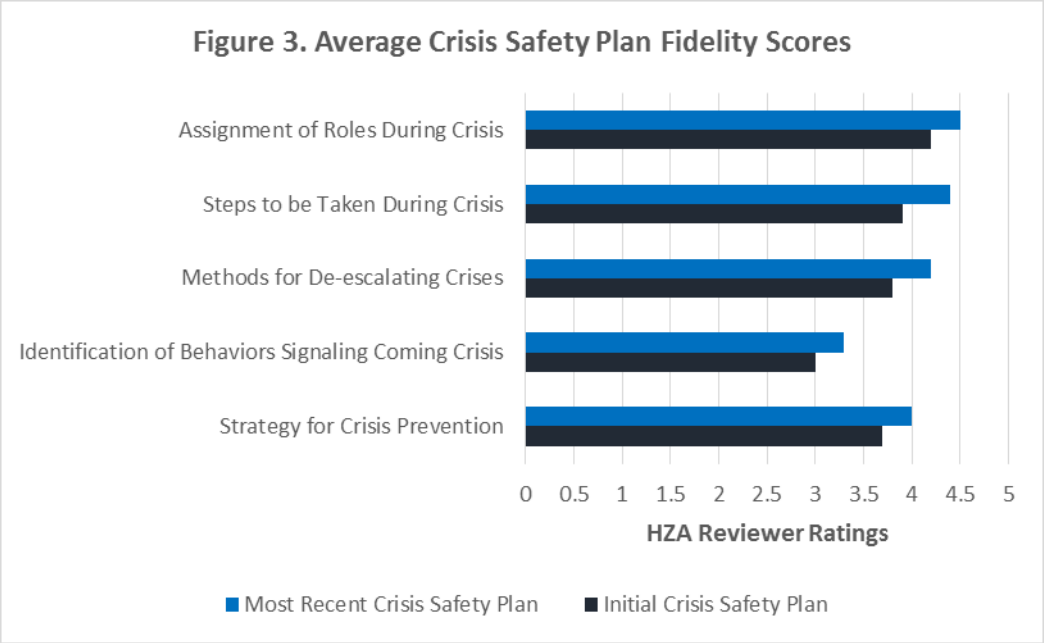


All but one of the items showed improvement in the fidelity scores from the initial to the most recent plans; there was no change for the "Services/Supports Consistent with Youth's/Family's Culture" item. As LCAs learned more about the youth and their families and built a rapport with team members, they were able to conform better to the requirements of the Safe at Home model. It should be noted, however, HZA reviewers noted it was difficult to identify data on the families' cultural needs in the record. Overall, items were rated relatively high with no scores below a 3.3 at any point. The greatest degree of improvement was evidenced on the "Opportunities for Youth to Engage in Community Activities" item.

Initial crisis safety plans are also to be completed within 30 days of Safe at Home. On average, all LCAs completed the initial crisis plans within 39 days of referral, falling slightly short of meeting the required timeframe. Subsequent crisis safety plans are to be updated

and refined as necessary, and on average this occurred every 53 days. When the same agency which stood out as not meeting the required timeframe for initial CANS is excluded from the statewide analysis of initial crisis safety plans, the statewide average is 30 days, which meets the required timeframe for this measure.

Similar to its review of the wraparound plans, HZA reviewed the initial and most recent crisis safety plans to assess their thoroughness, again using a five point Likert scale to assess their completeness. Figure 3 displays the average scores for each item assessed, showing comparisons between the initial and most recently completed crisis safety plans.



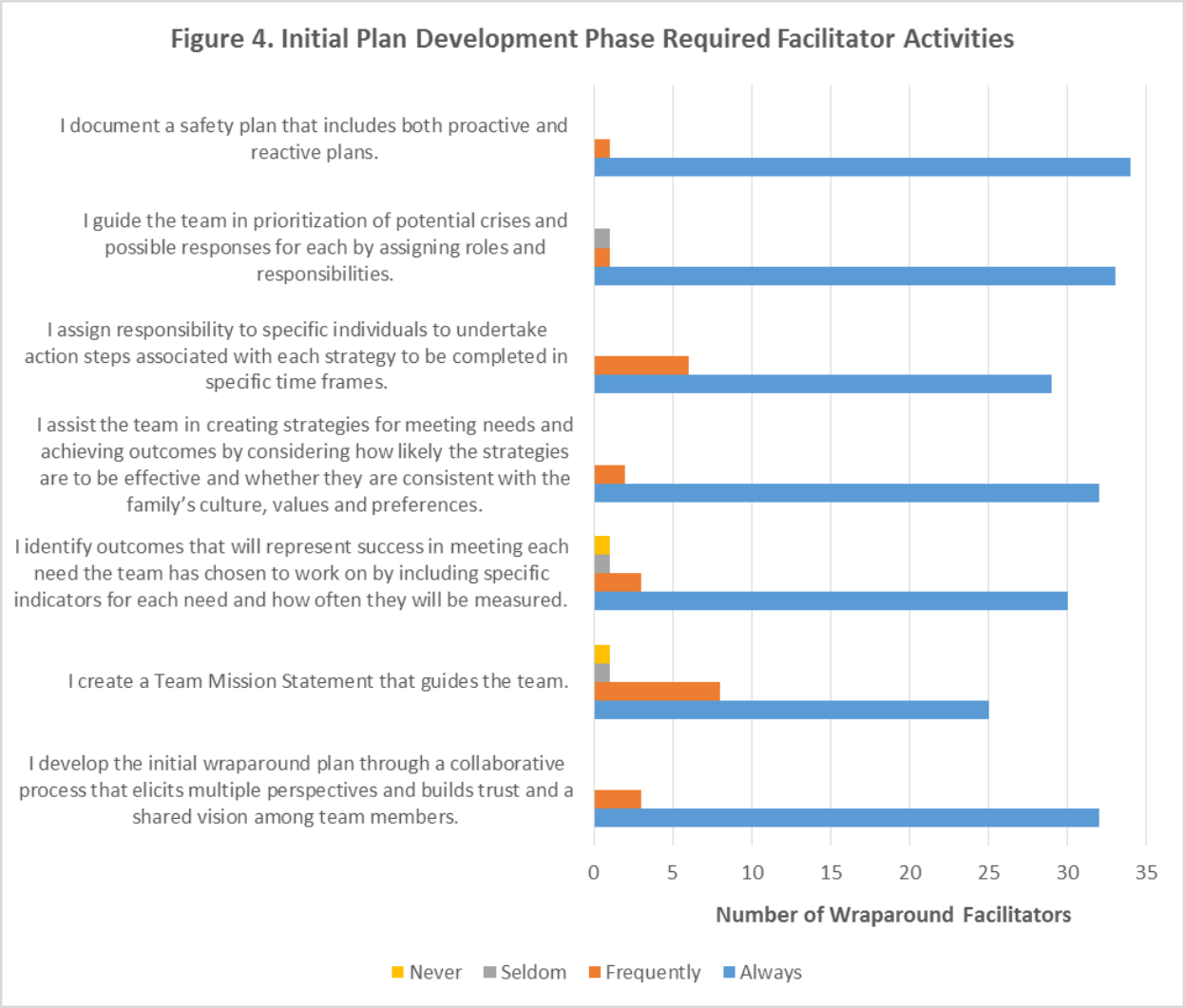
LCAs exhibited improvement on all items from the time of the initial to the time of the most recent plans, demonstrating that LCAs have improved in meeting crisis safety plan fidelity measures over time. The "Assignment of Roles During Crisis" item was rated the highest on both the initial and most recent plans. The "Identification of Behaviors Signaling Coming Crisis" item was rated the lowest on both initial and most recent crisis safety plans.

Caseworkers generally reported that their involvement was minimal in crisis safety planning and usually the wraparound facilitators took the lead and caseworkers provided their input when necessary. In only one instance did a caseworker state that they were not involved in crisis safety planning, and this was attributed to conflicts between the

caseworker and facilitator. Half of the youth could not remember anything about crisis safety planning and this

was also the case for three of the 16 parents. The remaining youth and parents all reported that they have been involved in crisis safety planning. Facilitators reported that youth/families were always involved in crisis safety plan development and refinement, but that plans were sometimes not implemented because youth never experienced a crisis.

The surveys of LCA and DHHR staff were also used to measure the extent to which required tasks were performed during the early stages of providing wraparound. Due to the low response rate for caseworkers, only wraparound facilitator responses are included in Figure 4.



Nearly all wraparound facilitators surveyed reported completing all of the required casework activities "Always" or "Frequently" during the Initial Plan Development Phase.

Phase III: Plan Implementation

The third phase of wraparound, Plan Implementation, is when the wraparound plan is put into action. It also offers an opportunity to revisit and update plans whenever necessary, to ensure that the youth/family and team members remain engaged, to continually monitor progress and address any challenges as they arise, and to celebrate successes.

Wraparound facilitators are required to have weekly contact with youth/families to

start and then gradually reduce contact as progress is being made and youth/families get closer toward transition; all stakeholders reported that this was occurring. In cases where youth had graduated the program, stakeholders reported the visits were gradually reduced from weekly to biweekly and then to monthly contact. Most interviewees agreed that the amount of contact between wraparound facilitators and youth/families was adequate. However, in a couple of cases stakeholders across the board believed that the frequent contact was too overwhelming/invasive for the youth/family. In two cases, facilitators stated that the contact was not frequent enough but that the youth/families consistently cancelled meetings.

All stakeholders were asked to share both the formal and informal services that youth/families have received during their participation in Safe at Home. Services were tailored to meet the needs of youth/family and as one caseworker reported of the wraparound facilitator's flexibility and creative service planning, "[S/he] makes referrals, finds placements, takes [the youth] out to do things, [s/he's] just a support for [the youth]. Anything I need [s/he] helps me with. [S/he] has found [the youth] non-formal support systems of people that will be good for [him/her] like a mentor. [S/he] helps us in getting [the youth] clothes or any other basic needs. Anything [the youth] needs, [s/he] is willing to do or get." Services varied due to different needs and/or goals. The ten most common services received included:

- individual therapy,
- tutoring,
- school advocacy,
- family therapy,
- life skills,
- youth coaching,
- medication management,
- community outings,
- mentoring and
- parenting classes.

Caseworkers and facilitators were evenly split as to whether or not service barriers were an issue with the cases reviewed. The greatest barrier they cited was the lack of

consistency by the youth/families and follow through or motivation to succeed. In a few cases placement changes/disruptions resulted in services stopping and starting, which could be a challenge as well. In two cases, disputes between the caseworker and facilitator made it difficult to come to an agreement about what services would be best for the youth. The most common responses as to which services were lacking included placements for teenagers with mental health needs, mentoring programs, medication management, adolescent psychiatry and services for youth with special needs.

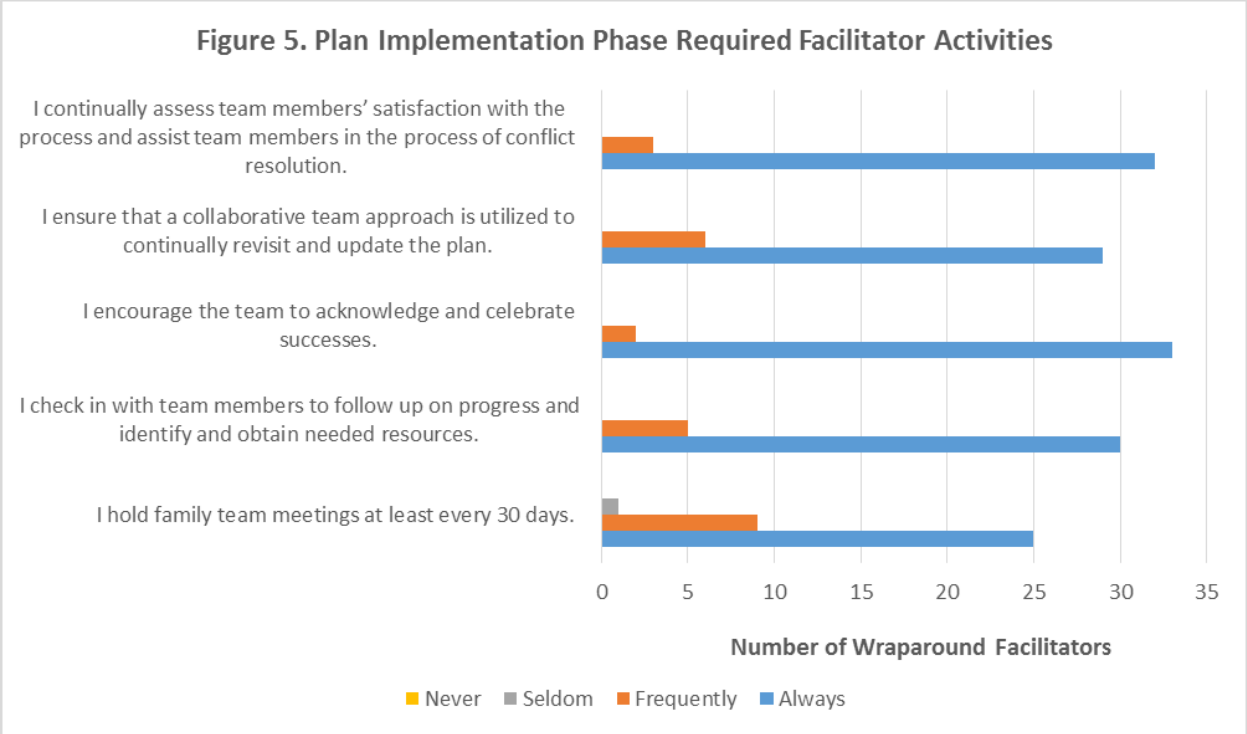
Facilitators provided examples on ways they have worked to overcome the challenges caused by service barriers such as: making lots of calls; physically being there to make sure youth/families follow through; staffing the case with LCA supervisors, DHHR staff and school staff; rewarding youth for participation; working to keep placements stable; looking for informal mentors; and tele-conferencing with doctors or getting them to prescribe for months out.

Nearly all stakeholders reported that wraparound facilitators identify and/or reward the success that youth achieve, and facilitators stated that determining the best reward comes down to figuring out what motivates each individual. In two cases, youth reported the facilitator does not recognize their success but also stated that there has not been much, if any, success at this point any way. Some of the most common rewards for youth received from facilitators were trips out to eat, specific gifts the youth wanted or needed, going out to participate in fun activities, verbal praise/acknowledgment and going to the movies. Stakeholders also reported successes youth have achieved. A few of the more frequent responses included improvements in the following: behavior, grades, school attendance, family relationships/communication and social skills. Wraparound facilitators monitored case progress in a variety of ways, such as through frequent contact with youth/families, provider reports, the CANS, monthly progress reports on the case and monthly wraparound team meetings. When youth/family progress was stunted, one caseworker said, “If [the facilitator] sees they are struggling [s/he] calls me and we do a home visit together and try to see what's going on and remind the family that we need to make progress and see what's going on so we can get back on track.”

Caseworkers, youth and parents reported that in most cases wraparound facilitators were diligent and, for the most part, successful in getting youth to make active decisions in ongoing planning activities. For example, one caseworker said, “[The facilitator] engages [the youth] by keeping the dialogue open with the youth, getting them to speak about their

future, their hopes and dreams. [The youth] wants to be a nurse, so the facilitator got [him/her] tutoring, helped [him/her] find programs for college and getting a nursing/LPN/assistant nurse certification - all of this came from [the youth] as the program went on." In the remaining few cases where youth were not active in planning, caseworkers reported that facilitators made substantial efforts to engage youth in service planning, but engagement was a challenge due to parental issues, lack of motivation or interest from the youth and youths' serious mental health issues.

