WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia

Strengthening families & children within their home communities

Semi-Annual Progress Report

October 1, 2017 – March 31, 2018

West Virginia Department of
Health and Human Resources

Bureau for Children and Families

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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

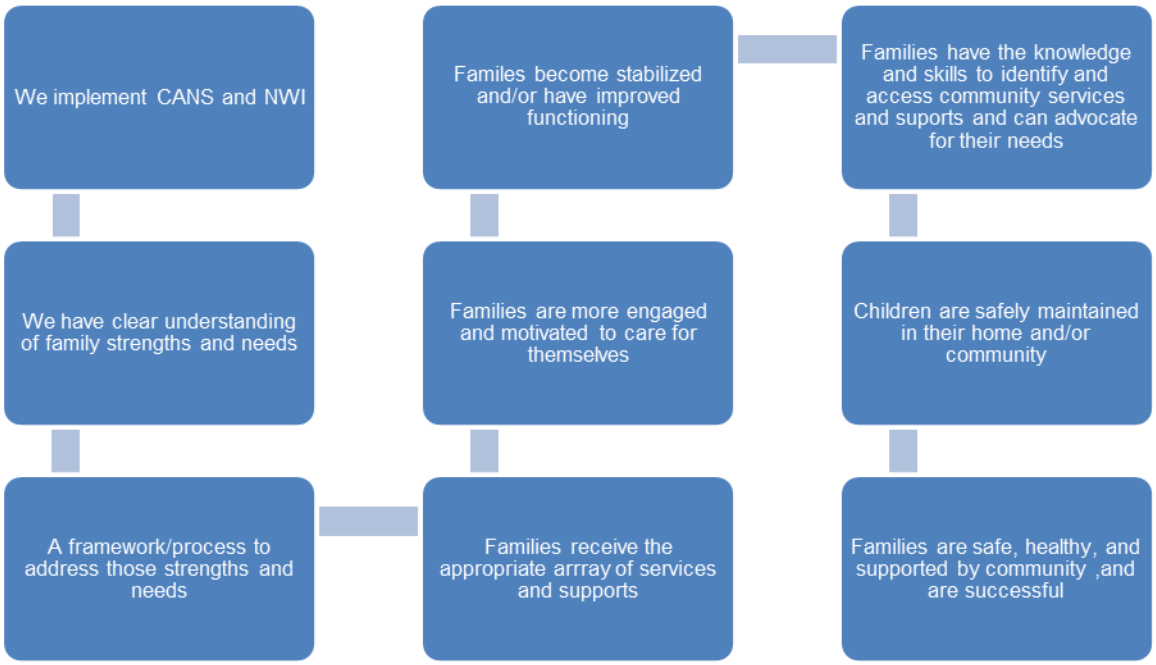
So that

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.

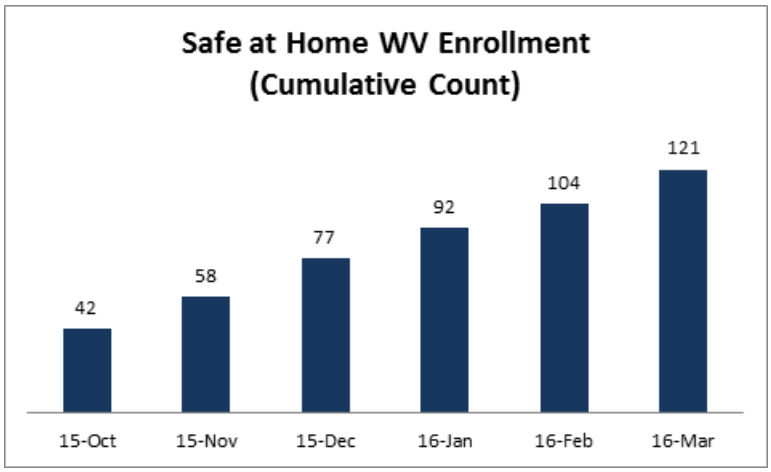
On August 1, 2016, West Virginia began Phase 2 of implementation by expanding to the 24 counties of Barbour, Brooke, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Lewis, Marion, Mineral, Mercer, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Pocahontas, Preston, Randolph, Summers, Taylor, Tucker,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

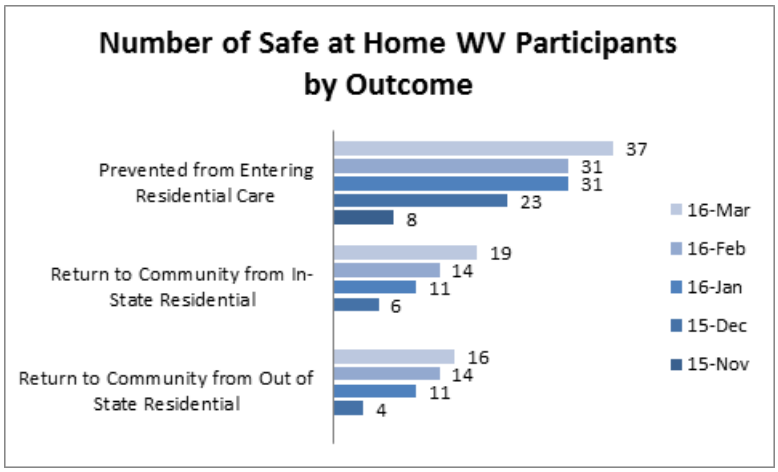
On April 1, 2017, West Virginia began Phase 3 of implementation by expanding to the remaining 20 counties of; Braxton, Clay, Jackson, Roane, Ritchie, Doddridge, Pleasants, Wood, Marshall, Tyler, Wetzel, Calhoun, Gilmer, Wirt, Fayette, Raleigh, McDowell, Wyoming, Mingo, and Webster. This phase brought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

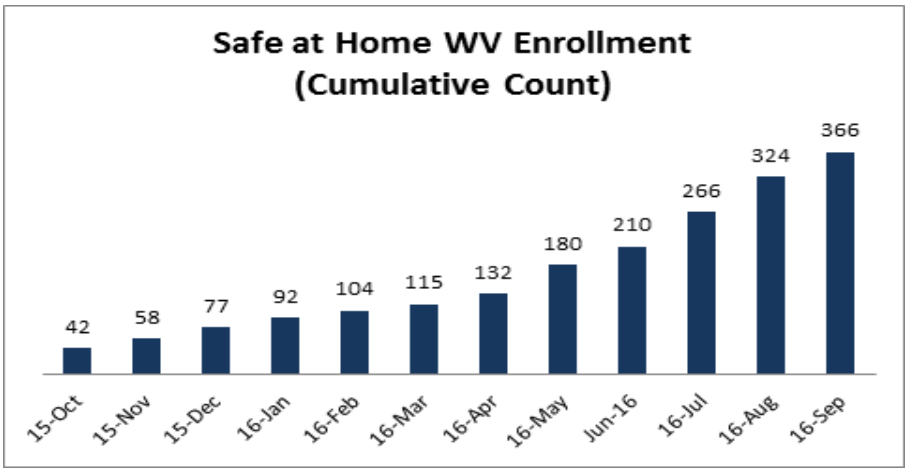
As of March 31, 2018, 1,783 youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 73 youth from out-of-state residential placement back to West Virginia, 223 Youth have stepped down from in-state residential placement to their communities, and 26 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 1,120 at risk youth.

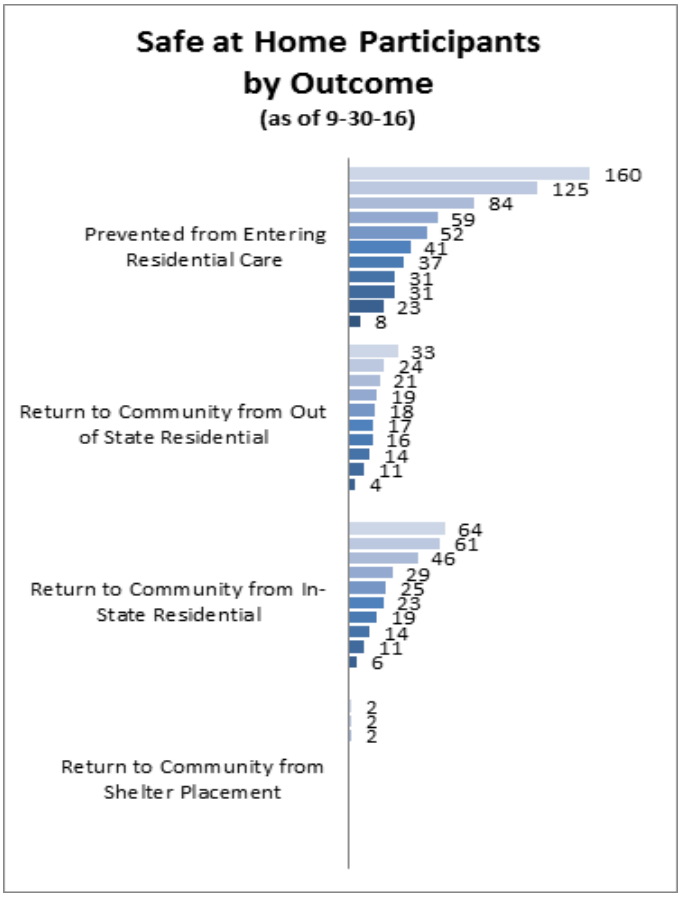
The breakdown of placement type at time of enrollment is as follows:

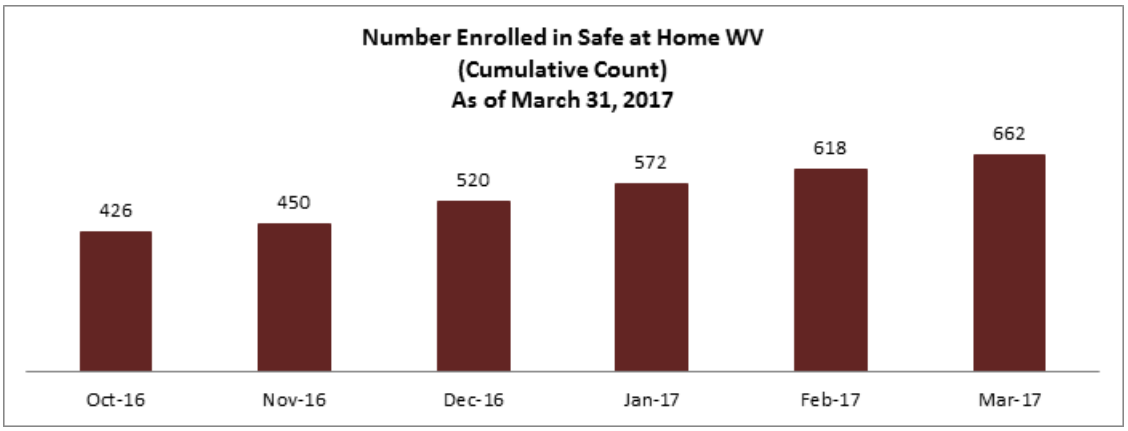
- 106 were or are in out-of-state residential placement at time of enrollment with 73 returning to WV
- 344 were or are in in-state residential placement at time of enrollment with 223 returning to community
- 1,277 were or are prevention cases at time of enrollment with only 157 entering residential placement
- 56 were or are in an emergency shelter placement at time of enrollment with 26 returning to their community

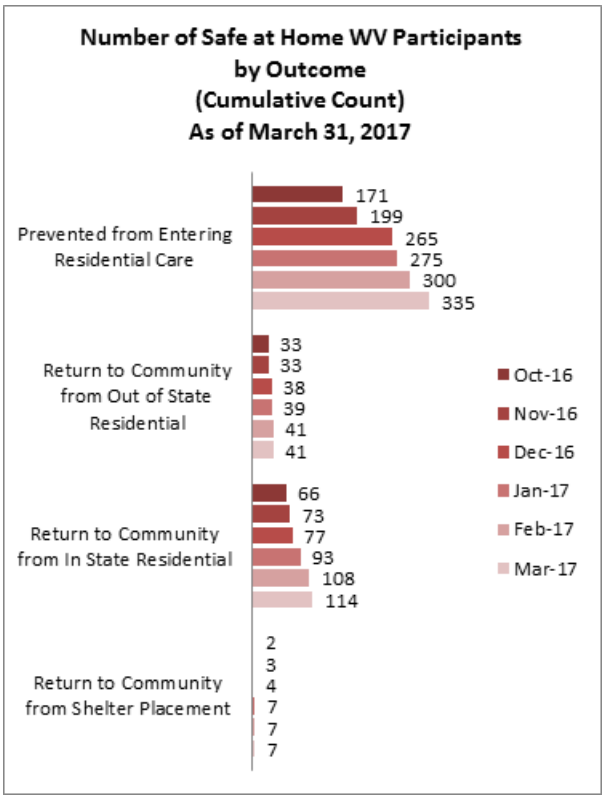

Safe at Home WV Enrollment
(Cumulative Count)
42
58
77
92
104
121
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar

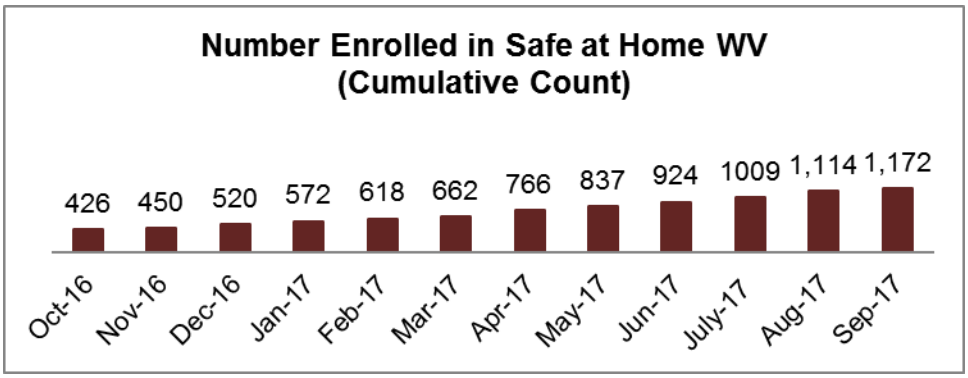

Number of Safe at Home WV Participants
by Outcome
Prevented from Entering Residential Care
37
31
31
23
8
Return to Community from In-State Residential
19
14
11
6
Return to Community from Out of State Residential
16
14
11
4
16-Mar
16-Feb
16-Jan
15-Dec
15-Nov