Here too, the fidelity surveys asked facilitators and caseworkers about the extent to which required tasks were performed during this phase of wraparound. Based on the low response rate for caseworkers, results for the wraparound facilitators are only included in Figure 5.



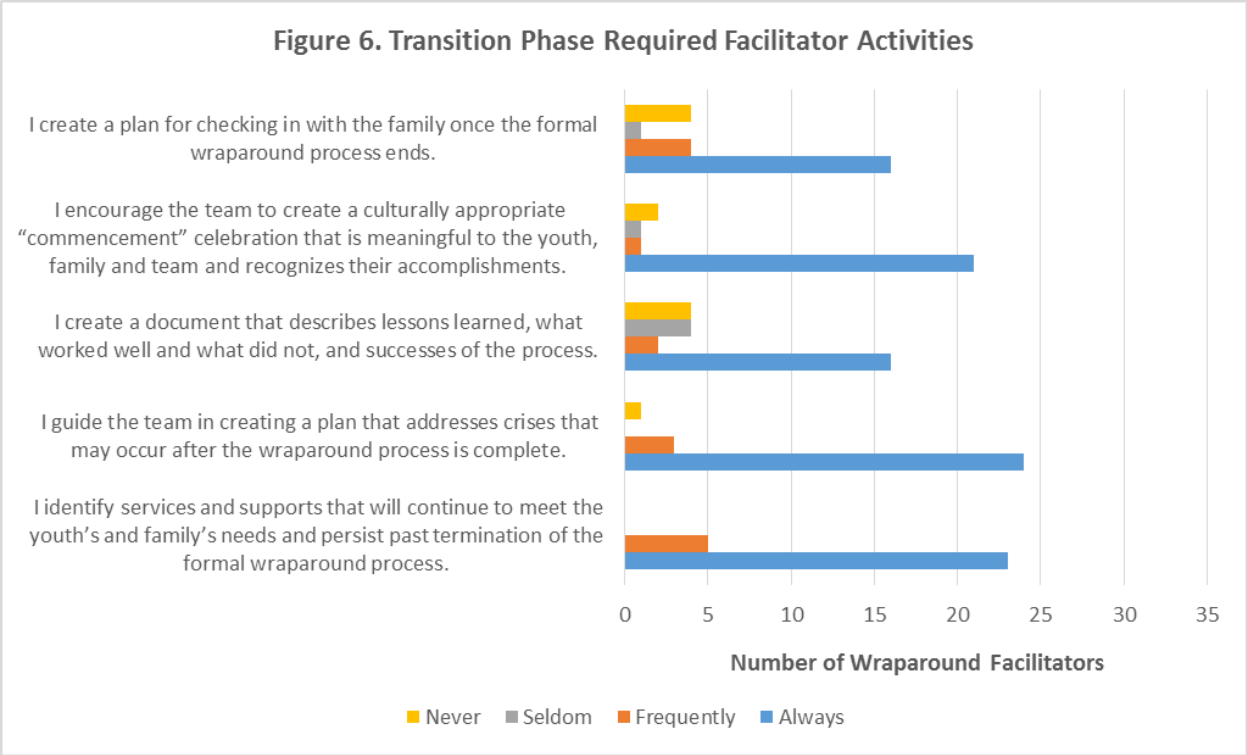
Nearly all 35 wraparound facilitators who responded to the survey reported completing all of the required casework activities at a frequency of "Always" or "Frequently" during the Plan Implementation Phase.

Phase IV: Transition

The purposes of the Transition Phase are to plan for the end of wraparound services when the team's goals and objectives have been met, to conduct a commencement or some type of ritual to celebrate success and to formally discuss where the family can go for help in the future.

Of the 14 closed Safe at Home cases in the sample, eight had successfully graduated the program, and thus, completed the Transition Phase. Stakeholders from the eight completed cases reported that the team knew the youth was ready to graduate Safe at Home because all the goals set forth had been achieved. All interviewees stated that facilitators held some sort of celebration for youth/families to symbolize graduation from the program. Often times gifts were given to the youth and in a couple cases scrap books with pictures of the journey were also given. Youth, parents and facilitators stated that at the celebration the group discussed the youths' achievements and the progress they made throughout the life of the case. In five of the eight cases, wraparound facilitators gave youth a diploma/certificate, and in a sixth case the facilitator gave the youth a closing letter listing all of the successes. All stakeholders reported that the wraparound facilitator provided the youth/family with information on where to go for help in the future should it be necessary. In most of the cases, the wraparound facilitator offered themselves as a resource should issues arise in the future.

LCA and DHHR fidelity surveys asked facilitators and caseworkers about the extent to which required tasks were performed during each phase of wraparound. Results are limited to the surveys completed by wraparound facilitators, as displayed in Figure 6.

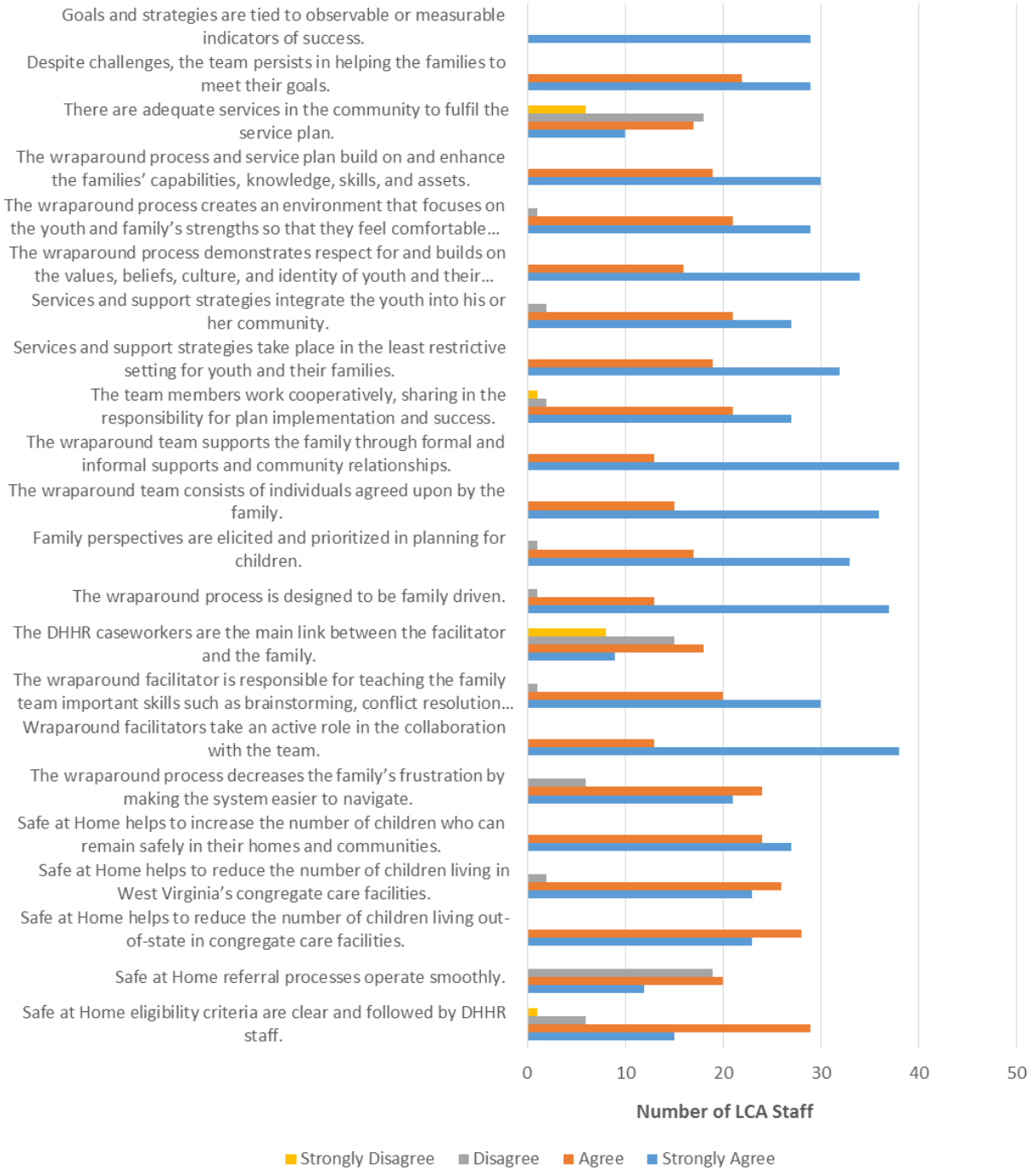


Compared to facilitator responses of required casework activities for the first three phases of wraparound, required activities are not being completed as regularly for the Transition Phase. For example, just over half (51%) of the facilitators responded that they "Always" or "Frequently" created a document that described lessons learned, what worked well and what did not, and the successes of the process. It is particularly concerning that only 57 percent of the facilitators "Always" or "Frequently" created a plan for checking in with the family once services end.

DHHR and LCA Staff Program Buy-In

In addition to the questions regarding fidelity, LCA and DHHR staff who participated in the survey were asked about the extent to which they agreed with statements regarding their buy-in to Safe at Home and also generally, their perceptions as to whether or not Safe at Home's implementation has gone as planned. Figure 7 represents the responses to those statements asked of LCA staff.

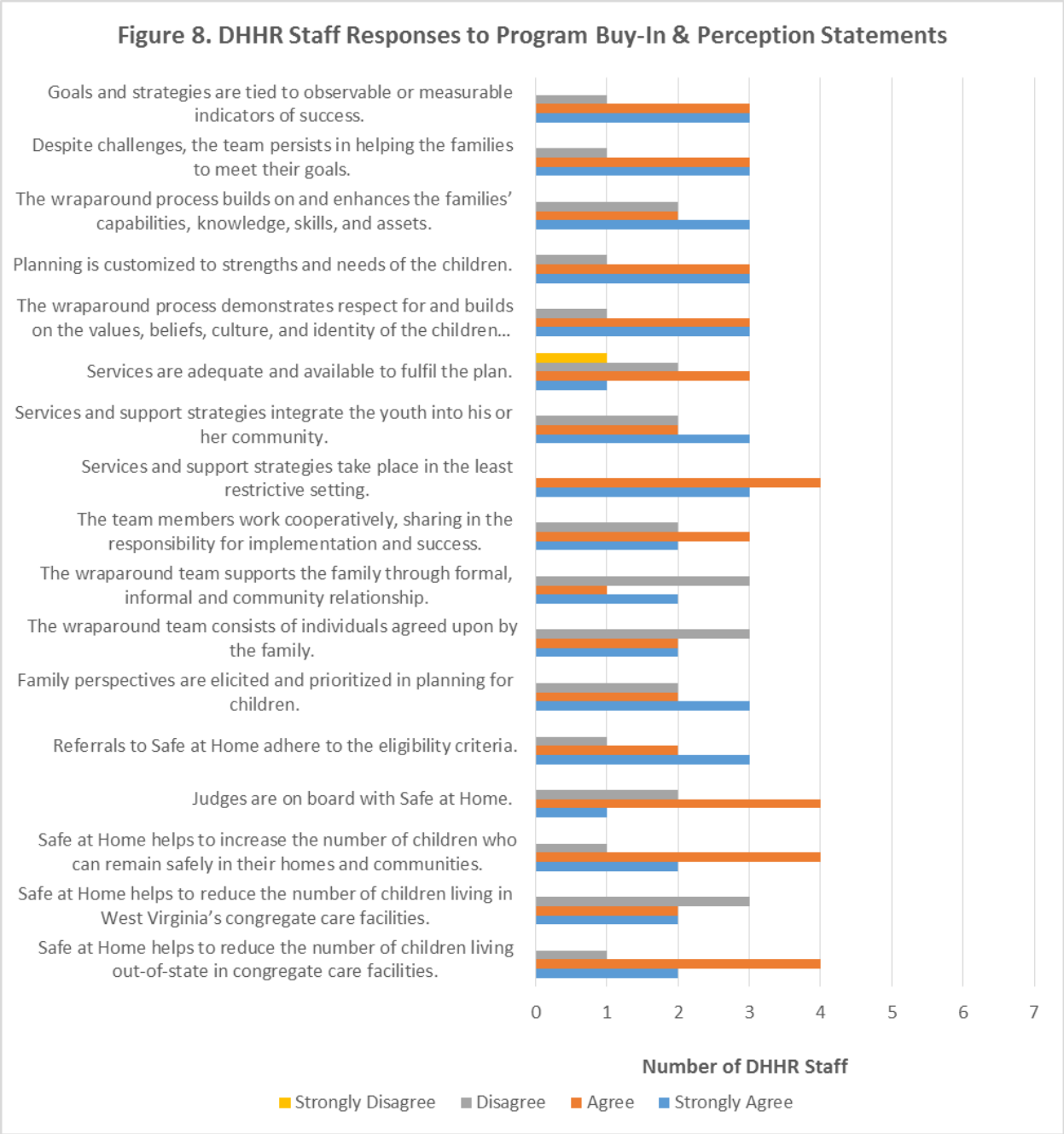
Figure 7. LCA Staff Responses to Program Buy-In & Perception Statements



Overall, LCA staff buy-in and perceptions of program success were relatively high, with most statements eliciting "Strongly Agree" or "Agree" responses. There were two items

which stand out as not following this trend as they received very mixed responses. First, only 53 percent of LCA staff believed there were an adequate amount of services in the community to fulfill service plans. The second item was related to DHHR and LCA teamwork, where only 53 percent of LCA staff believed caseworkers were the main link between the facilitator and the family.

Figure 8 provides similar feedback from the perspective of DHHR staff.



DHHR staff responses indicate relatively high buy-in for Safe at Home and positive overall perceptions of the program. Similar to LCA staff, DHHR staff held mixed views as to whether or not services were adequate and available to fulfill service plans.

Successes and Challenges

Interviewees were asked about the various successes and challenges that occurred with the 40 cases selected for review as well as any suggestions for program improvements.

Facilitators and caseworkers provided examples of what has worked well for the 40 cases reviewed; Table 3 offers the opportunity to review the extent to which their responses were similar as well as how they differed.

Table 3. Most Common Facilitator and Caseworker Perceptions of Case Success Factors	
Facilitator Responses (most common to least)	**Caseworker Responses (most common to least)**
Youth/Family Voice and Choice	Relationship Between the Youth and Facilitator
Youth/Family Motivation to Succeed	Proactive and Persistent Facilitators
Consistency and Flexibility of the Facilitator	Extra Support of the Facilitator
Changing the School Environment	Team Collaboration and Effort
Re-evaluating and Changing Approaches	Youth/Family's Motivation to Succeed
Low Turnover of the Formal Support Team	Thorough Insight into the Youth/Family

Caseworkers' three most common responses in regard to factors which contributed to case success with Safe at Home were all about the diligent work of facilitators. One caseworker said, "I think that the amount of time spent by the facilitator with [the youth] contributed to the success of [his/her] program. In general, I think that the Safe at Home program works because there is an extra person on-site at the youth's home and school, interacting with the family and not having caseworker responsibilities, so the facilitators spend time connecting to the youths, and this is what really makes the difference. They see firsthand what the needs are, and have the resources and time to get the needs addressed." Wraparound facilitators' two most common responses were about the contributions of the youth/family in making the case successful.

All youth reported that Safe at Home has been helpful to them. A few youth reported that if not for Safe at Home, they would likely be in placement. All parents reported positive overall impressions of the program with one stating, "It's good to have the support. In West Virginia, whenever anything happens, the only solution DHHR gives you is for your child to go into state custody, because you can't get services and help unless the state has custody. This is weird. Like you can't get help unless you give up everything? Safe at Home gives support and services without giving up custody and sending your kid away."