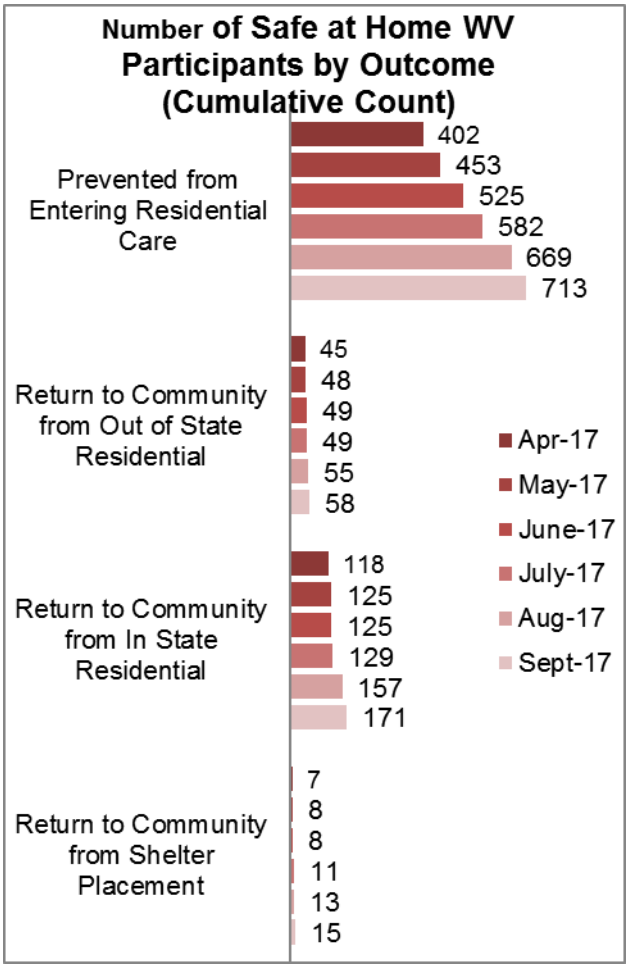

Safe at Home WV Enrollment
(Cumulative Count)
42
58
77
92
104
115
132
180
210
266
324
366
15-Oct
15-Nov
15-Dec
16-Jan
16-Feb
16-Mar
16-Apr
16-May
Jun-16
16-Jul
16-Aug
16-Sep

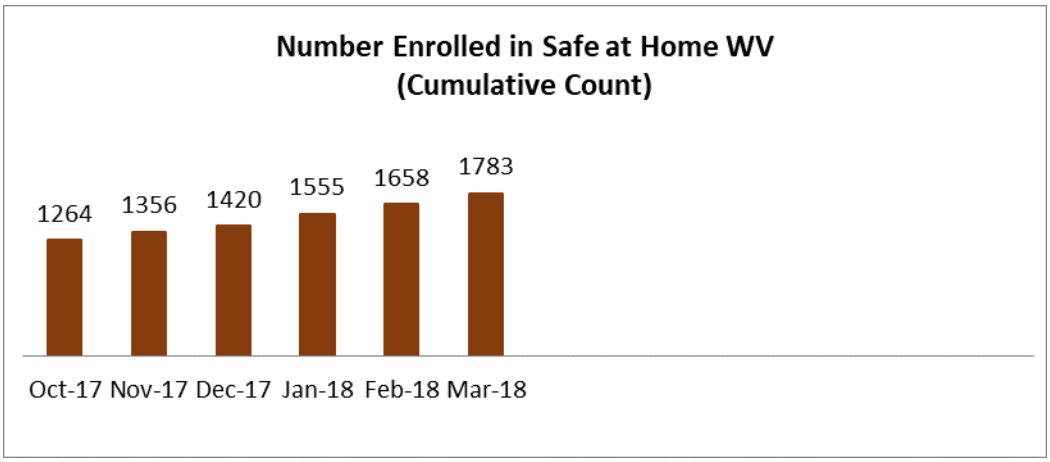

Safe at Home Participants
by Outcome
(as of 9-30-16)
Prevented from Entering Residential Care
160
125
84
59
52
41
37
31
31
23
8
Return to Community from Out of State Residential
33
24
21
19
18
17
16
14
11
4
Return to Community from In-State Residential
64
61
46
29
25
23
19
14
11
6
Return to Community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

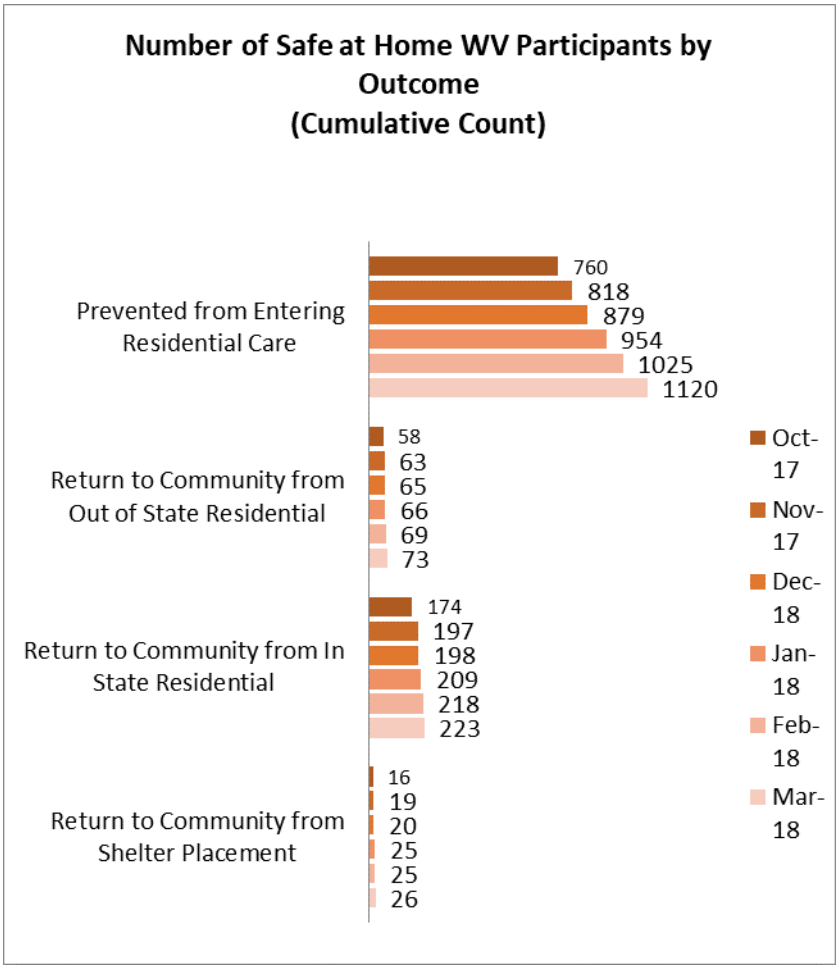

Number Enrolled in Safe at Home WV
(Cumulative Count)
As of March 31, 2017
426
450
520
572
618
662
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17


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


Number Enrolled in Safe at Home WV
(Cumulative Count)
1264
1356
1420
1555
1658
1783
Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18


Number of Safe at Home WV Participants by Outcome
(Cumulative Count)
Prevented from Entering Residential Care
760
818
879
954
1025
1120
Return to Community from Out of State Residential
58
63
65
66
69
73
Return to Community from In State Residential
174
197
198
209
218
223
Return to Community from Shelter Placement
16
19
20
25
25
26
Oct-17
Nov-17
Dec-18
Jan-18
Feb-18
Mar-18

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 quarterly newsletter that reaches all of our staff and external partners, conducted presentations across the state as well as media interviews and private meetings with partners. These activities continue as specific to each phase of implementation and sustaining. Our newsletters now reach over 1,000 partners. All program materials, newsletters, as well as other pertinent information are posted on our website for public viewing and use.

During the previous reporting period, West Virginia implemented the recommendations of our evaluator.

- Recommendation 1: Increase DHHR staff survey response rate.
    - West Virginia queried the BCF management team about survey participation and found that many had not received the survey notification. West Virginia then worked with our evaluator to determine the root cause of the lack of staff completing the survey. It was determined that the email process being used to send the notification of the survey and link came from the evaluators IT department with a different email address. This caused West Virginia's email system to block it as junk or spam. In cases where the email did get to staff, the staff deleted due to the odd email address. West Virginia and our evaluator worked on a process for notifying and sending the surveys that has alleviated the issue.

- Recommendation 2: Further Explore how to help youth/families build their natural support systems.
    - West Virginia and our Local Coordinating Agencies have discussed this at length and believe this is something that can be supported by deeper engagement with the families and youth. West Virginia is a very rural Appalachian state with deep roots in Celtic clan cultures. The isolation and culture does not naturally lend itself to trusting others. This is something that can only be overcome through true engagement and trust.
- Recommendation 3: Work with LCAs unable to meet the required timeframes for assessments and plans.
    - This included working with the Local Coordinating Agencies on the development of Plans for Improvement to address any deficiencies noted in the fidelity reviews conducted last reporting period. West Virginia's evaluator provided West Virginia with detailed fidelity review reports for each of the Local Coordinating Agencies. The reports were provided to the LCA's as well as a letter that outlined specific areas that should be addressed within an Plan for Improvement. Along with the fidelity reviews conducted by the evaluator WV also conducted a review of the monthly provider report, the outcomes of that review were also provided to the LCA's to assist with improvements.

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.

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 one-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

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

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

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

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

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

772 DHHR staff have been trained in CANS. 31 new Youth Service Workers have been trained during this reporting period. This ongoing training continues as planned.

During this reporting period 435 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 found that staff were having difficulty accessing advanced CANS experts to provide technical assistance. To address this Dr. Lyons came to West Virginia and spent a week with staff identified to go through the advanced CANS experts process. He also provides ongoing technical assistance calls with the experts to continue the development process. The goal has always been to have the internal capacity within West Virginia to continue this process and the transferring of learning. We believe that with the assistance of the current experts and Dr. Lyons we will have no difficulty proceeding as planned. At present, we have 10 ACES and 42 CANS Experts providing certification training and technical assistance throughout the state.

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

There are no significant changes in the design of our interventions to date but there have been innovations. 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.

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

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

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

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.

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

During this reporting period BHHF continued with its Children's Behavioral Health Wraparound. In March 2016, the Bureau for Behavioral Health and Health Facilities (BHHF) released a Request for Applications for Grants for Local Coordinating Agencies to hire Wraparound Facilitators to serve 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 171 referrals, 74 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.

We continue working with our partners in Positive Behavioral Support Program. They are assisting us with engagement and trainings in using the MAPs process. MAPs 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. The first such training is scheduled for April 12, 2018.

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.

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 have continued work on determining necessary financial information that will be needed and used by other workgroups to inform any program adjustments. This group received Technical Assistance through Casey Family Programs as well as our evaluator. Financial planning also affords West Virginia the needed information to determine level of service and commitment needed to continue with this valuable program and to assist with the development of any needed improvement packages determined to be appropriate.

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

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

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

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

III. Evaluation Status

Data Collection Activities:

During the most recent six-month evaluation period following the implementation of Safe at Home West Virginia, the evaluator, Hornby Zeller Associates, Inc. (HZA), conducted interviews with key stakeholders across the State and re-administered the Department of Health and Human Resources (DHHR) staff fidelity survey statewide. Additional analysis of data from DHHR's Statewide Automated Child Welfare Information System (SACWIS), FACTS, informed the outcome, process and cost evaluations. In addition to FACTS data, the outcome evaluation also utilizes data from the automated Child and Adolescent Needs and Strengths (CANS) tool. All data collection activities are discussed in greater detail below.

Interviews

Staff from HZA returned to West Virginia during the week of November 13-17, 2017 to conduct annual process interviews with key stakeholders to learn about any strategic and practice changes that may have occurred, to discuss any ongoing training efforts or changes made to training and to learn about the successes and challenges experienced by stakeholders in implementing Safe at Home. Interviews were conducted with a total of 73 stakeholders, inclusive of DHHR central and regional office staff, community services managers (CSMs), supervisors and caseworkers; staff from local coordinating agencies (LCAs), including Safe at Home program directors, wraparound supervisors and wraparound facilitators; and judges. Table 1 displays the number of stakeholders interviewed by type.

Table 1. Number of Stakeholders Interviewed by Staff Type	
DHHR	
Central Office Staff	6
Regional Office Staff	6
Community Services Managers	8
Supervisors	10
Caseworkers	16

Table 1. Number of Stakeholders Interviewed by Staff Type	
LCA	
Program Directors	5
Wraparound Supervisors	5
Wraparound Facilitators	11
Judicial	
Judges	6
Total	**73**

Surveys

During the previous reporting period (e.g., October 2017), HZA administered the annual fidelity survey to DHHR staff (e.g., CSMs, supervisors and caseworkers) from Phase I implementation counties. Since only seven responses were received, the data were not considered valid for reporting. HZA worked with the State and developed a work plan to re-administer the survey to DHHR staff for this April 2018 reporting period, in the hopes of eliciting a greater response rate. The plan included:

- a messaging effort from both the State and HZA to higher level DHHR staff (e.g., deputy commissioners and regional directors) prior to the survey's administration asking them to support these efforts;
- expansion of the survey to a statewide DHHR staff pool as opposed to pools defined by county implementation phase;
- programming and technical revisions to the online survey to ensure the survey was as user-friendly as possible;
- personal emails to each CSM from HZA describing the importance of survey participation for feedback on Safe at Home, with a link to the survey and instructions for forwarding the message on to their casework and supervisory staff; and
- daily monitoring of the survey response rate by county where HZA staff followed up with CSMs whenever there was little to no response.

As a result of these efforts 85 DHHR staff completed the survey. The breakdown of survey

respondents by staff position is available in Table 2. Staff from the "Other" category included an intake worker and two social services coordinators.

Table 2. Number of DHHR Staff Surveyed by Position	
Community Services Managers	11
Supervisors	16
Caseworkers	55
Other	3
Total	**85**

FACTS

HZA uses data from West Virginia's FACTS to measure the extent to which Safe at Home's goals are achieved (e.g., reduced placement in congregate care, fewer initial entries into congregate care, length of time spent in congregate care, etc.). Outcomes for youth involved in Safe at Home are compared to an historical comparison group of youth. The comparison groups (which are selected 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. Characteristics, including demographic data, case history and program qualifying characteristics, such as involvement in mental health and juvenile justice systems, were used to match comparison youth to the treatment group cohorts. Youth in the treatment group were partitioned into five subgroups according to referral and placement type: out-of-state congregate care facilities and group care, in-state congregate care facilities and group care, emergency shelter, family foster care placements and youth at home. The characteristics of youth in each comparison group are statistically similar to the youth in each of the four[2] treatment cohorts (see Appendix A for the statistical comparisons).

For this report, the outcome analysis has been updated to include regression analyses on a number of population-based factors (e.g., youth involvement in juvenile justice systems,

[2] HZA has not created the comparison pool for the most recent cohort because not enough time has elapsed to measure outcomes for these youth. Therefore, six-month outcomes will be available for the fifth cohort for the October 2018 semi-annual evaluation report.

youth age, type of placement at referral, etc.) with the goal of identifying the specific youth population(s) for whom Safe at Home works best.

CANS

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. The online CANS tool also provides the evaluation team with ready access to assessment data which are used to measure progress on well-being measures. Each youth who enters Safe at Home is required to have an initial CANS assessment completed by the wraparound facilitator within 30 days of referral to the program, and subsequent CANS assessments are to be completed every 90 days thereafter.

IV. Significant Evaluation Findings to Date

Process Evaluation Results

Youth Population Description

Table 3 provides a description of the Safe at Home youth population at the time of referral. Overall, 67 percent of the youth referred to Safe at Home were living in their own homes at the time of referral. Youth placed in a congregate care setting at the time of referral comprised 56 percent of Cohort I youth but only 14 percent of those in Cohort V. 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. As time has gone on DHHR and LCA staff and judges have reported observing more success with prevention-based cases and believe these youth hold the highest probability for success with the program.

Table 3. Safe at Home Youth Population Description at Referral

	Cohort I	Cohort II	Cohort III	Cohort IV	Cohort V
Placement					
Total	**124**	**221**	**297**	**445**	**457**
Out-of-state Congregate Care	31 (25%)	18 (8%)	12 (4%)	12 (3%)	13 (3%)
In-state Congregate Care	39 (31%)	73 (33%)	61 (21%)	60 (13%)	50 (11%)
Emergency Shelter	6 (5%)	18 (8%)	6 (2%)	13 (3%)	19 (4%)
Family Foster Care	2 (2%)	11 (5%)	13 (4%)	27 (6%)	29 (6%)
Home	46 (37%)	101 (46%)	205 (69%)	333 (75%)	346 (76%)
Age					
12 or less	10 (8%)	19 (9%)	25 (8%)	37 (8%)	55 (12%)
13	20 (16%)	26 (12%)	35 (12%)	64 (14%)	71 (16%)
14	30 (24%)	48 (22%)	67 (23%)	87 (20%)	92 (20%)

Table 3. Safe at Home Youth Population Description at Referral					
	Cohort I	**Cohort II**	**Cohort III**	**Cohort IV**	**Cohort V**
15	28 (23%)	58 (26%)	65 (22%)	135 (30%)	108 (24%)
16	32 (26%)	63 (29%)	92 (31%)	103 (23%)	106 (23%)
17	4 (3%)	7 (3%)	13 (4%)	19 (4%)	25 (5%)
Gender					
Male	75 (60%)	116 (52%)	186 (63%)	274 (62%)	267 (58%)
Female	49 (40%)	105 (48%)	111 (37%)	171 (38%)	190 (42%)
Race/Ethnicity					
White	96 (77%)	181 (82%)	245 (82%)	405 (91%)	390 (85%)
Black	8 (6%)	19 (9%)	15 (5%)	14 (3%)	22 (5%)
Mixed	16 (13%)	18 (8%)	32 (11%)	20 (4%)	33 (7%)
Other	4 (3%)	3 (1%)	5 (2%)	6 (1%)	12 (3%)
Systems Involvement					
Juvenile Justice	42 (34%)	16 (7%)	20 (7%)	16 (4%)	10 (2%)
Substance Abuse					
Yes	9 (7%)	15 (7%)	9 (3%)	16 (4%)	22 (5%)
No	115 (93%)	206 (93%)	288 (97%)	429 (96%)	435 (95%)
Mental Health Diagnoses[3]					
Behavioral Disorders[4]	88 (71%)	111 (50%)	113 (38%)	117 (26%)	92 (20%)

[3] Mental health diagnoses are examined prior to placement for youth who have been in placement or following referral for those youth in the prevention category who have never been in placement.

[4] Includes diagnoses such as Oppositional Defiant Disorder, Conduct Disorder, Attention Deficit and Hyperactivity

Table 3. Safe at Home Youth Population Description at Referral					
	Cohort I	Cohort II	Cohort III	Cohort IV	Cohort V
Psychiatric Disorders[5]	28 (23%)	42 (19%)	45 (15%)	41 (9%)	33 (7%)
Youth with Possible Mental Health Diagnoses[6]	32 (26%)	95 (43%)	172 (58%)	317 (71%)	354 (77%)

Youth referred to Safe at Home are typically between the ages of 14 and 16, male, and white. The goal of Safe at Home has shifted to focus on prevention, therefore the initial placement settings of youth have transitioned from predominately removed from their home to predominately remaining in their home. Furthermore, the percentage of youth with juvenile justice involvement or a behavioral or psychiatric disorder has decreased consistently from Cohort I to Cohort V. Possible mental health diagnosis is not listed in FACTS, however, because part of the Safe at Home criteria is youth should have a possible mental health diagnosis, any youth without a behavioral or psychiatric disorder are deemed to have a possible diagnosis.

DHHR supervisors and caseworkers and LCA staff who were interviewed reported that most Safe at Home cases were predominantly involved in one system—juvenile justice, which is consistent with the target group for the program, i.e., those 12 to 17. Given the decreasing population of youth involved with the juvenile justice system in Table 3, it is possible the interviews are not giving an accurate picture of the populations involved in Safe at Home. For those involved in the juvenile justice system, truancy and incorrigibility were identified by DHHR staff as the main issues, followed by delinquency. Some stakeholders reported that Safe at Home cases came from child welfare, behavioral health or a mix of all three systems.

Disorder, among others.

[5] Includes diagnoses such as Anxiety Disorder, Bipolar I and II Disorder, Major Depressive Disorder, Schizophrenia, among others.

[6] According to the State's Program Manual, referral criteria has been updated stating that youth in the prevention category now only need, "a *possible* [emphasis added] diagnosis of a severe emotional or behavioral disturbance, according to standardized diagnostic criteria, that impedes his or her daily functioning." Originally, all youth needed an official mental health diagnosis in order to participate in the program.

Planning Process, Communication and Program Oversight

Planning Process and Lessons Learned

Central office staff reported that there have not been any major changes in planning efforts among the three implementation phases.[7] In fact, nearly all central office staff (and all regional office staff who experienced multiple phases of implementation) agreed that with each new roll out, they had learned where improvement was needed and how to overcome the challenges, thus rendering only slight adjustments to programming necessary. Collaborative efforts and communication between DHHR central office staff and LCA program directors was identified as one key area that had continuously improved, leading to an overall easier implementation process as time went on. As one central office staff member said, "We have all worked together to meet difficult needs for special cases. All this collaboration has enabled us to develop a new bank of knowledge."

Half of central office staff reported that over time their involvement in the planning and development processes for Safe at Home had become less frequent since the program was now fully implemented statewide and, for the most part, running quite smoothly. For a couple of central office staff involved in the more day to day work for Safe at Home, roles had not changed much or even at all. A couple central office staff reported that their roles have now shifted from implementation planning and direct program oversight to program sustainability planning following the end of the Waiver demonstration period in September 2019.

Central office staff indicated that stakeholders from Phase III implementation counties were prepared for Safe at Home's implementation in primarily the same way as staff from counties in the other two implementation phases. One person said that a key difference in Phases II and III was that the preparation periods were less rushed for staff than had been the case in Phase I. Another reported that staff from Phases I and II met with staff from Phase III to share their experiences about what worked well and what the challenges were with their implementations so that similar mistakes would not be repeated.

[7] Phase I implementation rolled out October 1, 2015 and included 11 counties (eight from Region II and three from Region III). Phase II began August 1, 2016 and brought on an additional 24 counties, which was comprised of a mixture of counties from all four of the State's service regions. Phase III implementation brought the initiative statewide by adding the remaining 20 counties on April 1, 2017.

Regional office staff reported that their involvement in the planning process was mainly in preparing the region's staff and stakeholders for the implementation of Safe at Home. They reported that over time they learned the importance of keeping the lines of communication open, the need to educate stakeholders on an ongoing basis and the importance of actively working to keep community partners (e.g., courts, schools, other service providers, etc.) engaged.

Communication and Oversight

DHHR's Facebook, Twitter and Safe at Home website are available to the general public, so anyone who would like to learn more about the program can do so. Additionally, anyone can subscribe to Safe at Home's regular "email blasts." The email blasts provide general information about Safe at Home and include a wide variety of topics, such as updates (e.g., quarterly newsletters) and educational snippets on the wraparound model. More detailed information about the program is provided, and regularly updated, on the Safe at Home website by central office staff. A few of the items found on the website include: program and policy manuals geared toward a variety of audiences, including DHHR and LCA staff as well as youth and families; a frequently asked questions document; forms and tools for DHHR and LCA staff ongoing use; and the semi-annual evaluation reports.

Central office staff reported that presentations about Safe at Home are given to any interested stakeholder whenever they are requested. For example, one central office staff member shared, "Next week we are presenting at a probation officer conference." Regular collaborative and regional summit meetings also offer opportunities for any and all community partners to come together and share their ideas on how to meet client needs and address the current service gaps throughout the State.

As part of the early communication efforts for Safe at Home, program leaders worked to establish communication with judges and other court staff in order to educate them about the program and obtain their buy-in. However, central office staff reported that they learned after Phase I that their initial outreach efforts were not sufficient. Therefore, a combined communication plan was created for CSMs and LCA program directors to use with the judges in their areas.

The Safe at Home project director sent out preparation materials to CSMs two and a half months prior to roll out. CSMs and LCA program directors worked together to implement the combined communication plans by meeting with judges to prepare them for the program. They would also meet with other community partners as well if requested or necessary.

Meeting with judges was already a regular part of CSMs' work and the combined communication plan now added LCA program directors to some of these meetings in order to discuss Safe at Home with judges in more detail.

In addition to the outreach provided by CSMs and LCA program directors regarding Safe at Home, sometimes the Safe at Home project director and regional office staff also hold private meetings with judges, particularly if concerns about the program had been voiced. However, there are a few judges who have voiced concerns about Safe at Home and declined invitations to meet. Some central office staff also reported regularly attending the Court Improvement Program (CIP) meetings where Safe at Home would often be presented on or, at the very least, discussed. One example of a Safe at Home presentation at a CIP meeting would be the October 2017 CIP meeting, where DHHR central office staff asked for HZA staff to present Safe at Home evaluation findings to judges and other court staff from across the State.

DHHR already had its own internal management structure and communication procedures established prior to the program's implementation, so communication related to Safe at Home has, for the most part, been relatively intuitive and straightforward for DHHR staff. Central office staff do not regularly interact with county level staff beyond sending general emails with policy or program updates. Regarding the types of interaction regional office staff have with central office staff, regional office staff reported that they submit weekly tracking logs on Safe at Home cases and receive updates about the program through statewide meetings (which are then disseminated to their staff within the region's counties). Staff reported that the Safe at Home project director holds the primarily responsibility for working directly with regional office staff if any major issues arise with the program, and that she also works with them on a more ongoing basis to track cases at a regional level and monitor the amount and quality of referrals coming in.

Regional office staff provide closer oversight of staff at the county-level, mainly through the supervision of CSMs. Regional directors reported that they often communicate with CSMs regarding Safe at Home, and then CSMs pass along any information to supervisors and/or caseworkers within their county (or counties). Some regional directors indicated that Safe at Home is regularly discussed with CSMs in their monthly management meetings. Regional program managers reported that their role is primarily about being "the gatekeeper for referrals," where they approve or deny all referrals sent by supervisory and/or casework staff from all of the counties within the region. CSMs reported that they provide direct oversight of supervisors and caseworkers and only involve regional office staff when problems cannot be resolved at the local level. Both regional office staff and CSMs agreed that over time, they have

not needed to be as hands on in their involvement with subordinate staff regarding Safe at Home.

The most direct communication and oversight for DHHR caseworkers comes from their supervisors. Caseworkers and supervisors reported that they follow the regular chain of command if they are having issues with Safe at Home that they cannot resolve independently; how far up the DHHR management chain they needed to go was dependent upon the severity of the issue. Caseworkers started by trying to address issues with their direct supervisors, then included LCA facilitators and wraparound supervisors as necessary. If issues could not be resolved by these parties, then CSMs and LCA program directors would become involved. If issues could still not be resolved on a local/county level, then regional program managers and regional directors would become involved, and the most severe issues were addressed with the Safe at Home project director. Nearly all supervisors and caseworkers reported that when issues did come up, they were resolved; only two DHHR county-level staff reported that issues remained outstanding.

Most LCA staff reported that they have constant communication with county level DHHR staff about Safe at Home cases, with a few further sharing that they work closely as a team with DHHR. LCA staff reported sending monthly summaries to DHHR on each Safe at Home case, conducting monthly meetings with the youth and family which DHHR staff would often attend and that DHHR staff would make themselves available whenever issues arose. A few LCA staff stated that it was hard to keep DHHR staff involved due to their busy schedules and one stated that the level of participation and communication depended upon the county. LCA program directors reported that DHHR central and regional office staff are very responsive and easy to reach. Additionally, higher level LCA staff reported attending quarterly Safe at Home meetings hosted by central office staff. Nearly all LCA staff reported that whenever they have had issues, those issues have been resolved promptly.

The way central office staff monitor the work of LCAs has not changed for any of the implementation phases. The Safe at Home project director, regional directors and regional program managers provide ongoing monitoring and oversight of LCAs' work. The Safe at Home project director provides the most direct oversight, with communication with LCAs occurring on a near daily basis. LCAs are required to turn in weekly tracking logs for each Safe at Home case within their agency. The State uses the tracking logs to examine placement changes and to ensure, "LCAs are doing what they need to be doing." Additional monitoring includes HZA providing annual fidelity reviews to the State on each LCA for cases pulled into the statewide sample, and LCAs are required to complete their own grant reports. Whenever the State

notices issues with an LCA through these various sources, they work directly with the LCA to address it and will sometimes request a Program Improvement Plan (PIP) to be submitted. If the issues in the PIP are not resolved in a timely manner, then the State may terminate the contract with the LCA. The State can also perform additional audits on LCAs whenever deemed necessary.

Regional office and county-level staff also reported that they have their own processes for holding LCA staff accountable for their work. Some examples were that they too monitored the weekly reports LCAs provide on all Safe at Home cases, host monthly meetings between themselves and LCAs to staff cases and require LCAs to provide them with any additional information whenever it is requested. A few DHHR staff also reported that judges will sometimes hold LCA staff accountable for their work on each case by expecting regular updates on the work being conducted and the progress being made on Safe at Home cases in their courts.