Nearly half the youth and most of the parents reported that having the extra support of the wraparound facilitator was the best part of Safe at Home. Other program favorites shared by youth were getting involved in the community, finding a placement that was a good fit, crisis planning and learning social skills. Parents shared what they liked the best about Safe at Home and this included the use of creative and flexible services, the nonjudgmental engagement of youth/families and facilitators' willingness to try new services when progress is stalled.

Caseworkers and wraparound facilitators mostly agreed about what some of the most difficult challenges were with Safe at Home cases. The five most common responses were: youth/family engagement; youth behavior, serious mental health issues or trauma recovery; family conflict or problems with the home environment; poor placement choices; and obtaining services for youth/families.

Nearly all youth agreed that the program does not need any changes or improvements, but two youth did report that it can be overwhelming to have so many service providers involved at once. Parents' suggestions for program improvement ranged greatly, but a couple reported that ensuring facilitators' have excellent communication skills and that opening up the program to younger kids were areas that could be addressed.

Wraparound facilitators' most common recommended change for the program included better/faster communication from caseworkers. One facilitator suggested that a solution to the communication barrier might be in giving facilitators more legal decision making authority/power so they would not be at the mercy of getting ahold of caseworkers. The second most common recommended change for Safe at Home from wraparound facilitators was that the caseload of ten is too high. One facilitator suggested that the State should implement a caseload tier system so that those with more difficult cases are assigned fewer.

Caseworkers' three most common answers when asked what could be done to mitigate the challenges faced were finding more positive peer influences for youth, finding ways to ensure youth consistently attend therapy and better engagement skills which may aid in figuring out how to motivate youth to want to be successful.

Summary of Process Evaluation Results

Overall, LCAs did well with conforming to the requirements of the Safe at Home model and improvements were also noticed over time in wraparound and crisis safety planning. However, one area where multiple LCAs fell short was in meeting the required timeframe for completing initial wraparound plans. Additionally, one agency in particular did not meet the required timeframes for initial CANS assessments or crisis safety plans by a large margin and when this agency was excluded from the analysis, it was demonstrated that the remaining eight LCAs did in fact meet these timeframes.

In spite of wraparound facilitators' consistent efforts to get youth/families to identify natural supports, the vast majority of youth/families did not want others involved or did not feel as though they had any natural supports available to involve. In the few cases where supports were identified, half of them only included a formal support system. One of the key tenets of wraparound is in building and maintaining a strong natural support system so that when Safe at Home, DHHR and other formal supports leave, the youth/family will still be able to maintain their success without reliance on formal supports and systems.

The three most common goals youth/families had were improvements in grades, behavior and school attendance. Stakeholders also reported that these were also the areas in which the greatest level of success has been witnessed, indicating that Safe at Home teams are working hard to ensure youth achieve the goals set forth, and they are actually accomplishing what they have set out to do.

The five most common challenges shared by facilitators and caseworkers were: youth/family engagement; youth behavior, serious mental health issues or trauma recovery; family conflict or problems with the home environment; poor placement choices; and obtaining services for youth/families.

Outcome Evaluation Results:

Youth Cohort Analysis

Between the start of Safe at Home and September 30, 2017 1,058[5] youth statewide

[5] The numbers of youth reported by HZA and the State may differ slightly because the State utilizes weekly tracking logs and HZA relies on quarterly FACTS extracts for data. Delayed data entry also contributes to small changes in the numbers of youth reported per cohort in each semi-annual evaluation report.

have been referred to the program. For the analysis of outcomes, youth are divided into six-month cohorts based on the dates of referral to the program (Table 4). The analysis currently includes youth from four cohorts. All youth from Cohorts I, II and III have been in the program for at least six months which means sufficient time has passed to measure outcomes for them. The data presented for youth in Cohort IV are limited to descriptive information.

Using data from FACTS, the matched comparison groups were selected using Propensity Score Matching (PSM). The comparison pools are drawn from youth who meet the Safe at Home referral criteria (age 12-17 with a mental health diagnosis in out-of-state or in-state congregate care or at risk of entering this type of placement) during SFYs 2010 through 2015. Propensity scores were calculated using age at referral, gender, race, ethnicity, initial placement setting, count of years since the case opened, report allegation, number of prior placements, evidence of an axis one diagnosis and if the youth was ever in a jail, 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 treatment group (see Appendix D).

Table 4. Outcome Analysis Cohorts

Cohort	Group	Referral Period	Number of Youth
I	Treatment	October 1, 2015 – March 31, 2016	124
	Comparison	SFY 2010 – 2015	124
II	Treatment	April 1, 2016 – September 30, 2016	226
	Comparison	SFY 2010 – 2015	226
III	Treatment	October 1, 2016 – March 31, 2017	299
	Comparison	SFY 2010 – 2015	299
IV	Treatment	April 1, 2017 – September 30, 2017	409
	Comparison	SFY 2010 – 2015	409
Total	Treatment	October 1, 2015 – September 30, 2017	**1,058**
	Comparison	SFY 2010 – 2015	**1,058**

Unless otherwise specified, outcome measures are examined at or within six and twelve months post-referral to Safe at Home. For this report, six and twelve month

outcomes are analyzed for youth in Cohorts I and II; given the amount of time which has elapsed for youth in Cohort III, the analysis is limited to six month outcomes.

Youth Placement Changes

Table 5 examines the placement of Safe at Home youth from Cohorts I through III when they were referred to the program and six months later.

Table 5. Safe at Home Youth Placements at Referral and Six Months

Cohort I						
Placement at Referral	**Placement after Six Months**					
	Out-of-State Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	**Total at Referral**
Out-of-State Congregate Care	10	4	1	2	13	**30**
In-State Congregate Care	1	11	3	2	20	**39**
Emergency Shelter	0	2	0	0	1	**5**
Family Foster Care	0	2	0	0	0	**2**
Home	6	6	3	0	32	**48**
Total at Six Months[6]	**17**	**25**	**7**	**4**	**66**	**124**
Cohort II						
Placement at Referral	**Placement at Six Months**					
	Out-of-State	In-State Congregate	Emergency Shelter	Family Foster	Home	**Total at Referral**

[6] At six months there were three youth in detention and two youth with a status of "runaway" from Cohort I.

Table 5. Safe at Home Youth Placements at Referral and Six Months						
	Congregate Care	Care		Care		
Out-of-State Congregate Care	3	2	1	0	12	**18**
In-State Congregate Care	3	26	4	2	38	**74**
Emergency Shelter	0	6	4	3	4	**18**
Family Foster Care	0	2	2	4	3	**11**
Home	0	10	3	2	87	**105**
Total at Six Months[7]	**6**	**46**	**14**	**11**	**144**	**226**
Cohort III						
Placement at Referral	**Placement at Six Months**					
	Out-of-State Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	**Total at Referral**
Out-of-State Congregate Care	3	0	0	1	7	**11**
In-State Congregate Care	0	9	2	6	44	**62**
Emergency Shelter	0	0	1	0	5	**6**
Family Foster Care	1	1	2	8	1	**13**

[7] At six months there was one youth in detention and four youth with a status of "runaway" from Cohort II.

Table 5. Safe at Home Youth Placements at Referral and Six Months						
Home	4	30	6	6	159	**207**
Total at Six Months[8]	**8**	**40**	**11**	**21**	**216**	**299**

When looking at the placement changes of Safe at Home youth, fewer were in congregate care and more were living at home six months post-referral in all three cohorts. For Safe at Home youth in Cohorts I and II who began in congregate care, only one-third were living in congregate care six months after referral and this proportion was further reduced for youth in Cohort III (16%).

Conversely, one in four of the treatment youth from Cohort I who were living at home at the time of referral were in congregate care six months later, as were both of the youth referred while in a foster home. The results show some improvement for Safe at Home youth from Cohorts II and III with only one in six youth on average who started in their home or in a foster home placement living in a congregate setting six months later.

Table 6 examines the placement changes one year following referral to Safe at Home for youth in Cohorts I and II.

Table 6. Safe at Home Youth Placements at Referral and Twelve Months						
Cohort I						
Placement at Referral	**Placement at Twelve Months**					
	Out-of-State Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	**Total at Referral**
Out-of-State Congregate Care	5	4	3	2	15	**30**
In-State Congregate Care	3	8	3	2	21	**39**
Emergency Shelter	0	2	0	0	2	**5**
Family Foster Care	0	0	1	0	1	**2**

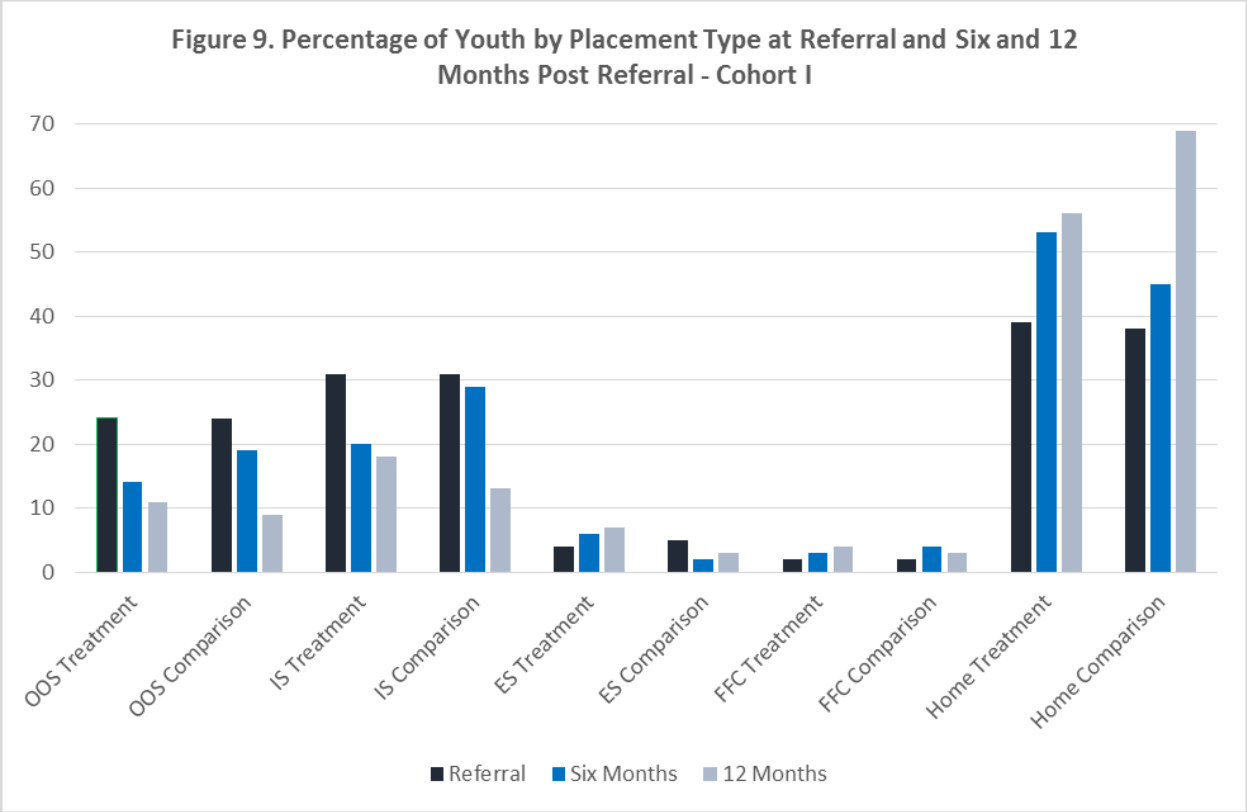
[8] At six months there were two youth in detention and one youth with a status of "runaway" from Cohort III.

Table 6. Safe at Home Youth Placements at Referral and Twelve Months						
Home	6	8	2	1	31	**48**
Total at Twelve Months[9]	**14**	**22**	**9**	**5**	**70**	**124**
Cohort II						
Placement at Referral	**Placement at Twelve Months**					
	Out-of-State Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	**Total at Referral**
Out-of-State Congregate Care	4	1	0	1	12	**18**
In-State Congregate Care	6	18	4	6	37	**74**
Emergency Shelter	1	5	2	6	3	**18**
Family Foster Care	1	2	0	4	4	**11**
Home	7	23	0	2	71	**105**
Total at Twelve Months[10]	**19**	**49**	**6**	**19**	**127**	**226**

As might be expected, the trends in both directions continued at the 12-month point, but the changes were not large. Most of the effects in both directions appear to occur within the first six months.

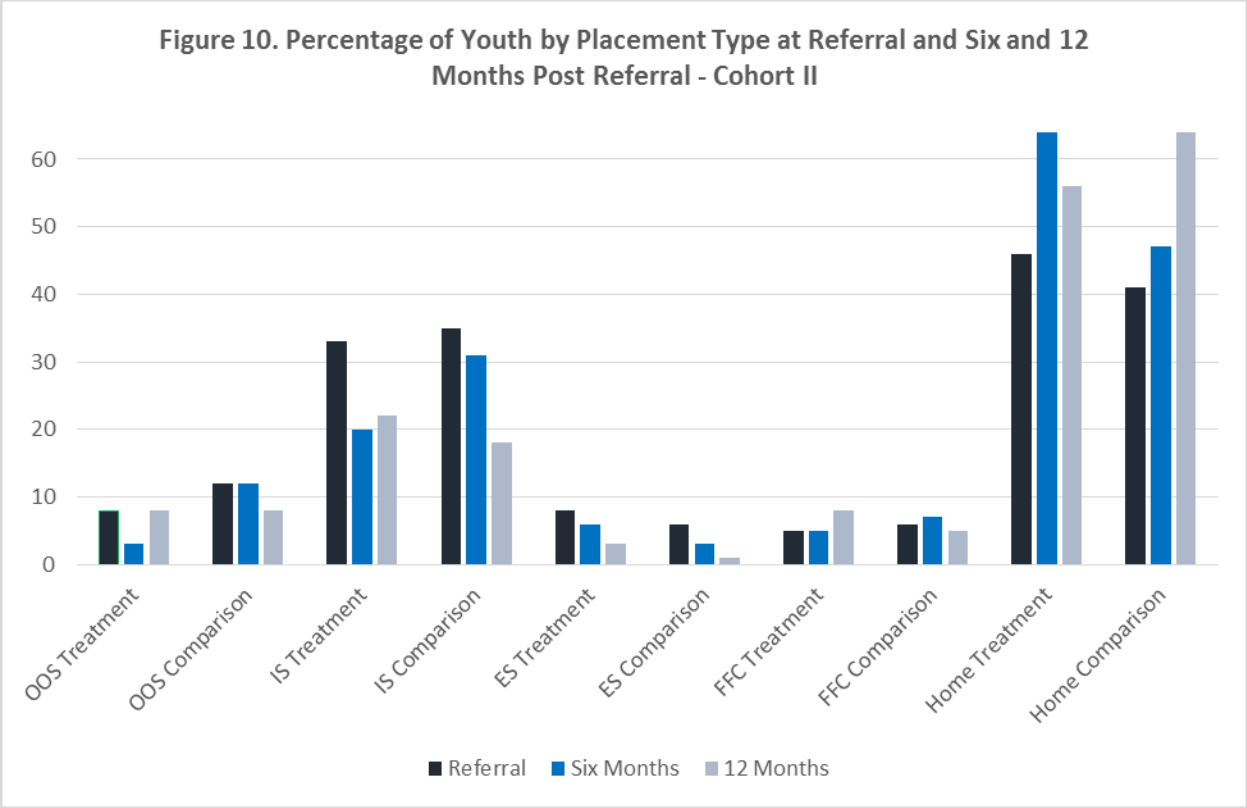
Contrasting the placement changes of youth in the comparison groups to those in the treatment groups offers an additional opportunity to assess the impact of Safe at Home. Figure 9 compares the placements of Safe at Home youth with the corresponding comparison youth for Cohort I at referral and at six and twelve months following referral.