Training

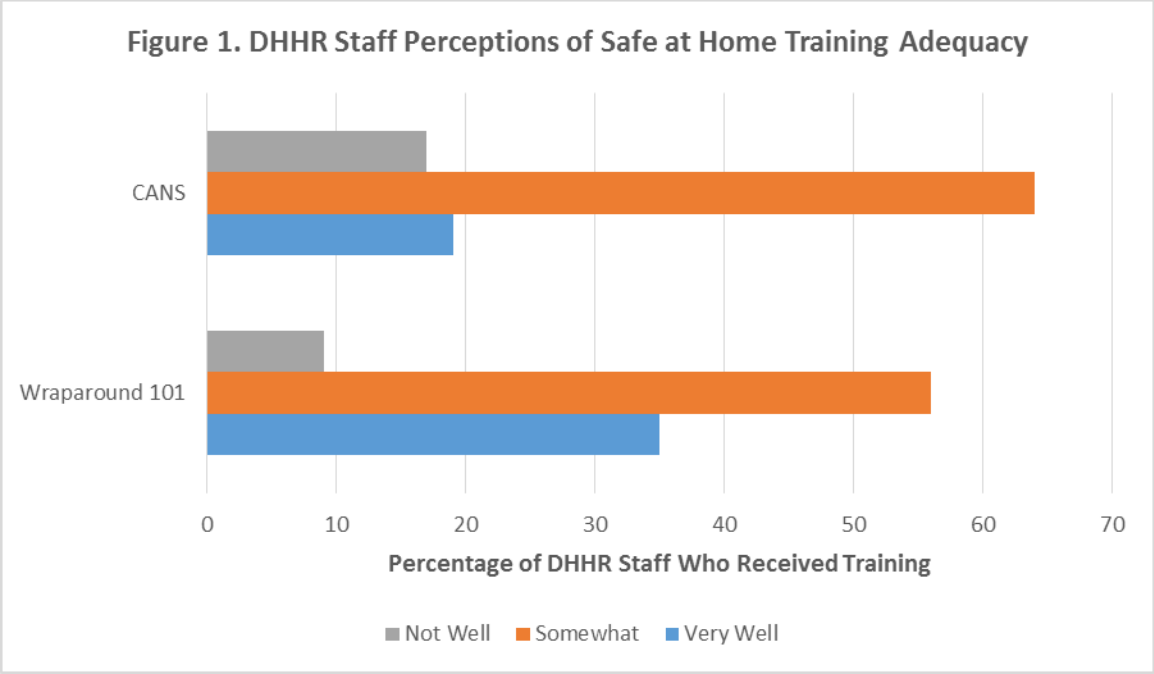
The inter-disciplinary service delivery workgroup originally designed and developed the Safe at Home trainings. Over time, LCA and DHHR staff have worked together and “tweaked” the trainings slightly to meet their needs. When asked how this inter-agency collaboration for training worked, one central office staff member said, "Quite frankly, I have felt the cooperation and partnership on this like I have never seen before."

Central office staff reported that training has ultimately not differed significantly for staff in each implementation phase, aside from efforts during early Phase I implementation to clarify caseworker vs. facilitator roles and responsibilities. The biggest and most recent change is in how the training is now delivered to DHHR staff. Safe at Home’s Wraparound 101 and CANS trainings are now incorporated into DHHR's standardized new worker training. This ensures that all new DHHR staff are trained on Safe at Home through the regular employee onboarding processes.

Of the 85 DHHR staff survey respondents, 82 percent reported that they had received training for Safe at Home.[8] Figure 1 shows the extent to which DHHR staff (caseworkers, supervisors and CSMs) who participated in the trainings, believed that the CANS and Wraparound 101 trainings prepared them for their role in the program. Most DHHR staff

[8] It is possible that the reaming 18 percent of staff were new and therefore had not yet been scheduled to complete training.

reported that Wraparound 101 and CANS training prepared them "Somewhat" or "Very Well" for their role in the program. DHHR staff satisfaction with training was a bit higher with the Wraparound 101 training.



Interview data were consistent with survey data regarding DHHR staff satisfaction with Safe at Home training. The vast majority of DHHR supervisors and caseworkers reported that the training for Safe at Home prepared them sufficiently for their role in the program. Many interviewees offered some suggestions for improving training, such as more details on the roles of DHHR and LCA staff, more clarity around what LCAs are and are not expected to do or pay for, training on building informal support systems and sustaining the family following Safe at Home closure, more role play and hands on work and general follow up training after implementation to address questions or problems. As one caseworker stated, "A refresher training detailing 'this is what we've learned, and this is what we've changed' would be helpful."

DHHR staff training needs are identified by DHHR central office staff in a couple of ways; one of which is through the feedback received from county-level staff. All staff are given surveys to fill out following participation in Safe at Home trainings, where they are asked to

share their opinions as to what they did not understand or would have liked to have learned more about. For example, staff were reporting role confusion between caseworkers and wraparound facilitators on the follow up surveys so a half day of training was added to the curriculum to address this specific topic. Another way training needs are identified by central office staff (for both DHHR and LCAs) is by looking at the quality of work being conducted with Safe at Home clients through the State's tracking logs and recognizing any problems in how Safe at Home is being implemented.

While DHHR staff must complete Wraparound 101 and CANS training for Safe at Home, LCA staff have a much more in-depth and intense level of training because they are the ones providing the direct Safe at Home/wraparound service to clients. Most recently, the Applied Wraparound training for LCA staff was adjusted to add more advanced material. Additional training requirements for LCA staff are outlined in past Request for Applications (RFAs) and include the following:

- 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.

In addition to the training required of LCA staff by the State, LCA staff reported that they also identify individual training needs within their agency and will often add more trainings for their staff in addition to what is minimally required. The amount and type of additional trainings added by LCAs varied by each agency according to its particular staff needs.

LCA staff had their own views on training and reported mixed responses as to how well their training has prepared them for their role in Safe at Home, with more staff agreeing that the training was adequate. LCA staff were more satisfied with the training offered internally than the State's training. Suggestions made by LCA staff to improve training included refreshers, more training on writing wraparound plans, training on documentation requirements and spending expectations and continued training on youth and family engagement.

Implementation

Program Understanding and Stakeholder Buy-In

All DHHR supervisors, caseworkers and LCA staff reported that they had an adequate understanding of both the goals of Safe at Home, and the methods employed to achieve those goals. They reported that the primary goal is to keep kids home or to get them back home (or at least back into the state or community) and shared that these goals are achieved through the use of wraparound services which:

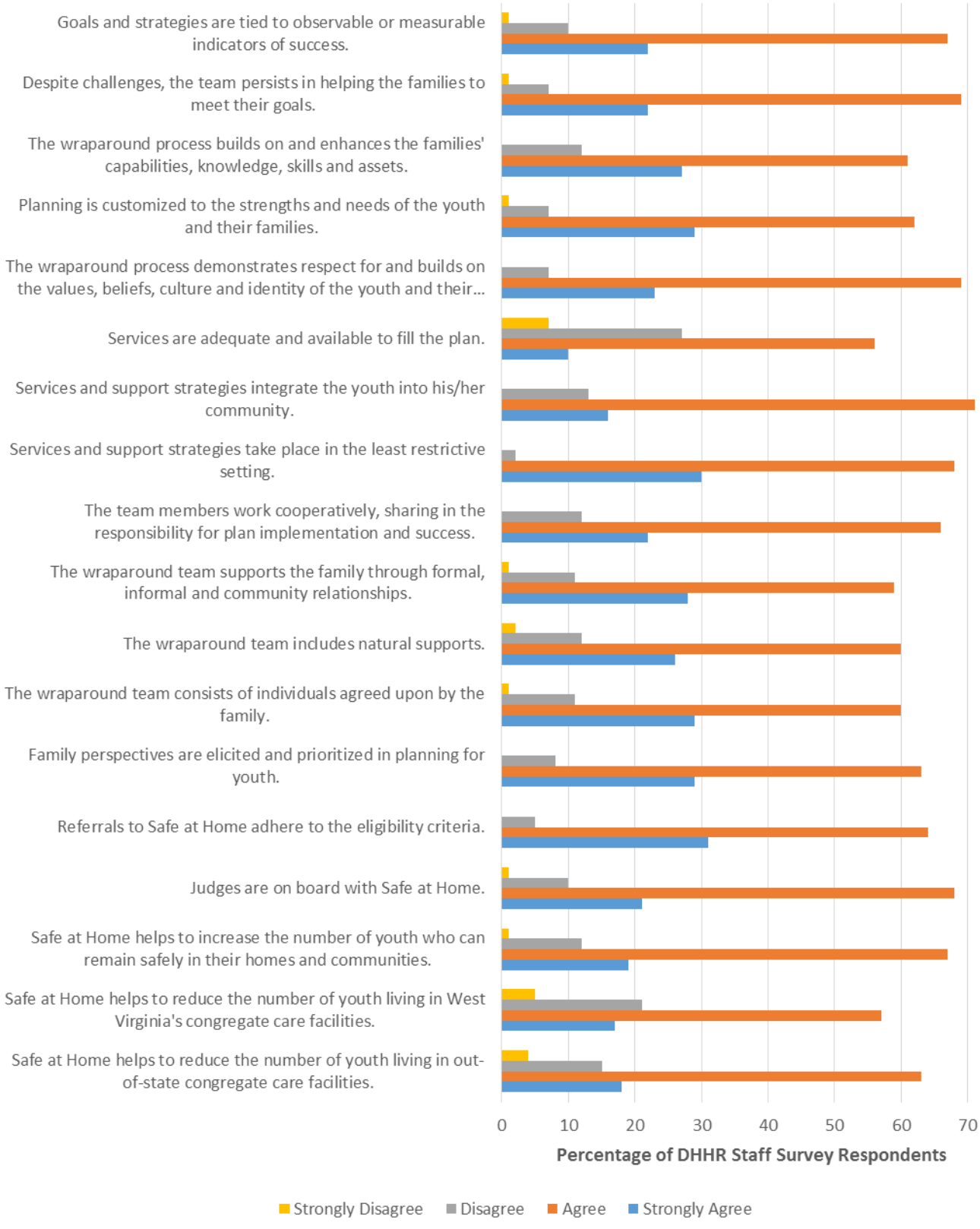
- elicit team collaboration,
- place an emphasis on youth/family voice and choice in service planning,
- utilize informal and community-based supports and services in addition to the more formal and traditional ones and
- tailor services to the unique needs of each youth and family.

One facilitator summed up the need for Safe at Home by stating, "There are many services in placement. Then the youth returns home to few or no services. We help to connect them to the services they need. That could be parenting, life skills, food banks, clothing or weatherization of the home... We do whatever is needed for each youth and family to be successful. We don't know what they'll need until we're in there. Some need more or less than others."

The DHHR staff survey asked respondents (CSMs, caseworkers and supervisors) the extent to which they agreed or disagreed with statements which are indicative of their level of buy-in with Safe at Home. These results are displayed below in Figure 2[9].

[9] Percentages are rounded and therefore may not always add to 100. Responses of "N/A" or "NULL have not been included in the calculations, since these responses are minimal and do not supply adequate information.

Figure 2. Extent of DHHR Staff Agreement on Program Buy-In Statements



For the most part, DHHR staff had a tendency to agree more often than not with buy-in statements regarding Safe at Home, indicating positive perceptions and support of the program. At the highest level of agreement, 98 percent of DHHR staff “Agreed” or “Strongly Agreed” that “Services and supports take place in the least restrictive setting.”

Positive sentiments regarding the initiative’s effectiveness were echoed by DHHR staff in interviews. For example, one supervisor said, "We have more successes than failures. We close more often for successful completion than we do for removal or something bad." For those staff who were less sure of the initiative's effectiveness, they reported that Safe at Home was often effective but reliant on certain contingencies, such as the youth/family's motivation to put in the work necessary to be successful, the quality of the LCA providing the services and the array of services available (which were perceived as particularly lacking in the more rural parts of West Virginia).

Nearly all LCA staff reported that Safe at Home has been effective in meeting the needs of youth and families and in achieving the goals of the initiative. One reason given for this success was the ability of LCAs to serve families creatively. One example of this was shared by a facilitator who stated, “We had another youth who is more than six-foot-tall and weighs over 200 pounds. [His/her] bed broke and an oversized bed is needed for [him/her]. We just got United Way to pledge $200 toward a new bed for [him/her]."

Other reasons given by stakeholders for the program's effectiveness included the ability to connect families to resources within the community that they did not know were available to them as well as families’ receptivity and willingness to participate in the program due to their voice being prioritized in service planning. As one caseworker from the survey shared, “Families that want the services are very grateful to have people on their team and when they understand that the wraparound process is about the family, it helps them to feel better knowing that they have a say in what happens to them.”

Apart from the buy-in of DHHR and LCA staff, most stakeholders agreed that the buy-in from judges is critical to program success because ultimately judges are the ones who control and determine youth placements. DHHR and LCA staff, along with one judge, reported that most judges see the program as a resource they can use to avoid the need to place youth.

DHHR and LCA staff further elaborated on the specific role of judges, stating that when judges help to make Safe at Home cases successful it is because they hold LCA and DHHR staff accountable for their work and they ensure that youth and families cooperate and participate in services. Judges involved with Safe at Home along with LCA and DHHR staff reported that

judges value and follow provider recommendations. In fact, judges who had direct experience with Safe at Home cases in their court reported that they almost always were on board with youth/families trying Safe at Home whenever it is recommended. The majority of regional office staff and CSMs reported that judges have been helpful when they have taken on a more active role with Safe at Home cases. One CSM shared, "[The judge] helps. [S/he] explains the program well to families and makes sure they understand it. [S/he] monitors the cases closely and is supportive of us and families."

Central and regional office staff and CSMs reported that at this point in the program's implementation, more judges have shown their support for Safe at Home than not. CSMs, supervisors and caseworkers echoed these sentiments, with 89 percent of survey respondents in agreement that "Judges are on board with Safe at Home." Nearly all judges interviewed agreed with the goals and premise of Safe at Home, with one stating, "If they're safe at home, then leave them home!" Central office staff stated that the increased buy-in of judges has been largely attributed to them being able to see the success of Safe at Home cases over time and sharing these success stories within their own professional circles. In spite of the reports about judges mostly buying into the premise of Safe at Home, those interviewed were evenly split about whether or not they believed the initiative would actually be effective in reaching its goals. Only one judge who was unsure about the effectiveness of Safe at Home provided an explanation as to why, stating, "I don't know that there are enough safeguards there [at home]. Immediate danger is handled well. I can't cite any specifically bad examples of Safe at Home... I was skeptical at first and still am a bit today. Far too often, we witness youth do well in placement, get home and the wheels fall off. Old habits, old associates; the progress they made disappears."