[9] At twelve months, there was one youth in detention and three youth with a status of "runaway" from Cohort I.
[10] At twelve months, there were two youth in detention, one youth in transitional living and three youth with a status of "runaway" from Cohort II.



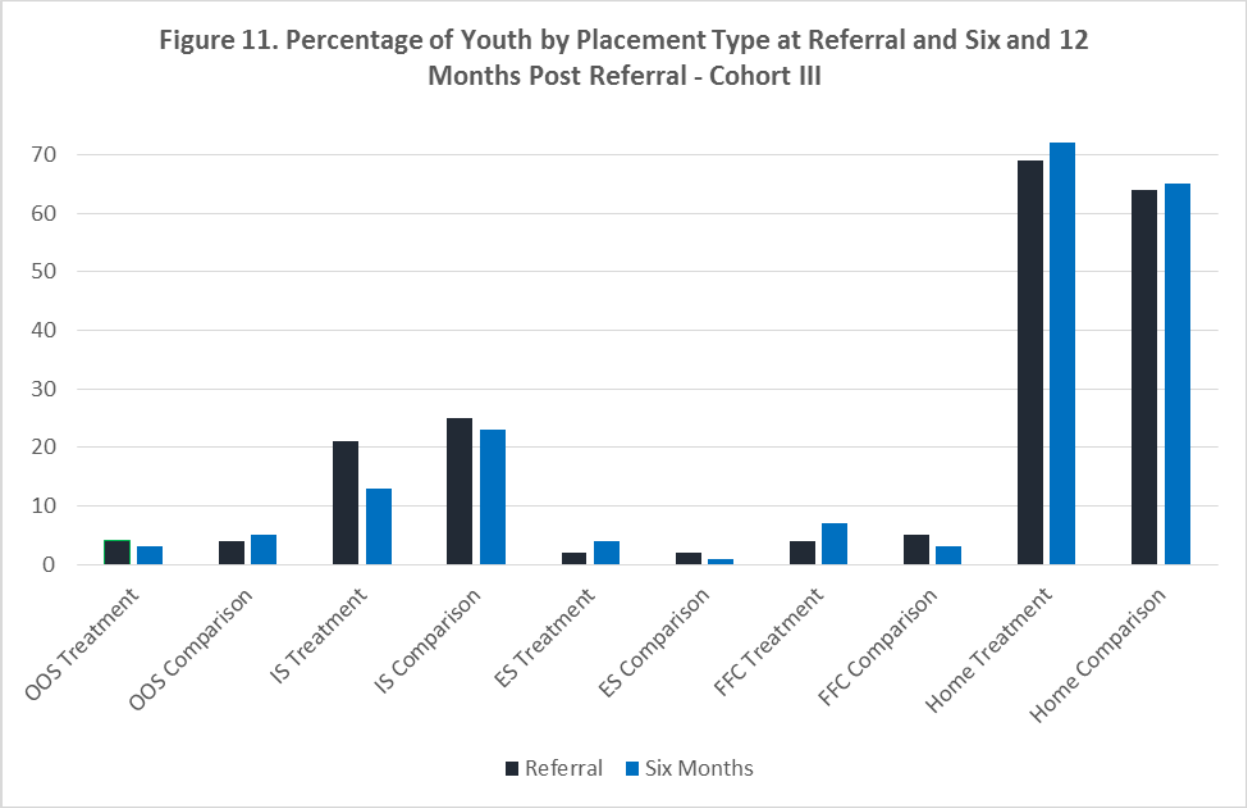
Both the treatment and comparison groups experienced reductions in congregate care placements (in-state [IS] and out-of-state [OOS]) between referral and six and twelve months. The reductions in congregate care placement were more dramatic for Safe at Home youth at six months than for comparison youth, but this trend reversed at twelve months. In regard to youth living at home, both treatment and comparison groups experienced increases at six and twelve months, with a more substantial increase witnessed for Safe at Home youth at six months. At twelve months the percentage increase of youth living at home was more prominent for youth in the comparison group (44% increase for Safe at Home youth and 82% increase for comparison youth).

Similar to Figure 9, Figure 10 compares the placements of Safe at Home youth with the corresponding comparison youth at referral and at six and twelve months following referral for youth in Cohort II.



Even with a small percentage of Cohort II's treatment and comparison youth being in an out-of-state congregate care placement at referral, the comparison group experienced no reduction at six months but Safe at Home youth had a 63 percent decrease in youth living in out-of-state congregate care. However, the same percentage of Safe at Home youth were living in out-of-state congregate at twelve months as they were at the time of referral while a smaller percentage of comparison youth were living in out-of-state congregate care twelve months later. Both treatment and comparison groups had reduced percentages of youth living in in-state congregate care at six and twelve months. At six months, the percentage decrease was more substantial for Safe at Home youth, but the opposite was true at twelve months.

Figure 11 compares the treatment and comparison group placements for Cohort III at referral and six months after referral.



Overall, Safe at Home youth from Cohort III displayed more positive placement changes at six months than did youth in the comparison group. There was a smaller proportion of Safe at Home youth in out-of-state congregate care at six months, whereas the comparison population actually experienced a slight increase. Safe at Home youth had a 38 percent reduction in in-state congregate care placements at six months and the comparison group only had an eight percent decrease. Both treatment and comparison groups had a higher percentage of youth living at home at six months, although the degree of change was small for both groups. Placement change results for Cohort III are similar to the first two cohorts, with Safe at Home youth showing greater improvements at six months.

In looking at the overall statistical significance of youth placement changes at six and twelve months for all three cohorts' treatment and comparison groups, *Safe at Home* youth performed better on all but one measure. Cohort II's treatment group had fewer youth in out-of-state congregate care at a statistically significant rate ($p<.01$) and the same was true for in-state congregate care at six months for Cohort II ($p<.05$) and Cohort III ($p<.01$). However, at twelve months Cohort I's comparison group had more youth at home at a statistically significant rate ($p<.05$).

Congregate Care

Another way to evaluate the impact of preventing placement into congregate care is to simply 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. The placement settings of youth placed 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 7). At six months, a higher percentage of youth in the treatment group from Cohorts I and III were placed in congregate care as compared to youth in the comparison groups. However, at six months a smaller percentage of Safe at Home youth in Cohort II had experienced an initial congregate care placement at a statistically significant rate ($p<.05$) compared to youth in the comparison group. At twelve months, a higher proportion of Safe at Home youth from Cohorts I and II had moved to congregate care than did youth in the comparison group, though the margin was smaller between the treatment and comparison groups for youth in Cohort II (but not at a statistically significant rate).

Table 7. Percentages of Youth from Lower Levels of Care to Congregate Care

Cohort	Group	Number Referred at a Lower Level	Percent in Congregate Care at 6 Months	Percent in Congregate Care at 12 Months
I	Treatment	55	29%	29%
	Comparison	55	**25%**	**16%**
II	Treatment	134	**13%**	29%
	Comparison	119	24%	**20%**
III	Treatment	226	16%	-
	Comparison	212	**13%**	-

Table 8 displays the results for youth in which sufficient time had passed since having exited to a lower level of care from a congregate care setting to measure re-entry into congregate care. A smaller proportion of youth from Cohort I's treatment group were in congregate care six months following discharge to a lower level of care than there was in the comparison group, but the opposite was true at twelve months (statistically significant at twelve months at $p<.01$). For Cohort II, more Safe at Home youth had re-entered congregate

care at six months than did youth in the comparison group. None of the six month results were statistically significant.

Table 8. Rate of Congregate Care Re-Entry					
Cohort	**Group**	**Number of Youth Moved to Lower Level of Care From Congregate Care at 6 Months**	**Percent of Re-Entry at 6 Months**	**Number of Youth Moved to Lower Level of Care From Congregate Care at 12 Months**	**Percent of Re-Entry at 12 Months**
I	Treatment	35	**29%**	28	43%
	Comparison	38	39%	38	**13%**
II	Treatment	38	39%	-	-
	Comparison	79	**30%**	-	-

While Safe at Home youth seem more likely to enter congregate care than their historical comparisons, they spend much less time in those settings. Table 9 identifies the average number of days youth spent in congregate care. Safe at Home youth from all three cohorts spent fewer days in congregate care within six months of referral than youth from the corresponding comparison groups. The same was true at twelve months for Safe at Home youth in Cohorts I and II. All results were statistically significant (all at $p<.01$).

Table 9. Average Length of Stay in Congregate Care Within 6 and 12 Months			
Cohort	**Group**	**Average Days in Congregate Care Within 6 Months**	**Average Days in Congregate Care Within 12 Months**
I	Treatment	**100**	**168**
	Comparison	156	229
II	Treatment	**85**	**145**
	Comparison	125	224
III	Treatment	**61**	-
	Comparison	128	-

Home Counties

Another 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, movements of youth leaving their home counties and returning to them are examined at six and twelve months post-referral; these results[11] are provided in Table 10. The overall percentages of county movement in both directions, positive and negative, were higher for the treatment group, which may indicate that closer attention is being paid to youth in Safe at Home.

Table 10. Youth County Movements

Cohort	Group	Percent at 6 Months	Percent at 12 Months
From Home-County to Out-of-County			
I	Treatment	31%	30%
	Comparison	**20%**	**15%**
II	Treatment	**18%**	26%
	Comparison	21%	**16%**
III	Treatment	17%	-
	Comparison	**14%**	-
From Out-of-County to Home-County			
I	Treatment	**61%**	**66%**
	Comparison	30%	63%
II	Treatment	**61%**	**59%**
	Comparison	37%	56%
III	Treatment	**81%**	-
	Comparison	42%	-

At six months, a higher proportion of Safe at Home youth from Cohorts I and III had moved out of their home counties than did youth from their corresponding comparison groups. The opposite was true at six months for Safe at Home youth in Cohort II, with a smaller proportion of Safe at Home youth moving out-of-county than their comparison counterparts. At twelve months, a higher percentage of Safe at Home youth from Cohorts I

[11] 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 settings for youth to achieve permanency than merely living within the home-county.

and II had moved out-of-county. However, none of these results was statistically significant.

On the other hand, at both six and twelve months and for all three cohorts, Safe at Home youth returned to their home-counties more often than did comparison youth. These results were statistically significant for all three cohorts at six months (all at p<.01).

Foster Care

Safe at Home has two goals related to foster care (understood as any out-of-home placement). The first is to reduce the percentage of youth who need placement outside the home, and the second is to reduce the percentage of youth who re-enter following discharge to their homes. Table 11 examines the initial entry into foster care following referral for youth who were referred while in their own homes. The percentage of youth with initial foster care entries at six months was higher for Safe at Home youth in Cohorts I and III. A smaller percentage of Safe at Home youth from Cohort II had initial foster care entries at six months than did their comparison counterparts. At twelve months post-referral, a higher proportion of Safe at Home youth from Cohorts I and II had experienced an initial entry into foster care than did youth in the comparison groups. Again, however, none of these results was statistically significant.

Table 11. Initial Foster Care Entries

Cohort	Group	Number of Youth Home at Referral	Percent With Initial Foster Care Entry at 6 Months	Percent With Initial Foster Care Entry at 12 Months
I	Treatment	48	33%	35%
	Comparison	47	**23%**	**13%**
II	Treatment	105	**15%**	31%
	Comparison	93	26%	**16%**
III	Treatment	207	23%	-
	Comparison	192	**15%**	-

The rate at which youth re-entered foster care at six and twelve months following discharge to their home was also calculated (Table 12). For all three cohorts, the percentage

of Safe at Home youth re-entering foster care at six months post-discharge was greater than that of comparison youth. These results were statistically significant for Cohort II at p<.01. At twelve months, a higher proportion of Safe at Home youth from Cohorts I and II had re-entered foster care following discharge.

Table 12. Rate of Re-Entry into Foster Care			
Cohort	**Group**	**Rate of Foster Care Re-Entry (%) at 6 Months**	**Rate of Foster Care Re-Entry (%) at 12 Months**
I	Treatment	14%	18%
	Comparison	**8%**	**11%**
II	Treatment	28%	21%
	Comparison	**11%**	**14%**
III	Treatment	18%	-
	Comparison	**13%**	-

Maltreatment

The initiative aims to increase youth safety by demonstrating decreased rates of maltreatment/repeat maltreatment. Table 13 displays the number of youth with a maltreatment referral subsequent to referral to Safe at Home and the number for which that referral led to a result of substantiated maltreatment. Within six (Cohorts I, II and III) and twelve months (Cohorts I and II) Safe at Home youth had fewer maltreatment referrals. These results were statistically significant for Cohort I at six and twelve months (p<.05 and p<.01, respectively), for Cohort III at six months (p<.01) and for Cohort II at twelve months (p<.05). There were no cases of substantiated maltreatment within six or twelve months for any youth in either the treatment or comparison groups.

Table 13. Number of Youth with a New Referral or Substantiation					
Cohort	**Group**	**Referral Within 6 Months**	**Substantiation Within 6 Months**	**Referral Within 12 Months**	**Substantiation Within 12 Months**
I	Treatment	**2**	0	**2**	0
	Comparison	9	0	14	0

Table 13. Number of Youth with a New Referral or Substantiation					
Cohort	Group	Referral Within 6 Months	Substantiation Within 6 Months	Referral Within 12 Months	Substantiation Within 12 Months
II	Treatment	**16**	0	**19**	0
	Comparison	23	0	35	0
III	Treatment	**11**	0	-	-
	Comparison	35	0	-	-

Youth 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 the outcomes of services received. 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 CANS helps LCA wraparound facilitators and DHHR caseworkers to identify needs/actionable items (i.e., those with a score of 2 or 3), indicating where attention should be focused in planning with the youth and family.

Wraparound facilitators from the LCAs are responsible for administering the CANS assessments to youth in the program. Once the assessments are completed, they are to be entered into the online WV CANS. As noted earlier, youth in the program are supposed to receive an initial CANS assessment within 30 days of referral[12] and subsequent CANS are to be performed every 90 days thereafter.

A total of 367 Safe at Home youth had at least two CANS assessments completed, i.e., an initial CANS and at least one subsequent CANS. There are no CANS available to compare to youth in the comparison groups, thus limiting the analysis to only youth in Safe at Home. For the purpose of this report, the results of the initial CANS assessments for youth from Cohorts I and II are compared to those 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 III.

[12] The standard for completing the initial CANS assessment was originally within 14 days of referral, however this timeframe has been extended to 30 days as of a June 2017 policy change.

Progress is measured by the extent to which scores have improved, meaning needs/actionable items have been reduced over time. As shown in Table 14, CANS assessments available for analysis become more limited with the passage of time. This is due to a variety of factors, including: inappropriate referral (for example, youth may not meet the age requirement for Safe at Home), youth placements into a detention center, or cases which close prior to six months because families decline participation or there is an inability to secure placements for youth.

Table 14. Number of Youth With CANS Assessments Available for Analysis			
	Cohort I	**Cohort II**	**Cohort III**
Number of Youth with an Initial CANS Assessment	86	167	209
Number of Youth with a Six Month Follow-Up CANS	51	89	42
Number of Youth Discharged Before a Six Month Follow-Up CANS can be Performed	25	25	17
Number of Youth Where Enough Time Has Passed & No Six Month CANS Was Performed	8	0	0
Number of Youth with a 12 Month Follow-Up CANS	22	19	-
Number of Youth Discharged Before a 12 Month Follow-Up CANS can be Performed	50	29	-
Number of Youth Where Enough Time Has Passed & No 12 Month CANS Was Performed	0	0	-

Table 15 provides an overview of the percentage of youth with at least one need item selected by the various domains at entry into the program. For a closer look at the needs on specific items within each domain, please see Appendix E.

Table 15. Percentage of Youth with an Actionable Item/Need on the Initial CANS Assessment			
CANS Domain	**Cohort I (N=86)**	**Cohort II (N=167)**	**Cohort III (N=209)**
Child Behavioral/Emotional Needs	81%	77%	69%
Child Risk Behaviors	48%	43%	38%
Life Domain Functioning	91%	90%	90%
Trauma Stress Symptoms	48%	44%	28%

Across all three Cohorts, 90 percent of the youth had at least one actionable item in the Life Domain Functioning domain followed by 76 percent of the youth in the Behavioral/Emotional Needs domain.

Table 16 shows the percentage of youth who had a six or twelve month follow up CANS and who also reduced at least one need in the domain (i.e., at least one item in the domain had gone from actionable to non-actionable or was no longer considered a need).

Table 16. Percentage of Youth with a Need on the Initial CANS Who Improved Scores on a 6 or 12 Month Subsequent CANS		
CANS Domain	**Youth with Improved Scores 6 Months Post-Initial CANS**	**Youth with Improved Scores 12 Months Post-Initial CANS**
Cohort I		
Child Behavioral/Emotional Needs	51%	89%
Child Risk Behaviors	46%	71%
Life Domain Functioning	60%	90%
Trauma Stress Symptoms	40%	79%
Cohort II		
Child Behavioral/Emotional Needs	59%	71%
Child Risk Behaviors	63%	100%
Life Domain Functioning	68%	81%

Table 16. Percentage of Youth with a Need on the Initial CANS Who Improved Scores on a 6 or 12 Month Subsequent CANS		
CANS Domain	**Youth with Improved Scores 6 Months Post-Initial CANS**	**Youth with Improved Scores 12 Months Post-Initial CANS**
Trauma Stress Symptoms	60%	55%
Cohort III		
Child Behavioral/Emotional Needs	63%	-
Child Risk Behaviors	63%	-
Life Domain Functioning	74%	-
Trauma Stress Symptoms	58%	-

Looking at the domain which showed the most need upon initial assessment, i.e., Life Domain Functioning, 60 percent of the youth from Cohort I showed a reduction in at least one item at six months; the same was true for 68 percent of youth in Cohort II and 74 percent of youth in Cohort III. At twelve months, the reduction in need in the Life Domain Functioning domain showed a marked improvement with 90 percent of Cohort I and 81 percent of Cohort II youth having improved their scores within the domain. Overall, the greatest need reduction was evident in Life Domain Functioning (with the exception of Cohort II at twelve months, where the greatest reduction was in Child Risk Behaviors), suggesting that while these are the most common needs identified, they are also the ones in which the program has been able to address most effectively.

Family Functioning

Progress in family functioning was analyzed by looking at the Family Functioning domain of the CANS which is also broken into specific items within the domain (Table 17).

Table 17. Number of Youth With Improved Scores in the Family Functioning Domain at 6 & 12 Months

CANS Items	Number of Youth With Need on Initial CANS	Number of Youth With a 6 Month CANS & Need on Initial CANS	Number of Youth With Improved Scores 6 Months After Initial CANS	Number of Youth With a 12 Month CANS & Need on Initial CANS	Number of Youth With Improved Scores 12 Months After Initial CANS
Cohort I					
Physical Health	5	1	1	1	1
Mental Health	2	2	0	1	1
Substance Use	1	1	1	1	1
Family Stress	23	17	10	7	6
Residential Stability	7	4	3	3	2
Total	**28**	**18**	**11**	**8**	**7**
Cohort II					
Physical Health	15	8	2	2	2
Mental Health	5	2	2	1	1
Substance Use	5	3	2	2	1
Family Stress	28	15	6	3	1
Residential Stability	10	5	2	2	2
Total	**44**	**23**	**9**	**5**	**3**
Cohort III					
Physical Health	7	1	1	-	-

Table 17. Number of Youth With Improved Scores in the Family Functioning Domain at 6 & 12 Months					
CANS Items	Number of Youth With Need on Initial CANS	Number of Youth With a 6 Month CANS & Need on Initial CANS	Number of Youth With Improved Scores 6 Months After Initial CANS	Number of Youth With a 12 Month CANS & Need on Initial CANS	Number of Youth With Improved Scores 12 Months After Initial CANS
Mental Health	9	2	2	-	-
Substance Use	3	2	0	-	-
Family Stress	31	11	7	-	-
Residential Stability	16	4	2	-	-
Total	**41**	**11**	**7**	**-**	**-**

Family Stress was identified as the most common need item for youth in all three cohorts on the initial CANS, followed by Residential Stability for Cohorts I and III and Physical Health for Cohort II. By six months, 59 percent of the youth in Cohort I saw a reduction in Family Stress; the same was true for 40 percent of youth in Cohort II and 64 percent in Cohort III.

The numbers of youth with assessments available for analysis at twelve months are limited. However, of the seven Cohort I youth who had identified Family Stress as a need on the initial CANS and had a twelve month follow-up, six no longer had Family Stress identified as a need at twelve months; this was the case for one of three Cohort II youth at twelve months.

Youth Educational Functioning

Interviews with youth, parents, wraparound facilitators and caseworkers from the 40 selected fidelity cases were used to explore improved educational functioning. A total of 79

stakeholders were interviewed and all provided information on youth progress and challenges related to education. This section of the report provides a summation of their responses.

Youth from all but two cases were enrolled in school for the fall 2018 semester. For the two youth who were not enrolled, one had run away and the other was planning to sign up for the GED. In a third case the youth, the parent and facilitator reported that the youth was advocating to drop out and his/her status was currently undecided. Youth from approximately half the cases were attending (or set to attend in the fall) school in some form of an alternative learning environment. Some examples of alternative learning included at home/online education, vocational/technical schooling and military based academies.

Youth from all but a few cases were in the appropriate grade level for their age. A few youth had individual education plans (IEPs) to address academic challenges and learning deficiencies. For youth that were not able to keep up with their grade level, parents provided reasons as to why this is the case, including a lack of effort by the youth, lack of placement stability, behavioral issues, drugs, poor peer associations and the parent not being strict enough. Stakeholders held mixed views as to how well youth were currently doing academically, leaning toward a little over half rating the youth's academic performance as good.

Most youth were in different schools or different school settings than they were prior to Safe at Home involvement. Wraparound facilitators and caseworkers shared that changes in school settings were most often the result of youth placement changes or youth needs which necessitated moves to new schools (or at least new school settings) as a way to address those concerns.

A few parents, facilitators and caseworkers reported that the Safe at Home team's decision to change the youth's learning environment had resulted in improved grades. This sentiment was echoed by a few wraparound facilitators with one providing the following example, "[The youth] despised science, but went to vo-tech and got very involved with it. [S/he] does better in smaller class settings where they are more hands on with the work. Now [s/he] actually enjoys learning and went from being in danger of failing in [the public school setting] to a 3.0 at vo-tech." In cases where youth were not doing well in academic achievement, wraparound facilitators from nearly all of those cases reported that this was

due to youth refusal to participate and complete the work. In a couple of cases behavior issues at school and skipping school were identified as the causes of poor grades. In only one or two cases were challenges with learning the material identified as the cause of poor grades.

Interviewees were asked how well youth were doing in regard to their peer relationships and responses across stakeholders were evenly split, with half reporting positive and the other half reporting negative peer relationships. One parent shared his/her frustration stating, "[S/he] can form bonds with teachers, but doesn't form bonds with age appropriate peers. [S/he] makes friends, but [s/he] steals and is clingy. In three days, the friendship is over." When youth struggled with peer relationships, the most common reason identified was inappropriate relationships with peers via hanging around bad influences or not understanding appropriate boundaries. In a few cases stakeholders reported that poor peer relationships were attributed to the youths' general challenge with social skills.

Most youth were not involved in extra-curricular school activities. Wraparound facilitators indicated this was primarily due to youth refusing to participate or having no interest in any of these activities and/or youth having gotten in trouble in school or having grades too low to permit participation. Those youth who did participate in school activities were most often involved in sports followed by band/choir, volunteer groups and military oriented groups such as the Junior Reserve Officer Training Corps (JROTC).

Prior to Safe at Home, most youth had a history of school suspensions and in a couple cases, expulsions. Parents reported some examples of what caused these disciplinary actions, including skipping school, fighting with peers and vandalizing. Wraparound facilitators and youth from nearly all cases reported marked improvement in youth involvement with disciplinary actions at school, yet caseworkers and parents were almost evenly split as to whether positive change had been evidenced. One facilitator witnessed the change in a youth, stating, "When it clicked for [him/her] that [his/her] peers were the source of negativity in [his/her] life, [s/he] stopped getting in trouble in and out of school because [s/he] stopped hanging around them. In the beginning, I got called over three times due to police being involved because of fighting… this doesn't happen at all anymore."

Summary of Outcome Evaluation Results

Overall, Safe at Home outcomes generally followed an interesting pattern, where Safe at Home youth do better than comparison groups for the first six months, but these successes have dissipated by twelve months. As the evaluation continues it will be important to understand what is happening with Safe at Home cases between six and twelve months that is potentially causing this change. This trend is especially apparent in Cohort II, indicating a need for further exploration as to what makes this group different in comparison to the others. As noted in the process section, the overall Safe at Home population appears to be changing drastically with each cohort. Most notably, the population has become increasingly prevention based/focused as time goes on. This is one area where exploration will begin.

Safe at Home youth from all three cohorts spent fewer days in congregate care within six and twelve months of referral and all congregate care length of stay results were statistically significant. These results indicate that while Safe at Home youth may have more instances of "relapse" which lead to congregate care entry and re-entry, more work is being done to ensure that Safe at Home youth do not spend an excessive amount of time in these placement settings and are stepped down to lower levels of care as soon as feasibly possible.

At six and twelve months a greater proportion of Safe at Home youth from all three cohorts had returned to their home-counties than did comparison youth (results were statistically significant for all three cohorts at six months). Safe at Home youth also had higher percentages of overall movement in both directions than did comparison youth, indicating that more active work is being done on Safe at Home cases and placement options are more readily explored.

Within six and twelve months Safe at Home youth had fewer maltreatment referrals. These results were statistically significant for Cohort I at six and twelve months, Cohort III at six months and Cohort II at twelve months. There were no cases of substantiated maltreatment within six or twelve months for any youth in any of the treatment or comparison groups. It is possible that the Safe at Home model's emphasis on youth and family strengths has shifted caseworker and service provider decision-making, where they may be more prone to identify protective factors in families which mitigate risk and thus eliminate the need to file reports.

Cost Evaluation Results:

The cost evaluation is used to determine whether *Safe at Home West Virginia* is more effective and more efficient from a cost perspective than traditional methods used in West Virginia's casework.

Four research questions guide the evaluation of costs.

- Are the costs of providing the Waiver services to a youth and family less than those provided before the Waiver demonstration?
- How does Safe at Home alter the use of federal funding sources as well as state and local funds?
- What is the 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 the treatment groups to those in the comparison groups for Cohorts I and II. It also provides a glimpse of the contracted costs for services provided by the wraparound providers.

When costs were first examined, a daily rate for room and board expenditures were developed using costs incurred by youth in Cohort I's comparison group. The cost of providing out-of-home care to the 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 eligible for review of costs for the treatment group was applied equally to the comparison group. Those costs were then used to compute an average daily rate which will continue to be used for the cost evaluation going forward. 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 waiver costs being higher just because of rate increases.

Using the data from the comparison cohort of youth matched to youth in the first treatment group, the following daily rates were determined.

Out of State Residential Care	$242.24
In State Residential Care	$147.77
Shelter Care	$164.26
Therapeutic/Specialized Care	$54.49
Preventive Care	$20.51

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 second treatment and comparison cohorts were in out-of-home placement. As illustrated in Table 18, the Safe at Home West Virginia initiative generated a cost savings of over $720,000 in costs for room and board for youth in the first treatment cohort and over $1.2 million for youth in the second treatment cohort. Overall, West Virginia has realized a cost savings of slightly more than $2 million in room and board expenditures. The largest savings is the result of reducing the time youth spend in out of state residential care, followed by a reduction in in-state residential care.

Table 18. Cost of Room and Board Payments

	Comparison Group	Treatment Group
Cohort I		
Out of State Residential Care	$1,520,061	$859,712
In State Residential Care	1,218,795	1,028,322
Shelter Care	257,073	342,819
Therapeutic/Specialized Care	14,712	73,942
Preventive Care	26,832	9,683
Totals	**$3,037,473**	**$2,314,478**
Cohort II		
Out of State Residential Care	$1,178,013	$331,384
In State Residential Care	2,823,589	2,124,194
Shelter Care	470,441	788,941
Therapeutic/Specialized Care	133,936	82,934
Preventive Care	54,741	52,280
Totals	**$4,660,720**	**$3,379,733**

Costs for fee-for-services (e.g., case management, maintenance, services) 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. With room and board costs lower for youth in the treatment groups, it is not surprising that other maintenance costs incurred to care for children removed from the home (e.g., transportation, clothing, school) are also lower than those incurred by youth in the comparison groups. Expenditures for "Other Approved Payments" were the primary reason the "Other" costs were higher for treatment youth in Cohort II in comparison to those in the comparison group.

Table 19. Cost of Fee-for-Service Payments		
	Comparison Group	**Treatment Group**
Cohort I		
Case Management	$6,053	$1,218
Assessments	5,028	6,390
Services	45,544	1,184
Maintenance Costs	133,821	85,712
Independent Living	11,256	1,776
Supervised Visitation	1,720	1,864
Other	4,872	5,952
Totals	**$208,294**	**$104,096**
Cohort II		
Case Management	$8,856	$2,193
Assessments	17,520	5,056
Services	38,831	7,525
Maintenance Costs	58,200	62,959
Independent Living	24,485	6,572
Supervised Visitation	2,390	560
Other	8,841	21,115
Totals	**$159,123**	**$105,980**

Contracted costs to provide wraparound services were also examined. A cost of $136 per day is paid to wraparound providers to provide assessments, case management and supervision. Using the number of days youth were enrolled in Safe at Home West Virginia, a total of just under $13.8 million has been incurred to provide services to enrolled youth. The costs equate to an average cost of $39,367 per youth to date.

Table 20. Cost for Wraparound Services			
	Days in Wraparound Care (First 12 Months)	Cost Per Day	Total Wraparound Costs
Cohort I	30,750	$136	$4,182,000
Cohort II	70,564		9,596,704
Total	**101,314**		**$13,778,704**

Summary of Cost Evaluation Results

The program has generated a cost savings of $2 million in room and board costs and a savings of over $157,000 for fee-for-services for treatment youth in Cohorts I and II. The most significant portion of these savings can be attributed to the reduced time youth spend in out-of-state congregate care. As noted above, costs to contract with wraparound service providers averages $39,367 per youth. Additionally, a total cost of $13.8 million has been incurred to provide wraparound services for youth in Cohorts I and II. However, some of the costs of wraparound services may be offset if caseworkers are spending less time on Safe at Home cases since wraparound facilitators are providing such intensive services for youth/families. At this point there does not appear to be a reliable way to determine whether that is the case.