Regional office staff and CSMs reported that judges' involvement with Safe at Home was significantly impacted and varied based on their current level of buy-in. A couple of regional office staff said that judges can make or break the success of a case depending on how supportive they are of the program. One regional office staff person and a few central office staff reported that a few particular judges have created a major hindrance with Safe at Home cases. According to caseworkers, supervisors and LCA staff, when non-supportive judges hinder success, it is because they do not recognize progress/small victories, they court order participation, they hold unrealistic expectations of youth and families and they expect Safe at Home to be a "quick fix" or "magic bullet."

DHHR Staff Responsibilities and Safe at Home Fidelity

Stakeholders reported that in order to make referrals, the caseworker evaluates the case to see if it meets the policy criteria which requires the youth to be: age 12-17, have a possible mental health diagnosis, be currently living in out-of-state or in-state residential placement/congregate care or be identified as at risk of entering this type of placement setting. Once a youth is identified as eligible, the caseworker must obtain the youth/family's consent to participate (the program is intended to be voluntary). Caseworkers reported that sometimes they will run the idea of a referral by the Multi-Disciplinary Team (MDT), the court/judge or with other involved stakeholders to see if all invested parties are on board. Once the caseworker believes the youth would be a good candidate for the program, he or she fills out the referral form, the supervisor reviews the referral and the referral is then sent to the regional program manager who either approves or denies it.

Stakeholders reported that the referral process has not changed over time. The majority of supervisors and caseworkers agreed that no changes are needed to improve the referral process because it runs effectively now, and most staff also reported that there is usually a quick turnaround on the approval or denial of referrals from the regional office. A few even said that the referral process has gotten significantly better/easier to handle over time. Only a couple staff reported that the referral form is too long and that the turnaround at the regional office level is too slow.

All LCA staff reported that Safe at Home referrals have usually been appropriate, and a couple of staff reported that the quality of information provided with referrals has improved over time. The few LCA staff who did report issues with the referral process indicated that the timing of the referral could make it difficult to meet initial timeframes and that there appeared to be a lag between when DHHR made the referral and the LCA finally received it.

While referrals are an important part of how DHHR caseworkers contribute to Safe at Home, it is not the only fidelity item for which they are responsible for. For example, in implementing the Safe at Home model in the way it is intended, DHHR staff are expected to assist LCA staff by supplying them with any needed information on youth/families, by participating in monthly wraparound team meetings and ensuring that recommended services are being delivered to youth/families. DHHR staff survey respondents were asked about the extent to which they completed Safe at Home fidelity items and required activities. Caseworkers were asked to respond in regard to their own Safe at Home cases whereas

supervisors and CSMs were asked to respond regarding the extent to which they or their subordinate staff completed each item. Figure 3 provides these results[10].

[10] Percentages are rounded and therefore may not always add to 100. Responses of "N/A" or "NULL have not been included in the calculations, since these responses are minimal and do not supply adequate information.

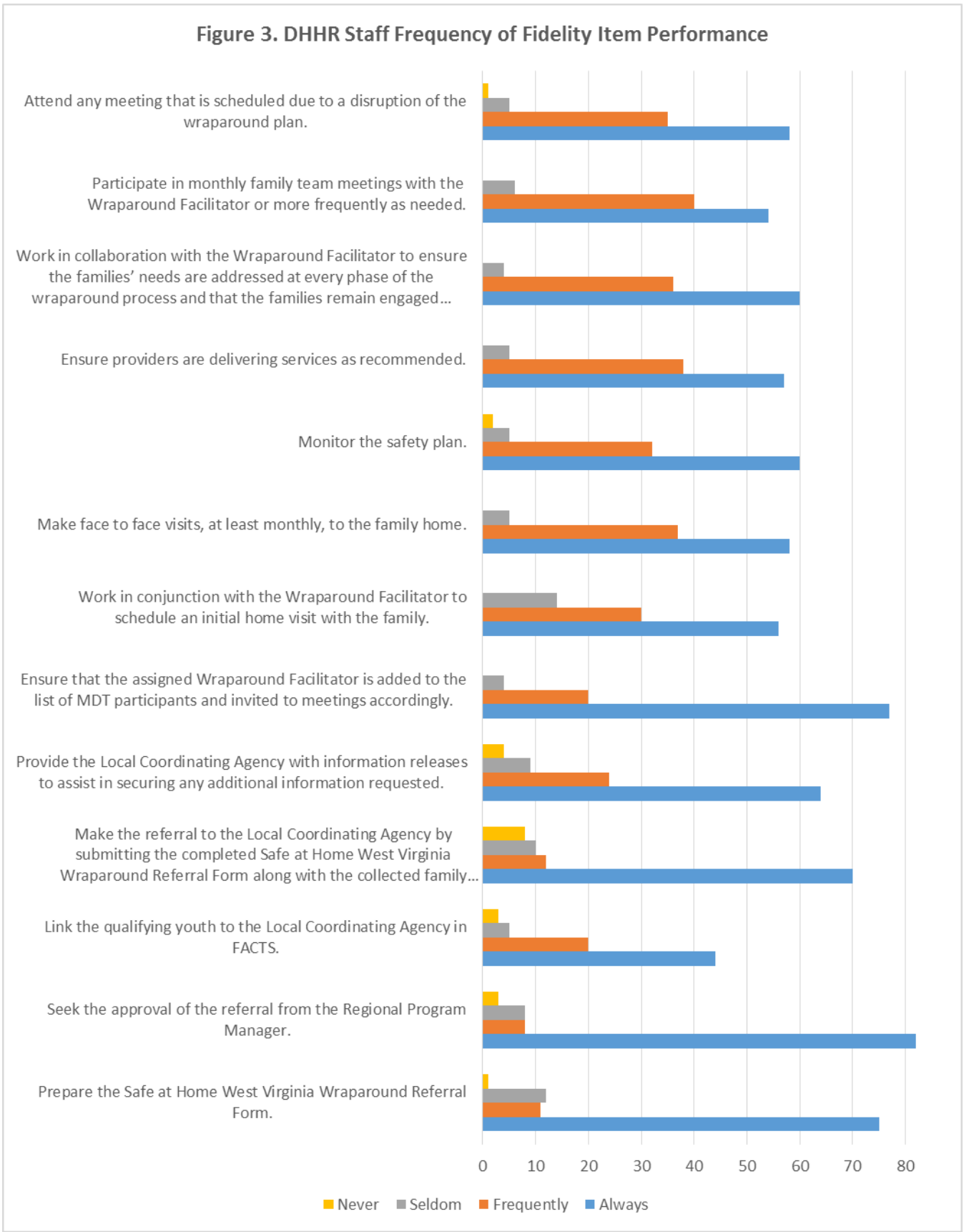


Figure 3. DHHR Staff Frequency of Fidelity Item Performance
Attend any meeting that is scheduled due to a disruption of the wraparound plan.
Participate in monthly family team meetings with the Wraparound Facilitator or more frequently as needed.
Work in collaboration with the Wraparound Facilitator to ensure the families' needs are addressed at every phase of the wraparound process and that the families remain engaged...
Ensure providers are delivering services as recommended.
Monitor the safety plan.
Make face to face visits, at least monthly, to the family home.
Work in conjunction with the Wraparound Facilitator to schedule an initial home visit with the family.
Ensure that the assigned Wraparound Facilitator is added to the list of MDT participants and invited to meetings accordingly.
Provide the Local Coordinating Agency with information releases to assist in securing any additional information requested.
Make the referral to the Local Coordinating Agency by submitting the completed Safe at Home West Virginia Wraparound Referral Form along with the collected family...
Link the qualifying youth to the Local Coordinating Agency in FACTS.
Seek the approval of the referral from the Regional Program Manager.
Prepare the Safe at Home West Virginia Wraparound Referral Form.
0
10
20
30
40
50
60
70
80
Never
Seldom
Frequently
Always

For the most part, DHHR staff reported that all required fidelity related tasks were performed "Always" or "Frequently" by either themselves or their subordinate staff. The two items most commonly completed "Always" or "Frequently" were "Ensure that the assigned Wraparound Facilitator is added to the list of MDT participants and invited to meetings accordingly" (completed 97% of the time) and "Work in collaboration with the Wraparound Facilitator to ensure the families' needs are addressed at every phase of the wraparound process and that the families remain engaged throughout" (completed 96% of the time).

Generally, DHHR supervisors and caseworkers reported that caseworkers have weekly contact with facilitators about youth in Safe at Home. Staff reported that facilitators send weekly reports to caseworkers and the two contact each other whenever issues arise. Caseworkers also reported attending monthly team meetings with facilitators, youth and families and other invested stakeholders. Some staff reported that monthly case staffings were held between DHHR county-level staff and LCA staff to discuss any current obstacles with Safe at Home cases and to brainstorm possible solutions.

Eighty-three of the 85 DHHR staff survey respondents answered a question regarding how much time/supervision they spend on Safe at Home cases versus their regular non-Safe at Home cases. Fifty-two percent of staff reported that the same amount of time is spent on Safe at Home cases, followed by 28 percent who reported that less time is spent; the remaining 21 percent of staff reported that they spend more time on Safe at Home cases. One caseworker alluded on the survey as to why Safe at Home allows for a lessened caseworker workload, saying, "The extra supervision and support needed for the family cannot be effectively done with just a DHHR worker. Some cases need more of our time and we often cannot accommodate such. The bond between Safe at Home workers and clients have often become a much stronger support and 'friend' than what the DHHR workers can be. Safe at Home has the time and funds to get kids involved in activities that are not so easily organized by the [case]worker." DHHR staff interviewees were asked a similar question and provided more detailed explanation for why more time is sometimes spent on Safe at Home cases. For those who reported spending more time, they stated it was because more meetings and reporting were required for Safe at Home cases.

LCA Capacity and Inter-Agency Collaboration

All LCA staff agreed that the goals and/or mission guiding their organization were already well aligned with those of Safe at Home. As one wraparound supervisor stated, "The goals of our agency align very well with those of Safe at Home. We are changing lives by preventing harm and keeping families safe and together." LCA staff shared that if any

organizational changes at all were needed in order for the LCA to successfully implement Safe at Home, then those changes were minor. Minor changes shared included hiring new staff, adding additional training, updating documentation systems and/or acquiring new office space to accommodate the influx of staff.

All but two LCA staff agreed that there are currently enough Safe at Home staff available to handle the number of Safe at Home cases within their agency. The two LCA staff who believed current caseloads were too high both stated that a caseload of six or fewer was optimal. All but one LCA staff reported that there have not been turnover issues with Safe at Home facilitators and supervisors. One wraparound supervisor stated, "I've seen a lot less turnover with Safe at Home than any other job in this field. I think it's because the job is more rewarding. You're working with families on a totally different level." Interestingly a few caseworkers from the DHHR staff survey were concerned about facilitator burn out with one stating, “The clients that Safe at Home are servicing have been done wrong by so many other agencies that the facilitators are constantly battling the family’s distrust that this program is going to really help them. This constant battle wears down the facilitator mentally and physically… I hope that Safe at Home recognizes facilitators for the good work they are doing. When I email the facilitators, I am in contact with I send them messages thanking them and appreciating them… I want them to know that I care about the service that they are providing to my clients.”

Most CSMs reported holding initial meetings with LCAs to prepare them for implementation and discuss their plans and the needs and expectations of DHHR county staff. Some CSMs hosted "lunch and learn" events to meet with LCAs and discuss the program. LCA and county staff reported working collaboratively through the initial problems of implementation. For example, one CSM shared, "In the beginning we were having issues with one LCA where we weren't getting reports from them so we sat down with the LCA, the regional director and regional program manager to work through what the expectations were." All supervisors and caseworkers reported that they were well prepared to work collaboratively with staff from the LCAs on Safe at Home cases. Many interviewees and nearly all survey respondents said that they had already established relationships with staff from the LCAs for other types of service provision for DHHR clients prior to the implementation of Safe at Home. All but four of the 34 county-level DHHR staff reported that they are able to work well with the LCAs for Safe at Home.

Available Services, Existing Needs and Youth/Family Engagement

One specific way in which wraparound facilitators assess youth/families' needs is through the use of the CANS. CANS assessments are required for every youth in the program within 30 days of referral and every 90 days thereafter. LCA staff reported that in addition to identifying needs, the results of CANS assessments are used to monitor case progress, help identify areas of strength which can be used to address needs, focus wraparound planning efforts, build rapport with youth and families and show where continued work and improvement is needed. All but one LCA staff person reported that they had no issues with performing CANS assessments or recording the data in the online CANS tool system.

Judges had their own perspectives on what they saw as the greatest issues and needs youth in their courts face. The most common responses were problems associated with the drug crisis and youth defiance/behavioral issues. All judges interviewed reported that Safe at Home could alleviate these issues. For example, one judge stated that when it comes to drug use, Safe at Home could help youth/families find the appropriate resources and services and that facilitators could help by addressing the problematic relationships within the home that supported continued drug use.

All LCA staff agreed that youth/families were very involved in the decision-making and planning process, though a couple of staff noted it can be harder when engagement issues with youth and families are present. One wraparound facilitator noted, "They [the youth and family] are the decision makers, we are the planners." Two-thirds of DHHR caseworkers and supervisors interviewed and the majority of LCA staff rated the quality of youth and family engagement with the program as high. Others reported that the quality of engagement was often a coin toss, dependent upon the individual youth/family's motivation and willingness to change. Very few stated that, overall, engagement is an issue.

LCA staff provided details as to how Safe at Home/wraparound services differ from traditional services in identifying the needs of youth/families, with examples including:

- seeing the entire family as the client;
- using community-based resources and informal supports;
- following a strengths-based model;
- prioritizing youth/family voice/choice;
- offering services that are not cookie cutter, but are instead creative, customized and flexible to meet the unique needs of each youth/family; and

- planning services by establishing closer relationships with youth/families to better target and gauge their needs.

One case example shared by a LCA program director illustrated how Safe at Home is able to identify and target needs in ways not possible with traditional services. “A single [parent] with two [children] had taken parenting classes from DHHR and passed and did all the things they told [him/her] to do, such as making a chore list, brushing teeth and going to bed on time. With Safe at Home, we came into the home and found out that the [parent] lived an alternative lifestyle and was a swinger and [s/he] shared way too much of this information with the [children]. The true problem with the parenting was that [s/he] had no boundaries and we needed to help [him/her] set up boundaries and educate [the parent] on what should and shouldn't be shared with the children. An issue like this would never be caught or addressed through traditional parenting services.”