V. Recommendations & Activities Planned for Next Reporting Period

West Virginia's Evaluator's Recommendations:

Recommendation 1: Increase DHHR staff survey response rate. The DHHR survey response rate of only seven was alarmingly low. This was in spite of contacting all the appropriate community service managers to take the survey and forward it to their casework and supervisory staff. There was also follow up messaging from HZA and a deadline extension to try to increase the response rate.

Recommendation 2: Further explore how to help youth/families build their natural support systems. Most youth/families either did not want to involve natural supports in the wraparound process or they did not believe they had any natural supports to involve. It would be beneficial for LCAs to emphasize to youth/families why natural supports are important to help them to build up supports, especially for post-wraparound involvement.

Recommendation 3: Work with LCAs unable to meet the required timeframes for assessments and plans. One LCA fell largely short of meeting all required timeframes for assessments and plans, and as a whole, multiple LCAs struggled in meeting the required timeframe for initial wraparound plans. HZA is currently in the midst of completing fidelity reviews for each agency which the state plans to use to work directly with each LCA to come up with plans for improvement where necessary. The agency reviews followed by the collaborative work between the State and the LCAs will hopefully lead to better results on initial timeframes for next year's fidelity assessment.

West Virginia Activities Planned for Next Reporting Period:

West Virginia will work with our evaluator and partners to plan for implementing recommendations as well as monitoring for any program or process improvements.

All provider agreements will be updated on March 31, 2018 bringing all Local Coordinating Agencies for all 3 implementation phases into a uniform schedule for provider agreements.

West Virginia will proceed with facilitation of the Applied Wraparound Training to all existing Wraparound Facilitators.

West Virginia has developed a strategic work plan for further training and development of BCF and Partner staff regarding the administration and use of the WV CANS and the further development of WV CANS Advance CANS Experts (ACES) for technical assistance. We are seeing that WV CANS are being administered but many do not yet understand how to use the results in the treatment or case planning process for youth and families. We have identified the continuing need to develop experts that can provide technical assistance on an ongoing basis. Our goal is for WV CANS to be completed on all children with an open child welfare case and that the WV CANS will be used to determine the appropriateness of a referral to Safe at Home West Virginia and assist in guiding the intensity of services. Please refer to the attached Logic Model which is a fluid with changes being made as needed.

As mentioned previously, West Virginia is working with our partners in Positive Behavioral Support Program. They are assisting us with engagement and ongoing trainings in using the MAPs process. "MAPs" refers 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. We are hopeful that these training will occur during the next reporting period.

West Virginia will continue with the combined meetings with Judges as well as community partners.

West Virginia will continue work on our sustainability plan as we prepare for transition out of the IVE Demonstration Waiver in 2019. At present West Virginia has a functioning workgroup that is focused on financial sustainability. This workgroup will continue with Technical Assistance through Casey Family Programs to determine and gather the necessary financial information to inform program decisions. During the first months of 2018 West Virginia will form other workgroups that can take the information from the Finance group as well as our evaluators and begin work on program decisions regarding sustainability. While the financial workgroup continues focus on different avenues of funding.

NEXT STEPS:

WEST VIRGINIA'S EVALUATOR:

HZA will return to West Virginia for a week during November 2017 to conduct the third round of process interviews to examine the strategic and practice changes that have occurred since the Phase III statewide roll out, learn about ongoing training in Phase I and II counties and new training in Phase III counties, and identify any successes or challenges with Safe at Home.

Interviews will be conducted in a distribution of counties which rolled out during all three phases so that any differences in implementation and practice can be identified. The following stakeholders will be interviewed: central and regional office staff, county staff (i.e., caseworkers and/or supervisors), LCA staff (i.e., facilitators, supervisors and/or program managers) and judges.

Additionally, in future reports HZA intends to further examine why outcomes appear to change between six and twelve months for youth in Safe at Home. There seems to be a trend where six month outcomes are more positive than those at twelve months (this is especially true for Cohort II). It will be important to establish what is changing with Safe at Home cases in that second six month period, and also particularly, what some of the factors are that may have made positive contributions to Cohort II's six month outcomes.

VI. Program Improvement Policies

- **Title IV-E Guardianship Assistance Program (previously implemented): An amendment to the title IV-E plan that exercises the option to implement a kinship guardianship assistance program.**

West Virginia amended its Adoption and Legal Guardianship Policies as well as its IV-E State Plan to accommodate claiming for Guardianship Assistance. This included kinship guardianship assistance. DHHR Office of Administration as well and the Office of Information Technology worked on the requirements for this expanded claiming. Although West Virginia is currently in the proposal process for the building of the new required CCWIS system the Office of Information Technology agreed to work with their current contractor to build a basic system within the existing SACWIS system to assist with this claiming. The build had a very tight timeframe and was completed and released on February 23, 2017. In conjunction to this activity was the preparation of the BCF IV-E eligibility staff for the necessary review and determinations and as well as work in the field offices with the pulling and identification of specific kinship guardianship cases. This work occurred concurrently with the build within the SACWIS system.

- **Preparing Youth in Transition (new): The establishment of procedures designed to assist youth as they prepare to transition out of foster care, such as arranging for participation in age-appropriate extra-curricular activities; providing appropriate access to cell phones, computers and opportunities to obtain a driver's license; providing notification of all sibling placements if siblings are in care and sibling location if siblings are out of care; and providing counseling and financial support for post-secondary education.**

West Virginia has made a conscious effort to "normalize" activities for all foster children. We have made a concerted effort to increase staff and stakeholder knowledge of youth transitioning by creating a Youth Transitioning Policy that outlines all activities and requirements for youth aging out of foster care. Several webinars and presentations have been presented across the state to increase awareness of services available to older youth. These presentation and webinars include information about allowing our youth to participate in everyday activities, completing transition plans that include giving them information about advance directives, Chafee funding, completing record checks and developing reasonable plans.

West Virginia provides every youth who graduate or obtains a GED wile in foster care a computer and any needed software or accessories. We continue to work on advising them of their sibling's location. However, due to West Virginia's focus on relative/kinship placements, most of our foster youth are placed with siblings.

West Virginia continues to struggle with the issue of youth in care obtaining drivers licenses and continues to work on resolving this.

All necessary policies have been drafted and released to the field staff on September 17, 2015 with an effective date of September 28, 2015. The policy is also posted on the Bureau for Children and Families Website. A memo was sent releasing the policy to the field as well as explaining the policy update. A power point was also created for the use of Home Finding staff with foster parents. At present a webinar is in developed for all tenured staff and the new policy is being embedded into new worker training. West Virginia will continue to require all of our provider partners to assure that their staff are aware and trained in this area and that they provide information to their foster families.

This program improvement policy is complete. The policy may be accessed on the BCF website. http://www.dhhr.wv.gov/bcf

Attachments:

Appendix A – WV CANS Logic Model

Appendix B – Fidelity Assessment On-Site Case Record Review Instrument

Appendix C – Fidelity Assessment On-Site Interview Protocols

Appendix D – Statistical Similarity of Treatment and Comparison Groups

Appendix E – Number of Youth with an Actionable Item/Need on the Initial CANS

Appendix A

CHILDREN AND ADOLESCENTS NEEDS AND STRENGHS (CANS)

Logic Model

Working Draft 10-24-2017

Goal 1: West Virginia will develop policy and protocols that support CANS implementation				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: Develop and Implement Youth Services (YS) Policy to include CANS	* *CANS will replace the YBE immediately* * *YS Policy regarding CANS completed* **June 1, 2016 COMPLETED**	▪ Professional staff that can identify a child's needs and develop or recommend appropriate treatment ▪ Reduce unnecessary requirements/tools	Michelle Dean BCF Leadership	
Objective 2: Develop and Implement Child Protective Services (CPS) Policy to include CANS	1. Determine if the CANS and/or FAST will be used for CPS cases and what other tools will be needed. 2. Map the FFA and PCFA to the CANS using FAST **DUE:** January 2018	▪ Professional staff that can identify a child's needs and develop or recommend appropriate treatment ▪ Reduce unnecessary requirements/tools	Streamline Committee Michelle Dean BCF Leadership Linda Dalyai Tammy Pearson	* *The FAST was selected to be used by both CPS and YS.* **FAST is the family version of the CANS.* **WVFAST includes safety, risk, human trafficking* **All staff will be trained in the WV FAST*
	2. Develop CPS policy regarding CANs **DUE:** January 2018	▪ Provides clear expectations		

Goal 2: **West Virginia will have 100% of DHHR Staff trained and certified in the CANS.**				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: All Youth Services (YS) staff will be trained and certified at .70 in the CANS.	1. Identify and track YS staff that need trained, certified and/or recertified. **DUE: Ongoing**	▪ YS supervisors will identify staff that have not been trained, those that have trained and need certification and those that require TA.	Linda Dalyai Tammy Pearson Gary Keen YS Supervisors	**YS staff was trained through Safe at Home rollout* ** CANS Youth Services tenure staff will be given training preference.* **** Training and Technical Assistance is planned for staff that did not receive training during rollout.*** .
	2. Identify Training and Type Needed (New Worker or Ongoing) and provide training notices to Supervisors and Regional Managers. **DUE: November 2017**	▪ Training will be delivered by: 1. DHHR CANS Trainers (Experts); 2. CANS-ACES; 3. DHHR Regional/State CANS Expert	Linda Dalyai Tammy Pearson Elva Strickland	
	3. YS staff will receive CANS training and certification through new worker training. **DUE:** Ongoing	▪ Training will be delivered by: DHHR, Division of Training CANS Trainers (Experts)		
Objective 2: All Child Protection Services (CPS) staff will be trained and certified in the CANS.	1. Identify and track CPS staff that need trained, certified and/or recertified.	▪ CPS supervisors will identify staff that have not been trained, those that have trained and need certification and those that require TA.	Linda Dalyai Tammy Pearson	** CPS staff was trained when Safe at Home was rolled out.* **CPS staff will receive CANS training and*
	2. Identify Training and Type Needed (New Worker or Ongoing) and	▪ Training will be delivered by: 1. DHHR CANS Trainers (Experts);	Linda Dalyai Tammy Pearson Elva Strickland	

	provide training notices to Supervisors and Regional Managers	2. CANS-ACES; 3. DHHR Regional/State CANS Expert		*certification through new worker training after decisions are made regarding recommendations from the Streamline Committee (Goal1-Objective 2)*
Objective 3: Ensure all YS and CPS staff are certified & Recertified	1. Determine who will monitor certification and recertification **DUE: 05/2017**	▪ State Office will monitor certification and recertification until all staff have had an opportunity to certify or recertify	BCF Leadership	** The Praed Foundation sends those that have certified in CANS a notification 1 month prior to their certification expiration date.*
	2. Monitor certification and recertification **DUE:**	▪ Identify 1 Regional Coordinator per each DHHR Region to continue to monitor staff certification		
	3. Determine the consequences for failure to meet .75 certification standards.	▪ After multiple attempts, staff may need re-assigned	BCF Leadership	

Goal 3: **West Virginia will build BCF Internal Capacity Statewide.**				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: Provide ongoing technical assistance Regionally and statewide.	1. Identify and train/certify internal CANS Experts. **DUE: Completed/Ongoing**	▪ Ongoing technical assistance offered by Regional CANS Experts will allow Supervisors and staff to feel supported.	Linda Dalyai Tammy Pearson Michelle Dean	** Criteria for CANS Experts has been developed.* ** CANS Experts must certify at .80* ** Only CANS Experts can provide TA*
	2. Develop short-term and long-term Technical Assistance goals and protocol (expectation, cost, dates, locations, etc.) ▪ Identify those that will provide TA ▪ Identify and support DHHR staff that meet the criteria as CANS Experts	▪ This will support sustainability and allow staff to be supported within their own Regions	Linda Dalyai Tammy Pearson BCF Management	
	3. TA will include supporting staff by reviewing completed CANS and provide ongoing quality assurance. **DUE: Completed/Ongoing**	▪ Reliable and valid CANS	Linda Dalyai Tammy Pearson	
Objective 2 Explore Higher Education Support of CANS in Curriculum and Certification	1. Discuss with Universities the need for students to be trained and certified in the CANS prior to employment	▪ A workforce that is competent in using the CANS ▪ Priority given to those with current certification in the hiring process	Linda Dalyai Tammy Pearson Elva Strickland BCF Management Div. of	

Process			Training	

Goal 4: **West Virginia will have a fully automated CANS system.**				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: Utilize or develop software to capture the CANS information across participating agencies and DHHR staff	1. Determine if: a) Software is designed only for Safe at Home cases; b) Can software be expanded to include all cases	▪ Promotes the full use of the CANS	Hornsby/Zeller FACTS BCF Management Linda Dalyai Tammy Pearson Elva Strickland	* *A mechanism that allow the CANS scores (initial and ongoing) to be documented, tracked and data to be obtained and distributed.*
	1. Determine if software belongs to the DHHR, BCF, and if so, contract with a University to: a) Maintain CANS information across participating agencies b) Evaluation and Reports	▪ The DHHR will have available information on a child or family so the diagnostic process can be minimized		
	1. FACTS Redesign will include slight modification of the YBE screens that mirror CANS items and additional screens added for CANS that are needed. 2. FACTS to interface with external partners	▪ Documentation for workers will match policy		

Goal 5: **West Virginia will establish threshold (algorithms)/Total Communication Outcome Management (TCOM)**				
	Inputs: What will we do to implement the objective?	**Outputs**: What will be the results of what we implement?	**Project Lead**	**Other**
Objective 1: Algorithms and automated feedback are specified for each key decision-point in service / support process	1. Determine when algorithms will be used and who will use them.	▪ At a practice level, algorithms guide decisions toward the level of care or intensity of service needed.	BCF Management Linda Dalyai Tammy Pearson	* *Dr. Lyons identified Algorithms based on a WV case record study* * *Algorithms are indicators that guide decisions at multiple levels.* * *Algorithms are to be considered along with other information when making service decisions for a child and family.*
	2. Determine what tool can be used to guide decision making	▪ This will allow consistent results		

OUTCOMES:

Benefit to children, youth and families from the utilization of CANS

1. Safety, Permanency and Well-being outcomes are met when needs and strengths are identified.
2. Identified strengths in the area of talents/interests and spiritual/religious are strong predictors for placement stability and positive outcomes.
3. The CANS is completed as a shared visioning activity rather than the opinion of one person.
4. The CANS is used to support placement, level of care, or intensity of intervention decisions that it is also used for other work as well (i.e. creating the permanency plan).
5. Engaging youth and families in actively collaborating on the assessment process is helpful to staring personal change. The appropriate use of the CANS is an engagement strategy.

Benefit to Professional DHHR Staff

1. Youth Services and Child Protective Services staff will expand their competence in intervention techniques and approaches. These enhanced professional skills will help them to work with families to overcome life's most difficult challenges.
2. With ongoing support, staff will value the performance of their work and view their documentation as part of their work rather than as a paperwork activity. ** Key to creating that support is the use in supervision.*
3. The CANS is replacing other documentation not simply adding documentation burden.
4. Creates a model that informs effective case planning and linking children and family needs to specific strategies and placements.
5. Having an organized way of communication about children and families facilitates (professionalizes) case worker communications with other partners, in particular, the courts and mental health professionals.

Benefits at Program Level

1. At the program level, provides supervisors with a way for their case workers to organize themselves so that supervision is more targeted and efficient.
2. Reveals training needs and opportunities for practice development
3. Allows the monitoring of effectiveness of interventions

Benefits at the System Level

1. Significant savings for re-investment from better management of expensive interventions
2. Improved resource mapping for system right-sizing.
3. Re-structuring payment and rate setting systems to better match children and families and encourage improvement.

Excerpts from, John S. Lyons, Ph.D. Chapin Hall at the University of Chicago Praed Foundation. *Use of the Child and Adolescent Needs and Strengths (CANS) in Child Welfare in the United States*. Report prepared for the Ohio Association of Child Caring Agencies, Inc. (March 23, 2014)

Appendix B

Fidelity Assessment On-Site Case Record Review Instrument

Case Number:	Family Name:
Client Number:	County: Region:
Local Coordinating Agency:	Wraparound Facilitator:
Reviewer:	Review Date:
Referral Placement:	Current Placement:

FAMILY INFORMATION

1. Please describe the household members involved in the case, beginning with the youth in the program.

Name	Role in Family	Date of Birth (of Target Youth Only)	Race/Ethnicity	Gender

Role Codes: 1 = Parent 2 = Child 3 = Other Relative 4 = Non-relative

Race Codes: 1 = Asian 2 = Black 3 = Hispanic 4 = White
5 = Mixed/Other

Gender Codes: 1 = Female 2 = Male

WRAPAROUND CHRONOLOGY

Please provide the dates of relevant activities; if the activity has not occurred indicate 05/05/1955.

2. DHHR case opening date: _ _ / _ _ / _ _ _ _

3. Removal date (most recent): _ _ / _ _ / _ _ _ _
4. Date of referral to wraparound services/*Safe at Home*: _ _ / _ _ / _ _ _ _
5. Date of return home (most recent): _ _ / _ _ / _ _ _ _
6. Date of initial CANS: _ _ / _ _ / _ _ _ _
7. Date(s) of subsequent CANS (earliest to latest): _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
8. Date of initial wraparound plan: _ _ / _ _ / _ _ _ _
9. Date(s) of subsequent wraparound plans (earliest to latest): _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
   _ _ / _ _ / _ _ _ _
10. Date of initial crisis safety plan: _ _ / _ _ / _ _ _ _
11. Date(s) of subsequent crisis safety plans (earliest to latest): _ _ / _ _ / _ _ _ _
    _ _ / _ _ / _ _ _ _
    _ _ / _ _ / _ _ _ _
    _ _ / _ _ / _ _ _ _
    _ _ / _ _ / _ _ _ _
12. Date of wraparound/*Safe at Home* closure: _ _ / _ _ / _ _ _ _
13. If wraparound/*Safe at Home* has closed, what is the reason?
    - Successful completion of the program/graduation
    - Unable to complete/discharged (specify reason): _____
    - Other (specify reason): _____
14. DHHR case closing date: _ _ / _ _ / _ _ _ _

ENGAGEMENT AND TEAM PREPARATION PHASE

PREPARATION

15. Please note any information in the case record about preparation for wraparound (e.g., wraparound facilitator met with family to discuss process, listen to family concerns or identify hopes, dreams and strengths; family identified people to attend wraparound meetings; etc.).

INITIAL PLAN DEVELOPMENT PHASE

WRAPAROUND PLAN CONTENT

16. Based on the information in the case record, please indicate the extent to which the ***initial*** wraparound plan contained the following. Responses are:

5 = Thoroughly **4 = Mostly** **3 = Somewhat** **2 = Not Very Much** **1 = Not at All**

	5	4	3	2	1	N/A
Youth's Long Term Vision						
Mission Statement for the Team						
Outcomes Clearly Connected to the Vision						
Measurable Outcomes/Objectives						
Multiple Strategies						
Clear Relationship between Outcomes and Strategies						
Plan for Maintenance in or Transition to Least Restrictive Environment						

	5	4	3	2	1	N/A
Opportunities for Youth to Engage in Community Activities						
Services/Supports Consistent with Youth's/Family's Culture						
Services/Supports Consistent with Youth's/Family's Primary Needs						
Services/Supports Take Account of and Use Youth's/Family's Strengths						

17. Based on the information in the case record, please indicate the extent to which the ***most recent*** wraparound plan contained the following. Responses are:

5 = Thoroughly **4 = Mostly** **3 = Somewhat** **2 = Not Very Much** **1 = Not at All**

	5	4	3	2	1	N/A
Youth's Long Term Vision						
Mission Statement for the Team						
Outcomes Clearly Connected to the Vision						
Measurable Outcomes/Objectives						
Multiple Strategies						
Clear Relationship between Outcomes and Strategies						
Plan for Maintenance in or Transition to Least Restrictive Environment						
Opportunities for Youth to Engage in Community Activities						
Services/Supports Consistent with Youth's/Family's Culture						
Services/Supports Consistent with Youth's/Family's Primary Needs						
Services/Supports Take Account of and Use Youth's/Family's Strengths						

CRISIS SAFETY PLAN

18. Based on the information in the case record, please indicate the extent to which the ***initial*** crisis safety plan contained the following. Responses are:

5 = Thoroughly **4 = Mostly** **3 = Somewhat** **2 = Not Very Much** **1 = Not at All**

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Strategy for Crisis Prevention					
Identification of Behaviors Signaling Coming Crisis					
Methods for De-escalating Crises					
Steps to Be Taken during Crisis					
Assignment of Roles during Crisis					

19. Based on the information in the case record, please indicate the extent to which the ***most recent*** crisis safety plan contained the following. Responses are:

5 = Thoroughly 4 = Mostly 3 = Somewhat 2 = Not Very Much 1 = Not at All

If there is no indication in the record regarding an item, score it as "1."

	5	4	3	2	1
Strategy for Crisis Prevention					
Identification of Behaviors Signaling Coming Crisis					
Methods for De-escalating Crises					
Steps to Be Taken during Crisis					
Assignment of Roles during Crisis					

20. Please add any pertinent information about the case/program fidelity that you were unable to capture in the review tool.

***Please use the back if additional space is needed.

Appendix C

Fidelity Assessment On-Site Interview Protocols

SAFE AT HOME WEST VIRGINIA
YOUTH INTERVIEW PROTOCOL

Youth Name:	Interviewer Name:
Date of Interview:	County:
Local Coordinating Agency (LCA):	

PLACEMENT AND EDUCATION STATUS

1. Where are you living now?
    a. Has that changed since *Safe at Home* began?
    b. If yes, where were you living prior to *Safe at Home*?

2. Are you currently attending school?
    a. If yes, are you in the same school you were in prior to *Safe at Home*?
    b. If yes, since *Safe at Home* began have you remained at the same school? If not, why?
    c. If no, is this because you have graduated?
    d. If no, do you have plans to return to school? (Skip to Q4)

3. Generally speaking, how would you say you are doing in school?
    a. Academic achievement?
    b. Peer relationships?
    c. Involvement in school activities?
    d. Staying out of trouble?

4. Were you ever suspended or expelled from school prior to *Safe at Home*?
    a. If yes, how often was this occurring?
    b. If yes, has this changed since you began *Safe at Home*?

5. Have you been able to keep up with your grade level?
    a. What grade will you be entering in the fall?
    b. If you have not been able to keep up, how far behind are you? What are some of the challenges you have faced that have caused you to fall behind?

ENGAGEMENT AND TEAM PREPARATION PHASE

6. How did you learn about *Safe at Home*?

   a. Who explained *Safe at Home* to you?
b. What kind of information did they share with you?
c. Can you describe what services through *Safe at Home* are supposed to look like? Has it actually gone this way?

7. During your first meeting with the wraparound facilitator, were you encouraged to discuss you concerns, hopes, dreams, and strengths?
   a. How did the wraparound facilitator respond to your views?
   b. Was anyone else involved in this process in the very beginning?
   c. Did you struggle with opening up? If so, how did you overcome this?

8. Did you tell the wraparound facilitator about people you wanted to be involved with you through the *Safe at Home* program?
   a. If yes, who were the people you wanted involved *(relational responses, e.g., aunt, grandma, therapist, etc.)*?
   b. If yes, how did he/she respond to your suggestions?
   c. If yes, are those people actually participating?

INITIAL PLAN DEVELOPMENT PHASE

9. How much do you personally contribute in creating wraparound plans?
   a. Do you believe that your thoughts and opinions have been used in the plans?
   b. If yes, how has your input been used in the plans?

10. What are the main goals you have with *Safe at Home*?
   a. To what extent have the goals been achieved?
   b. If you are struggling to achieve the goals, what can be done to overcome the obstacles you face?

11. Were you involved in creating a crisis safety plan?
   a. If yes, did the wraparound facilitator explain why it was needed and how it works?
   b. How do members of your team assist you in case of a crisis?
   c. How helpful has the crisis safety plan been in meeting your needs?

PLAN IMPLEMENTATION PHASE

12. How often do you meet with the wraparound facilitator?
   a. Is this amount of contact enough? Too much?

13. What services have you received so far through *Safe at Home*?
   a. This includes "formal services," for example, therapy or medication management among many others, and:

b. "Informal services" which can be many different things, for example, help in school, going out to eat, getting back to school supplies, etc.:

14. Does the wraparound facilitator help you to identify the successes you have achieved since you have been working with *Safe at Home*?
    a. What are the successes?
    b. Does the wraparound facilitator do anything in particular to recognize or reward success?
    c. What are the challenges you face and what is being done to overcome them?

15. Do relatives, friends, and/or others provide support to you and your family?
    a. If yes, what type of support do they provide?
    b. If not, why do you think that is?

16. Are you actively helping to make decisions about the services you are receiving through *Safe at Home*?
    a. If yes, has your input been heard and used?
    b. If no, why do you think that is?

TRANSITION PHASE

17. Are you done with *Safe at Home*?
    a. If yes, what was the reason for *Safe at Home* ending?
    b. If positive, how did you and your team know you were ready to finish the program?
    c. If negative, was there anything that could have been done to change the outcome of your case? If so, what?

Questions 18-20 only apply if the case is closed or no longer active.

18. Was there a final meeting and/or a celebration/graduation service to recognize your completion of *Safe at Home*?
    a. If yes, what happened?
    b. If yes, what kind of information was shared?

19. Did you receive a record of the work you have completed and the accomplishments you have made?
    a. If yes, what did the record contain?
    b. If no, do you think it would have been beneficial to have something like this?

20. Did you and your family receive information about where you could go for help in the future should you need any?

a. If yes, what information was given to you?
b. If no, did you receive any kind of information about what to do when services are finished?

CONCLUSION

21. Overall, how helpful has the *Safe at Home* program been to you?

22. What have you liked best about the program?

23. What could be done to make the program better?

SAFE AT HOME WEST VIRGINIA
PARENT/CAREGIVER INTERVIEW PROTOCOL

Parent/Caregiver Name:	Interviewer Name:
Youth Name:	LCA:
Date of Interview:	County:

PLACEMENT AND EDUCATION STATUS

1. Where is your youth currently living?
    a. Has that changed since *Safe at Home* began?
    b. If yes, where was your youth living prior to *Safe at Home*?

2. Is your youth currently attending school?
    a. If yes, is he/she in the same school he/she was in prior to *Safe at Home*?
    b. If yes, since *Safe at Home* began has he/she remained at the same school?
    c. If no, is this because he/she has graduated?
    d. If no, does your youth have plans to return to school? (Skip to Q4)

3. Generally speaking, how would you say your youth is doing in school?
    a. Academic achievement?
    b. Peer relationships?
    c. Involvement in school activities?
    d. Staying out of trouble?

4. Was your youth ever suspended or expelled from school prior to *Safe at Home*?
    a. If yes, how often was this occurring?
    b. If yes, has this changed since your youth began *Safe at Home*?

5. Has your youth been able to keep up with his/her grade level?
    a. What grade will he/she be entering in the fall?
    b. If he/she has not been able to keep up, how far behind is he/she? What are some of the challenges your youth has faced that have caused him/her to fall behind?

ENGAGEMENT AND TEAM PREPARATION PHASE

6. How did you learn about *Safe at Home*?
    a. Who explained *Safe at Home* to you?
    b. What kind of information did they share with you?
    c. Can you describe what services through *Safe at Home* are supposed to look like? Has it actually gone that way?

7. During your first meeting with the wraparound facilitator, to what extent were you and your youth encouraged to discuss your concerns, hopes, dreams, and strengths?
    a. How did the wraparound facilitator respond to your views?
    b. Was anyone else a part of this process in the very beginning?
    c. Did you or your youth struggle with opening up? If so, how did you or your youth overcome this?

8. Did you tell the wraparound facilitator about people you wanted to be involved with your family through the *Safe at Home* process?
    a. If yes, who are the people you wanted involved *(relational responses, e.g., aunt, grandma, therapist, etc.)*?
    b. If yes, how did he/she respond to your suggestions?
    c. If yes, are these people actually participating?

INITIAL PLAN DEVELOPMENT PHASE

9. How do you personally contribute in creating wraparound plans?
    a. Do you believe that your thoughts and opinions have been used in the plans? If yes, how so?
    b. How much does your youth contribute to creating the wraparound plans? Is his/her voice heard? How has his/her input been used in plans?

10. What are the main goals you have with *Safe at Home*?
    a. To what extent have the goals been achieved?
    b. If you and your youth are struggling to achieve the goals, what can be done to overcome the obstacles you face?

11. Were you and your youth involved in creating a crisis safety plan?
    a. If yes, did the wraparound facilitator explain why it was needed and how it works?
    b. How do members of the team assist your youth and family in case of a crisis?
    c. How helpful has the crisis safety plan been in meeting your youth/family's needs?

PLAN IMPLEMENTATION PHASE

12. How often do you meet with the wraparound facilitator?
    a. Is this amount of contact enough? Too much?

13. What services has your youth received so far through *Safe at Home*?

a. This includes “formal services,” for example, counseling or medication management among many others, and:
b. “Informal services” which can be many different things, for example, help with advocating in school, taking the youth out to eat, getting back to school supplies, etc.:

14. Does the wraparound facilitator help you to identify the successes your youth and has achieved since you have been working with *Safe at Home*?
    a. What are the successes?
    b. Does the wraparound facilitator do anything in particular to recognize or reward success?
    c. What are the challenges you and your youth face? What is being done to overcome those challenges?

15. Do relatives, friends, and/or others provide support to you and your youth?
    a. If yes, what type of support do they provide your family?
    b. If no, why do you think that is? Do you have thoughts about how to engage them in providing support?

16. Have you and your youth actively made decisions about services through *Safe at Home*?
    a. If yes, has this input been heard and used?
    b. If no, why do you think that is?

TRANSITION PHASE

17. Are you/your youth finished with *Safe at Home*?
    a. If yes, what was the reason for *Safe at Home* ending?
    b. If positive, how did everyone know that your youth/family was ready to end services?
    c. If negative, was there anything that could have been done to change the outcome of your youth’s case? If so, what?

Questions 18-20 only apply if the case is closed or no longer active.

18. Was there a final meeting and/or a celebration/graduation service to recognize your youth’s completion of *Safe at Home*?
    a. If yes, what happened?
    b. If yes, what kind of information was shared?

19. Did you/your youth receive a record of work completed and accomplishments made?
    a. If yes, what did the record contain?

b. If no, do you think this would have been beneficial to have something like this?

20. Did you and you and your youth receive information on where to go for help in the future should you need any?
    a. If yes, what information was given to you?
    b. If no, did you receive any kind of information about what to do when services are finished?

CONCLUSION

21. What has been your overall impression of *Safe at Home*?
    a. What were some of the best parts?
    b. What could be improved?
    c. Other comments?