Central office staff agreed that to come up with a comprehensive list of the types of services available to Safe at Home clients would be nearly impossible because of the way wraparound is designed and intended to work. It was reported that the more traditional and standard services, like therapy and psychiatry, are of course available to clients if necessary, but wraparound is designed to meet the needs of clients by whatever means necessary, and because each youth/family’s needs vary greatly, so do the necessary services. For example, one central office staff member said, "I can’t make a comprehensive list of services. It’s so huge and not every child needs the same thing. Tomorrow we might have a kid who needs a prosthetic, for example, or maybe mom just needs coffee dates with grandma to vent instead of formal therapy."

While following the wraparound model means that individual youth and family needs vary significantly, LCA staff provided some examples of the different types of services and providers they have used for their Safe at Home clients. As expected, the reported services and providers varied greatly and are listed by frequency of response in Table 4. Items starred in Table 4 are those in which at least one LCA staff person reported that the agency was able to offer the service through his/her own agency to Safe at Home clients.

Table 4. Services/Providers Used by Safe at Home Clients as Reported by LCA Staff	
Service/Provider	**Number of Staff Reporting**
Therapy*	16
Mentoring*	10
Tutoring*	6
Crisis Intervention*	5
Community Volunteer Opportunities	4
Parenting Skills*	
Life Skills*	
Professional and Paraprofessional In-Home Family Support*	
Foster Care*	3
Transportation*	
Supervised Visitation*	
Division of Rehabilitative Services	
YMCA	2
Youth Coaching*	
Psychiatry*	
Food Banks	
School Advocacy/IEP Work*	
Court Advocacy*	1
Mountaineer Challenge Academy	

Table 4. Services/Providers Used by Safe at Home Clients as Reported by LCA Staff	
Service/Provider	**Number of Staff Reporting**
Community Closet	
Catholic Charities	
Warm Hearts/Warm Hands	
Vocational Training	
Budgeting/Money Management*	
Family Supports	
Food Stamps	
Drug and Alcohol Outreach Ministries	
Respite*	
Music Lessons	
Payment for Utility Bills	
Gym Memberships	
Boxing	
Sports-General	
Daycare Referrals (for Younger Siblings)	
Church-Based Outreach Programs	
Youth Groups	

Interestingly, the four most commonly reported services (e.g., therapy, mentoring, tutoring and crisis intervention) were also services in which some LCAs were able to provide the service directly to clients through their own agency. Where in-house service offerings were possible, LCA staff reported that they already provided the service prior to Safe at Home, or

they saw the need for the service for Safe at Home clients and therefore developed it within their agency. On occasion, some LCAs would also subcontract with other service providers to help address needs. One example of this reported by a central office staff member involved a LCA which wrote a grant and hired a subcontractor to provide transportation services for Safe at Home clients. Nearly all central office staff agreed that so far, Phase I and II implementation counties have done well with fulfilling the service needs of Safe at Home youth and families, mainly because LCAs have been creative in meeting the needs of clients.

Most DHHR and LCA staff did agree that service needs in the most rural counties would be a challenge in general. Concerns regarding a general lack of services across the entire state were also expressed by DHHR staff survey respondents, where 34 percent of staff either "Disagreed" or "Strongly Disagreed" with the statement that, "Services are adequate and available to fulfill the plan."

The specific services DHHR and LCA staff reported were lacking included transportation, informal services/supports, mentoring, drug treatment for youth, after school program options for youth and therapy. Regarding informal supports, one caseworker survey respondent said, "Informal supports [outside the family itself] appear to be non-existent within the area. It appears that the plans thus consist of only the family members who live in the home and formal supports." Supervisors and caseworkers shared some of the various methods employed to help address service barriers. For example, in overcoming the transportation issues some LCAs hired their own transporters or provided gas cards. Staff also reported that the entire wraparound team works together to come up with creative solutions to problems. A few staff reported that the team tries to evaluate the family's informal support system to see where that can help.

Successes, Challenges and Hopes

All 73 interviewees were asked about both the successes and challenges they have experienced in working with Safe at Home, as well as what they hoped for the initiative in the near future. Table 5 provides a summation of the most common responses.

Table 5. Most Common Interview Responses on the Successes, Challenges and Hopes for Safe at Home	
Sentiment	**Number of Interviewees in Agreement**
Successes/What is Working Well with Safe at Home	
The responsiveness and extra support provided by wraparound facilitators	16
The amount of time facilitators have available to work directly with youth/families	11
LCA and DHHR collaboration	9
Youth/family voice and choice	9
The extra level of monitoring in the home provided by facilitators	9
The wraparound model/overall program design	8
The use of non-traditional, customized and flexible service delivery	7
Community involvement of youth/families	6
The creativity of LCAs to meet service needs of clients	6
Prevention of congregate care placement	6
Challenges/Contextual Factors Impacting Safe at Home	
Challenges associated with the current opioid/drug epidemic/crisis	22
Youth/family engagement, compliance and motivation to succeed	17
The general lack of services available statewide	12
Challenges associated with the State's economic depression and poverty	11

Table 5. Most Common Interview Responses on the Successes, Challenges and Hopes for Safe at Home	
Sentiment	**Number of Interviewees in Agreement**
Lack of services available in rural areas	10
General budget concerns/fear of cutbacks	8
DHHR and LCA collaboration	6
Program funding and sustainability concerns following the end of the Waiver demonstration period	5
Communication	4
Buy-in and support from judges/court staff	4
Hopes for Safe at Home in the Near Future	
More kids prevented from entering congregate care placement	14
More youth referred to Safe at Home	9
Program sustainability following the end of the Waiver demonstration period	9
More success stories	6
Continued stabilization and/or reduction of out-of-state congregate care placements	6
Continued development of services	6
Make the program available to younger children	5
Fewer kids in foster care	4
Continued/increased support from community partners (e.g., courts, schools, etc.)	3

Table 5. Most Common Interview Responses on the Successes, Challenges and Hopes for Safe at Home	
Sentiment	**Number of Interviewees in Agreement**
More CPS based cases referred to Safe at Home	3

Interview data made it clear that stakeholders viewed the role of the wraparound facilitator as one which contributes to success. As one caseworker expressed it, "Just having another person in their life paying attention to them and someone who cares about them. A lot of these youth have never had that before." The program model itself was another facet of the program that stakeholders agreed set the foundation for success with Safe at Home. One caseworker who responded to the survey said, "I think the concept is great overall. I think it has helped many of our children. I do not see one thing working well. I see it working well as a whole. Each part of the process is important to the goal."

The most common challenge for Safe at Home reported by stakeholders was the current opioid/drug epidemic/crisis throughout the State. Interviewees elaborated on the reasons why West Virginia's drug crisis have hindered the initiative's ability to achieve some of its goals. Some of the reasons included:

- a substantial increase in the foster care population due to drug-addicted parents;
- a lack of placements for children in care due to entire families and communities impacted by addiction;
- difficulties in finding appropriate informal/natural supports for youth since a large portion of the State's population is addicted;
- associated budget problems due to having so many children in care;
- burnt out DHHR staff with increased workloads who are sometimes sleeping in their offices with kids because they cannot find homes for them;
- younger kids who are more impacted by the drug epidemic, but unable to benefit from Safe at Home because they do not meet the age criteria; and
- challenges associated with working with youth who are severely drug-addicted.

Stakeholders hoped that the initiative would prevent more youth from entering congregate care placement in the future. Interestingly, prevention of congregate care placement was also an area where some stakeholders had already observed success with Safe

at Home. Following prevention of congregate care placement, stakeholders hoped more youth would be referred to the program and that Safe at Home would be sustained following the end of the Waiver demonstration period in September 2019.

Summary of Process Evaluation Findings

Changes to Safe at Home planning processes and implementation efforts were reportedly not substantial over time. In fact, higher level DHHR staff reported that they have been able to pull back on their direct oversight roles in the program because it is currently running so well. Some higher-level staff have now turned their attention and focus to program sustainability following the end of the Waiver demonstration period in September 2019.

One of the biggest changes was in how training is now delivered to DHHR staff. Safe at Home training is now a standard part of new worker training, ensuring that all new staff are trained. LCAs continually monitor their own individual training needs and will often host additional trainings for their staff beyond what is minimally required by the State. DHHR staff reported higher overall satisfaction with training whereas LCA staff held mixed views. LCA staff were more satisfied by training provided within their agency than training offered/required by the State. Suggestions for training improvement included refresher courses, training on how to build informal/natural support systems, training on wraparound planning/documentation procedures and more advanced training on how to engage youth and families.

Outreach to judges/courts was updated to include combined communication plans for CSMs and LCA program directors to implement together in order to educate judges and increase their level of support for Safe at Home. Most stakeholders reported noticing an increase in the amount of buy-in from judges, to the extent that judges are now perceived as more frequently receptive to the program than not. Additionally, stakeholder buy-in for the program was high among all groups interviewed and surveyed.

Communication was a noted area of improvement, where conflict resolution within DHHR and between DHHR and LCAs has reportedly gone well. Only a couple of staff reported that problems have remained unresolved. DHHR and LCA staff reported working closely together to ensure successful implementation at both programmatic and case levels. Approximately half of DHHR staff surveyed reported that the same amount of time is spent working on Safe at Home cases and two-thirds reported that less time is now spent. DHHR staff who reported that less time needs to be spent on Safe at Home cases stated that this was primarily because of the extra support of wraparound facilitators who have more time available to work directly with clients and find creative ways to meet their needs and link them to the

appropriate services.

Stakeholders also described how Safe at Home differs from traditional services. Most of the responses were related to an intense focus on the unique needs of each and every youth and family, which creates an atmosphere of focused planning and creative service delivery. Additionally, Safe at Home was reported to differ from traditional services because of its strengths-based model and prioritization of youth and family input in planning.

Due to the tailored nature of wraparound/Safe at Home in addressing youth/families' needs, many stakeholders struggled with, and even stated it was impossible to come up with a comprehensive list of services. This was evident in the services shared by LCA staff which ranged from therapy and parenting classes to boxing and paying a family's utility bills. The top services LCA staff stated were received by Safe at Home clients included therapy, mentoring and tutoring; all of which were services that some LCA staff reported they were able to offer in-house to clients. LCA staff reported that when they could not offer a service in-house, they subcontracted with other providers or worked closely with other community-based resources to ensure it was provided. Most stakeholders agreed that rural areas were most impacted by a lack of services overall.

Stakeholders reported that Safe at Home has been successful because of wraparound facilitators who provide an additional level of support to youth and families by spending a great deal of time working directly with their clients to learn what they need and then by working creatively to ensure that the services and supports address those needs. The greatest challenges for Safe at Home were overwhelmingly associated with the drug/opioid crisis/epidemic, which impacts youth either directly (e.g., drug-addicted parents and youth) or indirectly (e.g., lack of placement options due to increases in overall foster care population). Stakeholders hope for more referrals, more prevention of placement and continuation of the program following the end of the Waiver.

Outcome Evaluation Results

Youth Cohort Analysis

From the first day of program implementation (October 1, 2015) to March 31, 2018 1,544[11] total youth have been referred to Safe at Home and remained in the program for at

[11] The numbers of youth reported by HZA and the State differ slightly because the State utilizes weekly tracking

least three days. For the analysis of outcomes, youth are divided into six-month cohorts based on the date of referral to Safe at Home (Table 6). The evaluation currently includes youth for a total of five cohorts. All youth from Cohorts I through IV have been in the program for at least six months, which means sufficient time has passed to measure outcomes for them. The data available for youth in the most recent cohort (i.e., Cohort V) are limited to descriptive information about the youth population[12] because a full six months in the program have not passed for youth in this cohort.

The matched comparison groups were selected by using Propensity Score Matching (PSM), which relies on data from FACTS. The comparison pools were drawn from youth who meet the Safe at Home referral criteria (e.g., youth ages 12-17 in congregate care with a mental health diagnosis or at risk of entering congregate care with a possible mental health diagnosis) during SFYs 2011 through 2015. Propensity scores were calculated using age at referral, gender, race, ethnicity, initial placement setting, report allegation, number of prior placements, evidence of an axis one diagnosis, juvenile justice involvement and if the youth was ever in a psychiatric hospital or group home. These scores were matched using a nearest neighbor algorithm to select a comparison group that is statistically similar to the treatment group (see Appendix A).

Table 6. 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	221
	Comparison	SFY 2010 – 2015	221

logs (e.g., real-time data) to count the number of youth in the program and HZA relies on quarterly FACTS extracts for data (e.g., slightly delayed data). HZA's counts are lower due to delayed data entry into FACTS which results in small differences in the total numbers of youth and the number of youth reported for some of the cohorts.

[12] Please see the "Process Evaluation Results" section.

Table 6. Outcome Analysis Cohorts			
Cohort	**Group**	**Referral Period**	**Number of Youth**
III	Treatment	October 1, 2016 – March 31, 2017	297
	Comparison	SFY 2010 – 2015	297
IV	Treatment	April 1, 2017 – September 30, 2017	445
	Comparison	SFY 2010 – 2015	445
V	Treatment	October 1, 2017 – March 31, 2018	457
	Comparison	SFY 2010 – 2015	-
Total	Treatment	October 1, 2015 – March 31, 2018	**1544**
	Comparison	SFY 2010 – 2015	**1087**

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 through III; given the amount of time which has elapsed for youth in Cohort IV, the analysis is limited to six month outcomes only.

Stepwise Regression Analysis

To gain a better understanding of which populations Safe at Home best serves, HZA performed a stepwise regression analysis for each outcome measure. The process of a stepwise regression first runs a linear regression using a complete list of independent variables against the outcome measure. The program then determines if removing or adding (if they were removed) variables in a stepped fashion would produce a stronger correlation to the outcome. The stepwise regression is complete once no change in independent variables will produce a stronger correlation, resulting in the variables which are most strongly correlated to the outcome. The variables examined are:

- county,
- gender,
- race,
- placement at referral,
- length of time out-of-state prior to referral,
- age,
- length of DHHR case activity prior to referral,
- presence of a mental health diagnosis,[13]
- juvenile justice involvement,
- substance abuse and
- if formal services have been received.

Each of the factors listed above have been run against all of the following outcome measures:

- initial congregate care entries,
- congregate care re-entries,
- length of stay in congregate care,
- county movement (e.g., home-county to out-of-county and out-of-county to home-county),
- initial foster care entries,
- foster care re-entries and
- new referrals.