WEST VIRGINIA TITLE IV-E WAIVER
TEAM MEMBER INTERVIEW PROTOCOL

Caseworker Name:	Interviewer Name:
Date of Interview:	County:
Case 1 Youth Name:	Case 1 LCA:
Case 2 Youth Name:	Case 2 LCA:
Case 3 Youth Name:	Case 3 LCA:
Case 4 Youth Name:	Case 4 LCA:
Case 5 Youth Name:	Case 5 LCA:
Case 6 Youth Name:	Case 6 LCA:

We understand that some caseworkers may have multiple *Safe at Home* cases within our review sample. To simplify the process I am going to interview you once about all of your cases identified in our random sample. I will ask you to answer each question for each youth as we go along.

PLACEMENT AND EDUCATION STATUS

1. Where is the youth living now?
    a. Has that changed since *Safe at Home* began?
    b. If yes, where was he/she living prior to *Safe at Home*?

2. Is the youth currently attending school?
    a. If yes, is the youth in the same school he/she was in prior to *Safe at Home*?
    b. If yes, since *Safe at Home* began has the youth remained at the same school?
    c. If no, is this because the youth has graduated?
    d. If no, does the youth have plans to return to school? (Skip to Q4)

3. Generally speaking, how would you say the youth is doing in school?
    a. Academic achievement?
    b. Peer relationships?
    c. Involvement in school activities?
    d. Staying out of trouble?

4. Was the youth ever suspended or expelled from school prior to *Safe at Home*?
    a. If yes, how often was this occurring?
    b. If yes, has this changed since he/she began *Safe at Home*?

5. Has the youth been able to keep up with his/her grade level?
    a. What grade will the youth be entering in the fall?

b. If the youth has not been able to keep up, how far behind is he/she? What are some of the challenges the youth has faced that has caused him/her to fall behind?

RELATIONSHIP TO YOUTH

6. What is your role in providing support to the youth/family through *Safe at Home*?

ENGAGEMENT AND TEAM PREPARATION PHASE

7. How was wraparound initially explained to the youth and his/her family?
a. Who was responsible for doing that?
b. What information was shared with them?
c. Did they seem to have a good understanding of how services would be coordinated? If no, why?
d. Were they encouraged during this beginning phase to share their concerns, hopes, dreams, and strengths?
e. Did other team members play a role in the engagement phase?

8. Did the youth and his/her family identify people they wanted to be involved in the wraparound process?
   a. If yes, who did they identify *(e.g., relational responses, such as aunt, uncle, coach, teacher, therapist, etc.)*?
   b. If yes, how supportive was the wraparound facilitator in including these supports?
   c. If yes, to what extent have those people actually participated?
   d. If those people have not participated, what efforts were made to involve them?

INITIAL PLAN DEVELOPMENT PHASE

9. How do you assist in creating wraparound plans?
   a. How are the youth and family involved in creating plans?
   b. How are family supports involved in creating plans?
   c. How is the CANS used in developing plans?

10. What are the essential features of plans and/or goals for the youth and family through *Safe at Home*?

11. What is your level of involvement with crisis safety planning through *Safe at Home*?
    a. How helpful has the plan been in meeting the needs of the youth and his/her family?

12. To what extent has the youth and family engaged with the program?
    a. What strategies do you use to keep the youth and family engaged?
    b. In what ways could youth and family engagement be improved?

PLAN IMPLEMENTATION PHASE

13. How often does the wraparound facilitator meet with the youth and their family?
    a. Is that amount of contact adequate? Too much? Too little?

14. What services have the youth actually received so far through *Safe at Home*?
    a. Formal services?
    b. Informal services/supports?

15. Have there been any barriers in trying to obtain services for the youth?
    a. If so, for which services has this been a struggle?
    b. If so, how did the team work to overcome this challenge?

16. How does the wraparound facilitator reward or recognize the successes the youth and his/her family have achieved?
    a. What are the successes so far?
    b. What are the challenges and what steps are being taken to overcome them?

17. How do you help to ensure that relatives, friends, and others are remaining involved and providing support to the youth and his/her family?

18. How is the wraparound facilitator ensuring that the youth is actively participating in making decisions about services?
    a. What are some examples of instances where his/her input has been used in the plan?
    b. If the youth is not actively participating, why do you think that is?
    c. What is your level of participation with wraparound planning?

19. How does the wraparound facilitator monitor the progress being made toward reaching the youth's and family's goals?
    a. How does the wraparound facilitator help to ensure that progress is actually being made if the youth/family is struggling?
    b. How do you help to ensure that progress is actually being made if the youth/family is struggling?

TRANSITION PHASE

20. Is this case closed for *Safe at Home*?
    a. If so, what was the reason for case closure?

b. If the reason for closure was positive, how did the wraparound facilitator/team know that the youth was ready for transition?
c. If the reason for closure was negative, was there anything that could have been done to change the outcome of this case? If so, what?

Questions 21 and 22 only apply to closed or inactive cases.

21. Did the wraparound facilitator hold a final meeting and/or a celebration/graduation service to recognize completion of *Safe at Home*?
    a. If yes, what happened?
    b. If yes, what kind of information was shared?
    c. Did the youth receive a record of work completed and accomplishments made?

22. Did the wraparound facilitator present information on where the youth and his/her family could go for help in the future?
    a. If yes, what information was given to them?
    b. If no, was any transition information given to them?

CONCLUSION

23. What has contributed to the success of this case so far?

24. What barriers to success have you seen?
    a. What could be done to mitigate those barriers to improve the outcome?

SAFE AT HOME WEST VIRGINIA
WRAPAROUND FACILITATOR INTERVIEW PROTOCOL

Facilitator Name:	Interviewer Name:
Date of Interview:	County:
LCA Name:	
Case 1 Youth Name:	Case 2 Youth Name:
Case 3 Youth Name:	Case 4 Youth Name:
Case 5 Youth Name:	Case 6 Youth Name:

We understand that some caseworkers may have multiple *Safe at Home* cases within our review sample. To simplify the process I am going to interview you once about all of your cases identified in our random sample. I will ask you to answer each question for each youth as we go along.

PLACEMENT AND EDUCATION STATUS

1. Where is the youth living now?
    a. Has that changed since *Safe at Home* began?
    b. If yes, where was he/she living prior to *Safe at Home*?

2. Is the youth currently attending school?
    a. If yes, is the youth in the same school he/she was in prior to *Safe at Home*?
    b. If yes, since *Safe at Home* began has the youth remained at the same school?
    c. If no, is this because the youth has graduated?
    d. If no, does the youth have plans to return to school? (Skip to Q4)

3. Generally speaking, how would you say the youth is doing in school?
    a. Academic achievement?
    b. Peer relationships?
    c. Involvement in school activities?
    d. Staying out of trouble?

4. Was the youth ever suspended or expelled from school prior to *Safe at Home*?
    a. If yes, how often was this occurring?
    b. If yes, has this changed since he/she began *Safe at Home*?

5. Has the youth been able to keep up with his/her grade level?
    a. What grade will the youth be entering in the fall?
    b. If the youth has not been able to keep up, how far behind is he/she? What are some of the challenges the youth has faced that has caused him/her to fall behind?

ENGAGEMENT AND TEAM PREPARATION PHASE

6. How was wraparound/*Safe at Home* first explained to the youth and his/her family?
    a. Who was responsible for doing that?
    b. What information was shared with them?
    c. Did they seem to have a good understanding of how services will be coordinated? If no, why?

7. To what extent were the youth and his/her family encouraged to discuss their concerns, hopes, dreams, and strengths?
    a. How did you get the youth/family to share with you?
    b. Did the youth/family struggle when opening up to you? If yes, how did you work to engage them?
    c. How did other team members play a role in this initial engagement phase?

8. Did the youth and his/her family identify people they wanted to be involved in the wraparound process?
    a. If yes, who were those people *(e.g., relational responses such as, brother, teacher, friend, therapist, etc.)*?
    b. If yes, to what extent have they actually participated?
    c. What efforts did you make to ensure that they would participate?

INITIAL PLAN DEVELOPMENT PHASE

9. When you create wraparound plans, how do you involve the youth and his/her family?
    a. How are family supports involved in creating the plan?
    b. If it is difficult to get the youth/family to participate in this process, what strategies do you use to engage them?

10. How do you use the CANS in developing wraparound plans?
    a. Do you face any challenges in completing the CANS? If yes, what are the challenges and how do you address them?

11. What are the essential features of plans and/or goals for the youth and family through *Safe at Home*?

12. What was the youth and family's level of involvement in crisis safety planning?
    a. What is your role in developing the crisis safety plan?
    b. How do others provide support in case of a crisis?
    c. How helpful has the crisis safety plan been in meeting the needs of the youth and family?

13. How do you get the youth to be an active participant in decisions about services throughout the wraparound process?

14. To what extent has the youth and family engaged with the program?
    a. What strategies do you use to keep the youth and family engaged?
    b. In what ways could youth and family engagement be improved?

PLAN IMPLEMENTATION PHASE

15. How often do you meet with the youth and their family?
    a. Is this amount of contact adequate? Too much? Too little?

16. What services have the youth actually received so far through *Safe at Home*?
    a. Formal services?
    b. Informal services/supports?

17. Have there been any barriers in trying to obtain services for the youth?
    a. If so, for which services have this been a struggle?
    b. If so, how did you work to overcome this challenge?

18. How do you help the youth/family identify success and/or progress?
    a. What are the successes so far?
    b. Do you do anything in particular to recognize and/or reward success?
    c. What are the challenges and what steps are being taken to overcome them?

19. How do you help to ensure that relatives, friends, and others are remaining involved and providing support to the youth and his/her family?

20. How are you monitoring the progress being made toward reaching the youth's and family's goals?
    a. How do you ensure that progress is actually being made if the youth and family are struggling?

TRANSITION PHASE

21. Is this case closed for *Safe at Home*?
    a. If so, what was the reason for case closure?
    b. If the reason for closure was positive, how did you know that the youth and family were ready for transition?
    c. If the reason for closure was negative, was there anything that could have been done to change the outcome of this case? If so, what?

Questions 22 through 24 only apply to closed or inactive cases.

22. Did you hold a final meeting and/or a celebration/graduation service to recognize completion of *Safe at Home*?
    a. If yes, what happened?
    b. If yes, what kind of information was shared?

23. Did you present a record of work completed with the accomplishments that the youth has made?
    a. If yes, what did the record contain?
    b. If no, do you feel this would have been beneficial for the youth to receive?

24. Did you provide information on where the youth and his/her family can go for help in the future?
    a. If yes, what information was given to them?
    b. If no, was any transition information given to them?

CONCLUSION

25. Overall, what has worked well with this case and contributed to its success?

26. What have been the barriers to success? What do you think could have been done differently to overcome those barriers?

27. Would you recommend any changes for future *Safe at Home* cases?

Appendix D

Statistical Similarity of Treatment and Comparison Groups

Measure	Significance Cohort I	Significance Cohort II	Significance Cohort III	Test
Gender	0.593	0.780	0.436	Chi-Squared
Hispanic	0.186	0.650	0.689	Chi-Squared
Black	0.583	0.708	0.630	Chi-Squared
UTD	1.000	1.000	1.000	Chi-Squared
White	0.883	0.765	0.763	Chi-Squared
NHOPI	0.969	0.156	0.317	Chi-Squared
Asian	0.956	1.000	0.317	Chi-Squared
AIAN	1.000	1.000	1.000	Chi-Squared
AsianPI	1.000	1.000	1.000	Chi-Squared
Unknown Race	0.530	1.000	0.476	Chi-Squared
Declined	1.000	1.000	1.000	Chi-Squared
Placement Type	0.999	0.814	0.326	Chi-Squared
Parent Jail	0.530	0.067	0.563	Chi-Squared
Abandonment	1.000	1.000	0.082	Chi-Squared
Child Alcohol	1.000	1.000	0.317	Chi-Squared
Parent Alcohol	0.594	0.703	1.000	Chi-Squared
Caretaker Unable to Cope	0.303	1.000	0.316	Chi-Squared
Child Behavior	0.454	0.926	0.739	Chi-Squared
Child Disability	0.340	1.000	1.000	Chi-Squared
Parent Death	1.000	1.000	0.563	Chi-Squared
Child Drugs	0.522	1.000	0.325	Chi-Squared
Parent Drugs	0.405	0.382	0.649	Chi-Squared
Housing	0.340	0.703	0.737	Chi-Squared
Neglect	0.524	0.563	0.862	Chi-Squared
Physical Abuse	0.854	0.413	1.000	Chi-Squared
Relinquishment	0.969	1.000	1.000	Chi-Squared
Sexual Abuse	0.608	0.587	1.000	Chi-Squared
Voluntary	0.340	0.154	1.000	Chi-Squared
Other	1.000	1.000	1.000	Chi-Squared
Number of Placements	0.219	0.335	0.605	Chi-Squared
Axis I Diagnosis	0.804	0.847	0.677	Chi-Squared
Juvenile Justice Involved	0.839	0.860	0.253	Chi-Squared
GAF	0.389	0.449	0.304	Chi-Squared
Removal	0.844	0.114	0.318	Chi-Squared
Jail	0.847	0.843	0.530	Chi-Squared
Psychiatric Hospital	0.408	0.568	0.157	Chi-Squared

Measure	Significance Cohort I	Significance Cohort II	Significance Cohort III	Test
Group Home	0.882	0.576	0.933	Chi-Squared
Age at Referral	0.823	0.085	0.534	One Way ANOVA
Years Since Case Opening	0.481	0.205	0.169	One Way ANOVA

Appendix E

Number of Youth with an Actionable Item/Need on the Initial CANS

CANS Domain	CANS Item	Cohort I (N=86)	Cohort II (N=167)	Cohort III (N=209)
Child Behavioral/Emotional Needs	Affective and/or Physiological Disregulation	10	16	15
	Anger Control	48	51	65
	Anxiety	13	37	38
	Attachment Difficulties	10	17	13
	Attention/Concentration	42	63	64
	Conduct	21	28	33
	Depression	18	51	50
	Eating Disturbances	2	5	0
	Impulsivity	33	50	49
	Oppositional Behavior	35	66	55
	Psychosis	2	7	4
	Somatization	0	2	1
	Substance Use	9	16	11
	Total	**70**	**128**	**142**
Child Risk Behaviors	Bullying	6	12	17
	Cruelty to Animals	0	3	2
	Danger to Others	15	24	34
	Delinquency	2	8	12
	Exploitation	1	0	7
	Fire Setting	1	2	3
	Intentional Misbehavior	13	17	19
	Non-Suicidal Self Injury	8	11	8
	Other Self Harm	5	10	3
	Runaway	5	22	25
	Sexualized Behaviors	8	11	2
	Sexually Abusive	1	2	4
	Suicide Risk	4	13	6
	Total	**41**	**71**	**79**
Life Domain Functioning	Brain Injury	2	0	4
	Child Involvement with Care	15	25	32
	Daily Functioning	8	6	10
	Developmental/Intellectual	17	26	27
	Family	33	72	66
	Legal	50	84	122
	Living Situation	18	47	45

CANS Domain	CANS Item	Cohort I (N=86)	Cohort II (N=167)	Cohort III (N=209)
	Medical	7	11	10
	Medication Compliance	9	9	16
	Natural Supports	42	86	68
	Physical	2	1	0
	Recreational	18	34	54
	School Achievement	20	44	73
	School Attendance	14	31	49
	School Behavior	31	50	54
	Sexual Development	5	8	9
	Sleep	16	23	22
	Social Functioning	29	45	47
	Substance Exposure	10	17	15
	Total	**78**	**151**	**187**
Trauma Stress Symptoms	Adjustment to Trauma	29	56	37
	Avoidance	7	11	13
	Dissociation	2	7	3
	Hyperarousal	17	34	31
	Numbing	5	2	12
	Re-experiencing	5	15	9
	Traumatic Grief	8	22	21
	Total	**41**	**73**	**58**