Whenever any of the factors from the stepwise regression analysis is found to have a notable impact (which can be either statistically significant or not) on any of the outcome measures, it will be described in greater detail while discussing the specific outcome measure. To determine if the Safe at Home program is more or less effective for certain populations than the comparison group, an identical regression analysis was performed for youth in the comparison group.

Youth Placement Changes

Table 7 examines the placement of Safe at Home youth in Cohorts I through IV when they were referred to the program and then six months later. It is possible for youth to be

[13] This analysis will be further broken down by the date of diagnosis; looking separately at those youth who received a diagnosis prior to congregate care entry, and those who received a diagnosis following entry.

placed in a detention or transitional placement or the youth could be on runaway status at six months. Due to the small number of youth this affects, they are included in a footnote for each cohort rather than in the table.

Table 7. 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	11	4	1	2	13	31
In-State Congregate Care	1	11	3	2	20	37
Emergency Shelter	1	2	0	0	1	4
Family Foster Care	0	2	0	0	0	2
Home	3	6	3	0	33	45
Total at Six Months[14]	16	25	7	4	67	119
Cohort II						
Placement	**Placement at Six Months**					

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

Table 7. Safe at Home Youth Placements at Referral and Six Months						
at Referral	Out-of-State Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	**Total at Referral**
Out-of-State Congregate Care	3	2	1	0	12	18
In-State Congregate Care	3	25	4	3	37	72
Emergency Shelter	0	6	4	3	4	17
Family Foster Care	0	2	2	4	3	11
Home	0	11	2	1	84	98
Total at Six Months[15]	6	46	13	11	140	216
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	3	0	0	1	8	12

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

Table 7. Safe at Home Youth Placements at Referral and Six Months						
Care						
In-State Congregate Care	0	9	2	6	42	59
Emergency Shelter	0	0	1	0	5	6
Family Foster Care	1	1	2	8	1	13
Home	4	30	6	6	158	204
Total at Six Months[16]	8	40	11	21	214	294
Cohort IV						
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	2	0	0	0	10	12
In-State Congregate Care	1	11	3	5	40	60

[16] At six months there were 2 youth in detention, 1 youth with a status of "runaway" and 0 youth in a transitional living setting from Cohort III.

Table 7. Safe at Home Youth Placements at Referral and Six Months						
Emergency Shelter	2	2	1	1	7	13
Family Foster Care	0	2	1	14	10	27
Home	6	49	7	1	268	331
Total at Six Months[17]	11	64	12	21	335	443

An increased percentage of youth in Cohorts III and IV who were referred while in congregate care and out-of-state congregate care facilities were returned to their homes within six months of the Safe at Home referral compared to those in Cohorts I and II. In Cohort IV, two-thirds of the youth referred while placed in a congregate care facility were home in six months of entry into Safe at Home and 83 percent referred while in an out-of-state congregate care facility were home in six months. Roughly 15 percent of youth across all Cohorts referred to the program while in their own home were placed in Congregate Care at six-months. In Cohorts III and IV, the population of youth in congregate care and out-of-state congregate care facilities six-months after referral primarily consists of youth referred when in their home.

Table 8 examines the placement changes one year following referral to Safe at Home for youth in Cohorts I through III. As with the six-month analysis, it is possible for youth to be placed in a detention or transitional placement or the youth could be on runaway status at 12 months, and these cases are described in footnotes for the relevant cohorts.

[17] At six months there were 2 youth in detention, 0 youth with a status of "runaway" and 0 youth in a transitional living setting from Cohort IV.

Table 8. 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	16	31
In-State Congregate Care	3	8	3	2	21	39
Emergency Shelter	1	2	0	0	2	6
Family Foster Care	0	0	1	0	1	2
Home	4	8	2	1	31	46
Total at Twelve Months[18]	13	22	9	5	71	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

[18] At twelve months there were 1 youth in detention, 3 youth with a status of "runaway" and 0 youth in a transitional living setting from Cohort I.

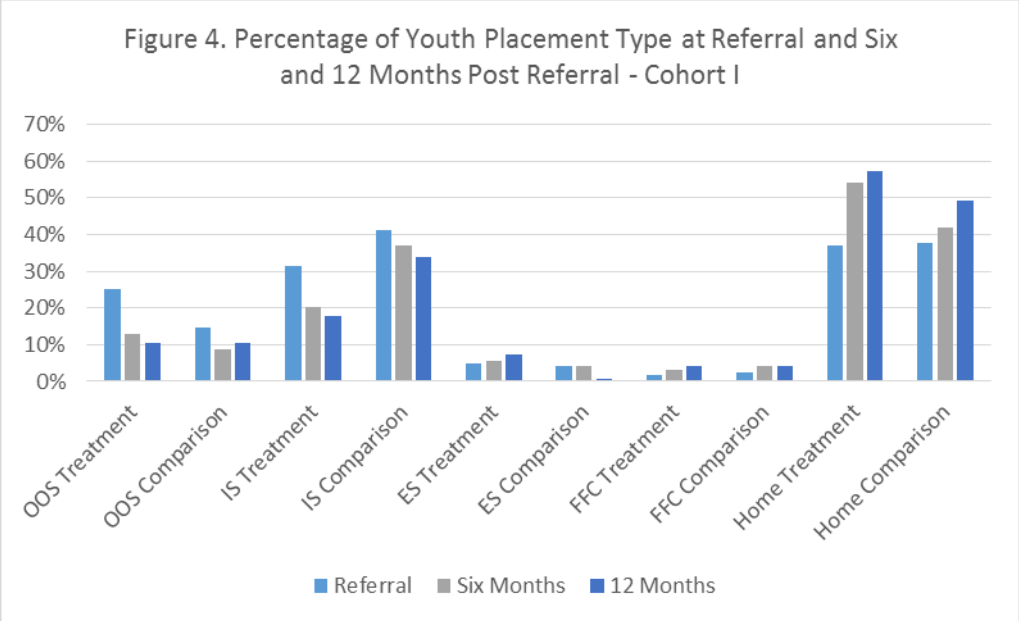
Table 8. Safe at Home Youth Placements at Referral and Twelve Months						
In-State Congregate Care	6	16	4	7	37	73
Emergency Shelter	1	5	2	5	4	18
Family Foster Care	1	2	0	4	4	11
Home	7	23	0	1	68	101
Total at Twelve Months[19]	19	47	6	18	125	221
Cohort III						
Placement at Referral	**Placement at Twelve Months**					
	Out-of-State Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	**Total at Referral**
Out-of-State Congregate Care	3	0	0	1	8	12
In-State Congregate Care	2	17	0	5	36	61
Emergency Shelter	0	0	1	2	3	6
Family Foster Care	0	3	0	4	6	13
Home	5	34	2	4	158	204
Total at Twelve Months[20]	10	54	3	16	211	296

[19] At twelve months there were 2 youth in detention, 3 youth with a status of "runaway" and 1 youth in a transitional living setting from Cohort II.

[20] At twelve months there were 1 youth in detention, 1 youth with a status of "runaway" and 0 youth in a

Placement results for youth at the 12-month mark from referral are generally like those at the six-month point. The most noticeable change from six-months to twelve-months, however, involves youth in the Cohort II congregate care population. Twelve more youth referred while in their home were placed in a congregate care facility at 12 months than at six months. Moreover, seven youth starting at home were moved to an out-of-state congregate care facility in the same timeframe.

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 4 compares the placements of Safe at Home youth along with their corresponding comparison youth for Cohort I at referral and at six and twelve months following referral.

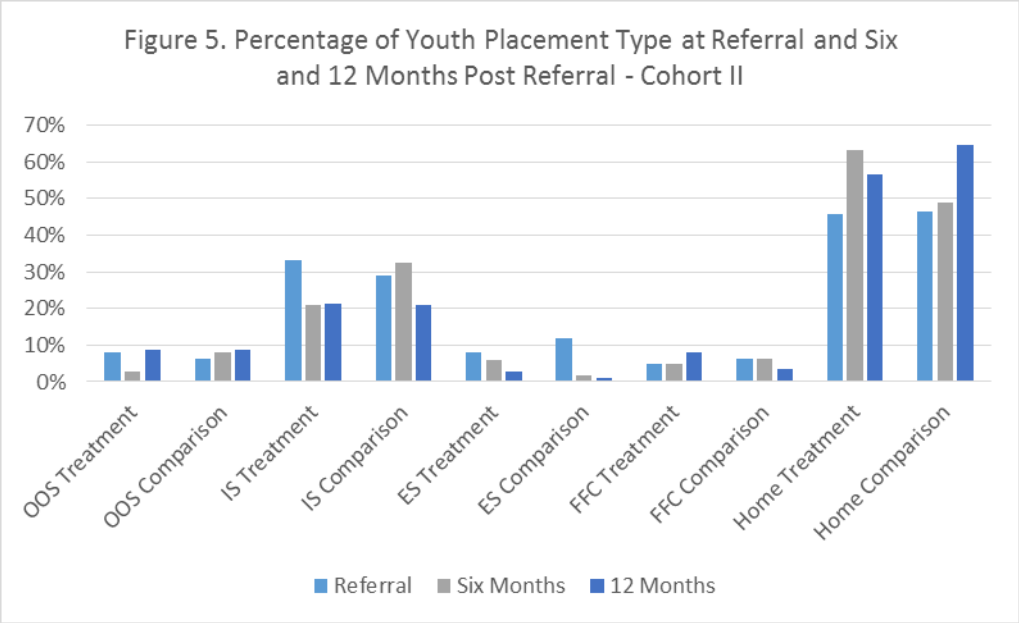


The treatment and comparison groups experienced reductions in both in-state (IS) and out-of-state (OOS) congregate care placement six and 12 months after referral. The reduction of youth in both facility types is more pronounced for the treatment group than the comparison group. Additionally, an increased percentage of youth are in their own homes six and 12 months following referral for youth in both the treatment (20 percentage points) and

transitional living setting from Cohort III.

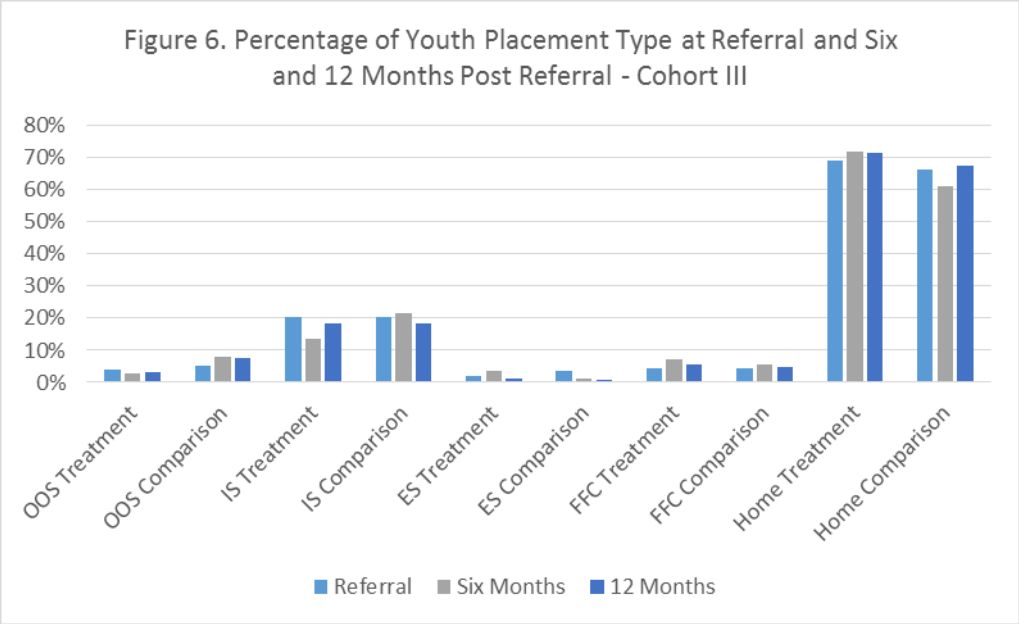
comparison groups (11 percentage points).

Similar to Figure 4, Figure 5 compares the placements of Safe at Home youth with their corresponding comparison youth at referral and at six and twelve months following referral for youth in Cohort II.



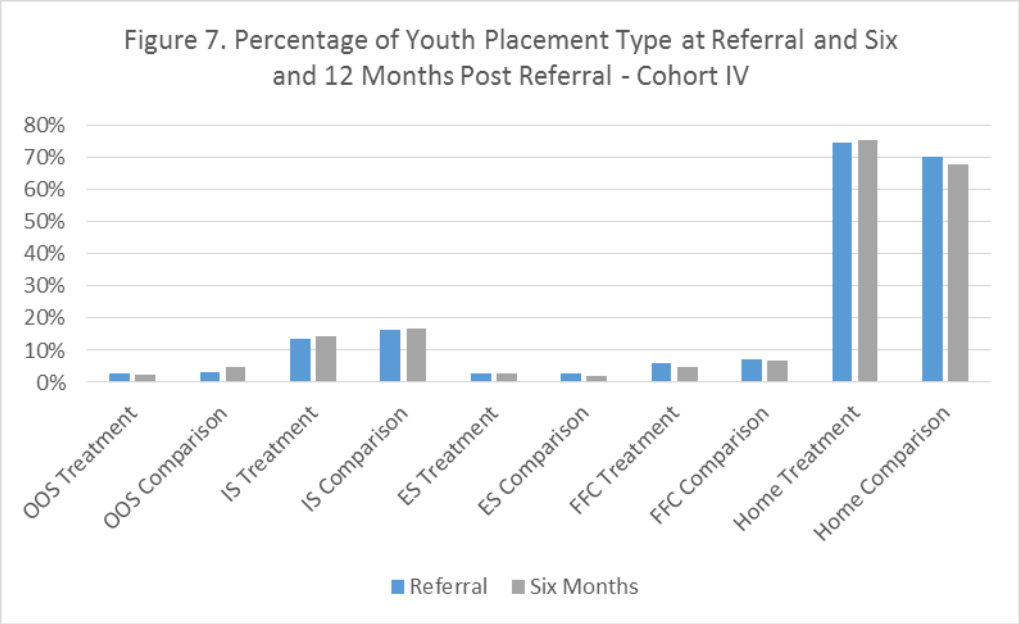
Even with a small percentage of Cohort II's treatment and comparison youth referred while in an out-of-state congregate care placement, the comparison group experienced a slight increase in youth placed outside of West Virginia at both the six and 12 months. Conversely, the percentage of Safe at Home youth living in an out-of-state congregate care decreased by five percentage points six months after referral but increased by the same amount at 12 months. The treatment group had reduced percentages of youth living in in-state congregate care at six and twelve months while the comparison group had increased percentages at six months but decreased percentages at 12 months. The percentage of youth in the treatment group who were placed in home increased from referral to six-months by 17 percentage points, then decreased by six percentage points from six-months to 12-months.

Figure 6 compares the treatment and comparison group placements for Cohort III at referral and six and twelve months after referral.



Overall, Cohort III displays more positive placement changes at six-months than youth in the comparison group. A smaller proportion of Safe at Home youth are in out-of-state or in-state congregate care facilities and more youth are in their home when compared to youth in the comparison group. Each of these results is significant at the $p < 0.05$ level. At 12 months, the treatment group and comparison groups have similar proportions of youth in all placement settings except out-of-state congregate care. A significantly lower percentage of Safe at Home youth are in this setting type than the comparison group.

Finally, Figure 7 compares Cohort IV's Safe at Home youth to their corresponding comparison youth at six months following referral.



The placement settings of Cohort IV youth at six months look similar between the treatment group and comparison groups. There are significantly more Safe at Home youth in home at six-months than comparison group youth.

In general, there are fewer Safe at Home youth in congregate care six month after referral than the comparison group and more youth placed in home. At twelve months, these differences become less dramatic as the percentage of youth in both treatment and comparison groups are placed is roughly similar in each setting at 12 months. In particular, Cohort II has a dramatic shift in treatment group placement settings from six to twelve months.

Congregate Care

Safe at Home has multiple goals related to out-of-state and in-state congregate care, including the prevention of initial placements into this higher level of care, returning youth to lower level settings and reducing the time spent in these types of settings.

One way to evaluate the impact of preventing placement into congregate care is to compare the results for youth in the treatment cohorts with those in the comparison cohorts who were in a lower level of care at the time of referral. Youth placed initially in lower levels of care, i.e., their own homes, family foster care or an emergency shelter, were examined at six and twelve months following referral (Table 9) to determine the extent to which those youth moved to congregate care. Cohort II and III treatment group youth show a lower percentage

placed in congregate care at six months than comparison group youth; however, at 12 months, a larger percentage of treatment group youth are in congregate care than comparison group youth. Furthermore, the results for Cohort II are significant at the $p < 0.05$ level at both six- and 12-months. Cohort I treatment and comparison group youth show similar trends in their placement while Cohort IV has a slightly larger percentage of treatment group youth in congregate care at six-months than the comparison group. There is no significance for Cohort I, III, or IV initial congregate care outcomes. In general, it appears youth in Safe at Home are more likely to enter congregate care than their comparison group counterparts.

Table 9. 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	54	26%	28%
	Comparison	55	24%	27%
II	Treatment	130	15%	30%
	Comparison	143	28%	17%
III	Treatment	224	16%	19%
	Comparison	221	20%	17%
IV	Treatment	373	16%	-
	Comparison	358	12%	-

From the stepwise regression analysis, youth who have an axis 1 diagnosis or an initial placement in a shelter are at higher risk to move to a congregate care facility from a lower level within six and 12 months of referral. Youth with juvenile justice involvement have a slightly, but not significantly ($p = 0.11$), lower risk of being placed in congregate care at 12 months. The regression on the comparison group also shows youth with an axis 1 diagnosis and initial shelter placement at higher risk. However, comparison group youth who received formal services are

at higher risk to enter congregate care, a result not shown in Safe at Home youth. This is suggestive that formal services received by Safe at Home youth are more effective at keeping youth from initially entering care. Furthermore, comparison group youth who are juvenile justice involved are more likely to enter congregate care, suggesting Safe at Home is more effective at keeping his population from entering.

Table 10 displays the results for youth who exited congregate care to a lower level of care within 12 months of referral and ultimately returned to congregate care at six or twelve months later. Results displayed below are for youth where sufficient time has passed to measure outcomes. Cohorts I and II display a lower percentage of treatment group youth re-entering congregate care at six-months than comparison group youth. Furthermore, the Cohort I six-month outcome is significant at the $p < 0.05$ level. The Cohort I treatment group youth also have a lower rate of re-entry into congregate care at 12-months than the comparison group youth, though this outcome is significant.

Table 10. Rate of Congregate Care Re-Entry

Cohort	Group	Number of Youth Moved to Lower Level of Care from Congregate Care within 12 Months	Percent of Re-Entry 6 Months After Congregate Care Discharge	Percent of Re-Entry 12 Months After Congregate Care Discharge
I	Treatment	32	28%	41%
	Comparison	28	54%	46%
II	Treatment	54	35%	-
	Comparison	34	47%	-

The stepwise regression revealed youth referred in Cohort III are at significantly less risk to re-enter congregate care within six months while males have a higher risk. Additionally, cases open longer at referral have a slightly lower risk of re-entering congregate care facilities at six months. There were no factors found to contribute to congregate care re-entry at 12 months. The comparison group regression shows a higher risk of re-entry for males, older youth, youth who are involved with juvenile justice, and youth in Hancock, Clay, Wayne, Harrison, and Webster counties. Conversely, youth placed initially in congregate care facilities are at lower risk of re-entry. These results indicate that males are at a higher

risk of congregate care re-entry, regardless of Safe at Home referral, and that Safe at Home is more effective at keeping youth across the state from re-entering congregate care than the comparison group.

To calculate length of stay in congregate care, Table 11 identifies the average number of days youth spent in congregate care. While Safe at Home youth seem more likely to enter congregate care than their historical counterparts, they spend much less time in those settings. Youth in all four treatment group Cohorts spent less time in congregate care following six-months of enrollment in Safe at Home than those in the comparison group. The same finding is true for Safe at Home youth in Cohorts I, II, and III at 12-months. All results are significant at the $p < 0.01$ level.

Table 11. 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	101	167
	Comparison	137	239
II	Treatment	84	144
	Comparison	131	237
III	Treatment	63	126
	Comparison	122	219
IV	Treatment	70	-
	Comparison	126	-

The regression analysis reported older youth and Safe at Home participants with initial placements at home, in foster care, or in shelters are at significantly less risk to spend more time in congregate care at both six and 12 months. Conversely, youth with axis 1 diagnoses are at higher risk to spend more time in congregate facilities at both timeframes. Participants

enrolling earlier in the program spend more time in congregate care, likely due to the large percentage of Cohort I youth with initial placements in congregate care. The comparison group analysis shows a higher risk for spending more time in congregate care for youth with initial placements in congregate care facilities, juvenile justice involved youth, and youth who were referred in Grant, Tyler, and Hampshire counties. Youth referred in Morgan, Marshall, and Mercer counties show less risk to spend time in congregate care. Similar to the congregate care re-entry, Safe at Home appears to be equally effective in all parts of the state since county is not a risk factor for these youth.

Detention

Since a proportion of Safe at Home youth are juvenile justice involved, HZA added initial detention entries and re-entries to the outcome measures. As shown in the "Youth Placement Changes" section of the report (above), the overall number of youth in detention is low and therefore a regression analysis will not provide meaningful insights to the population entering detention. However, the ramifications of this level of placement are serious enough to warrant further investigation. Youth cannot be referred to Safe at Home from a detention facility, therefore, none of them start at this particulate placement setting. Additionally, once youth enter a detention facility they are no longer eligible for Safe at Home and are subsequently discharged from the program (though they may be re-referred following their exit from detention).

Table 12 reveals a lower number of Safe at Home youth are in a detention facility six months after referral than comparison group youth. In Cohorts II, III, and IV, there are three-to-four times the number of comparison group youth in detention than the treatment group six months following referral to the program. At 12 months, there are a similar number of treatment and comparison group youth in detention in each Cohort. No results are significant.

Table 12. Initial Detention Entries at 6 and 12 Months Post-Referral

Cohort	Group	Number of Youth in Detention at 6 Months	Number of Youth in Detention at 12 Months
I	Treatment	3	1
	Comparison	4	1

Table 12. Initial Detention Entries at 6 and 12 Months Post-Referral			
Cohort	**Group**	**Number of Youth in Detention at 6 Months**	**Number of Youth in Detention at 12 Months**
II	Treatment	1	2
	Comparison	4	1
III	Treatment	2	1
	Comparison	7	1
IV	Treatment	2	-
	Comparison	6	-

Table 13 displays the results for youth in which sufficient time has passed since exiting detention to measure the extent to which they re-enter detention within six and 12 months after leaving and being referred to Safe at Home. Only the Cohort II treatment group youth show one youth re-entering a detention facility at six months; otherwise no youth re-entered detention at six or 12 months after leaving such a facility. No results are significant.

Table 13. Number of Youth Re-Entering Detention at 6 and 12 Months				
Cohort	**Group**	**Number of Youth Moved Out of a Detention Center 12 Months After Referral**	**Number Re-Entering Detention 6 Months After Leaving**	**Number Re-Entering Detention 12 Months After Leaving**
I	Treatment	4	0	0
	Comparison	8	0	0
II	Treatment	10	1	0

Table 13. Number of Youth Re-Entering Detention at 6 and 12 Months				
Cohort	**Group**	**Number of Youth Moved Out of a Detention Center 12 Months After Referral**	**Number Re-Entering Detention 6 Months After Leaving**	**Number Re-Entering Detention 12 Months After Leaving**
	Comparison	10	0	0
III	Treatment	6	0	-
	Comparison	14	0	-

County Movement

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 both youth leaving their home counties and of those returning are examined at six and twelve months post-referral; these results are provided in Table 14.[21] A lower percentage of Cohort II and III treatment group youth are placed out of their home county than the comparison group at six months. This trend does not hold at 12 months and Cohort II shows a significantly lower ($p < 0.05$) percentage of youth in the treatment group who are placed in their home county than the comparison group.

For the youth who were referred while out-of-county and moved to their home counties, nearly all Cohorts report a significantly higher percentage of treatment group youth moving back to their home county at six and 12 months. Only the Cohort II 12-month outcome does not show significance; however, there is still a higher percentage of treatment group youth moving back to their home county than of youth in the comparison group.

[21] 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 their home-counties.

Table 14. Youth County Movements				
Cohort	**Group**	**Denominator**	**Percent at 6 Months**	**Percent at 12 Months**
From Home-County to Out-of-County				
I	Treatment	59	27%	27%
	Comparison	55	24%	24%
II	Treatment	132	18%	27%
	Comparison	118	23%	14%
III	Treatment	227	17%	20%
	Comparison	213	20%	18%
IV	Treatment	366	15%	-
	Comparison	337	12%	-
From Out-of-County to Home-County				
I	Treatment	66	59%	64%
	Comparison	69	28%	39%
II	Treatment	96	61%	59%
	Comparison	103	29%	48%
III	Treatment	74	81%	72%
	Comparison	85	33%	45%
IV	Treatment	87	75%	-
	Comparison	109	28%	-

The regression analysis revealed youth are at higher risk of being moved out of their home counties if they have an axis 1 diagnosis, were placed in a shelter at the time of referral to Safe at Home, or have substance abuse issues. Additionally, youth from Berkeley, Braxton, Calhoun, and Putnam counties are at higher risk not to return to their home counties at 12 months. Youth referred to Safe at Home in Cohorts II and III are slightly more likely to return to their home counties at 12 months. The comparison group regression analysis showed youth are a higher risk movement out of county if they have an axis 1 diagnosis or received formal services within the first year of referral. Comparison youth in Tucker and Gilmer are a less risk to be moved out of county. Youth placed initially in congregate care facilities or received formal services are less likely to be returned to their home county while youth in Brooke, Lincoln, Marion, and Wetzel counties are more likely to return. These results suggest that formal services received by Safe at Home youth are more effective at moving youth back or keeping youth in their home county.

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 care following discharge to their homes. Table 15 examines the initial entry into foster care following referral for youth who were referred while living in their own homes. Treatment group members in Cohorts I and III show similar results to the comparison group at six and 12 months. Cohort II shows a lower percentage of treatment group youth in foster care at six months than the comparison group; however, a significantly higher ($p < 0.01$) percentage of safe at home youth are in foster care at 12 months following referral. Cohort IV has a higher percentage of treatment group youth in foster care at six months than the comparison group youth, though the result is not significant. In general, Safe at Home youth are just as likely to enter foster care as comparison group youth.

Table 15. 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	46	28%	33%
	Comparison	47	28%	30%
II	Treatment	101	15%	32%
	Comparison	103	23%	16%
III	Treatment	205	22%	22%
	Comparison	197	22%	20%
IV	Treatment	333	20%	-
	Comparison	312	14%	-

The regression analysis shows that youth with an axis 1 diagnosis are at higher risk of being placed into foster care within six and 12 months of referral to Safe at Home than those without a diagnosis. Additionally, juvenile justice involved youth have a slightly lower risk of entry into foster care at both timeframes, though the results are not significant. Finally, youth who received formal services during Safe at Home are at a significantly higher risk of entering foster care within 12 months of referral. The comparison group regression also showed youth receiving formal services having a higher risk of entering care, suggesting that formal services generally lead to a higher risk of initial foster care entries. Additionally, juvenile justice involved youth in the comparison group show a significantly higher risk to enter foster care, suggesting Safe at Home is preventing juvenile justice youth from entering foster care.

Table 16 displays the results for youth who exited foster care within 12 months of referral and ultimately returned to foster care at six or twelve months following discharge. Results presented below include youth where sufficient time has passed to measure outcomes. Both Cohorts show a higher percentage of Safe at Home youth re-entering foster care at each

timeframe than the comparison group youth. This outcome is significant at the $p < 0.05$ level for the Cohort II six-month outcome.

Table 16. Rate of Re-Entry into Foster Care				
Cohort	**Group**	**Number of Youth Discharged from Foster Care within 12 Months of Referral**	**Rate of Foster Care Re-Entry (%) at 6 Months**	**Rate of Foster Care Re-Entry (%) at 12 Months**
I	Treatment	41	17%	17%
	Comparison	27	7%	7%
II	Treatment	70	27%	-
	Comparison	53	11%	-

The stepwise regression shows youth who received formal services during Safe at Home are at significantly higher risk of re-entering foster care at six and 12 months after referral than those who do not. Additionally, the longer the case was open prior to the Safe at Home referral, the less risk the youth has to re-enter foster care at both timeframes. Youth in Cohort II have a higher risk of re-entering foster care than Cohorts I and III. The comparison group regression shows youth who receive services having slightly higher risk of foster care re-entry and juvenile justice involved youth having slightly lower risk. Youth in 31 counties show significantly less risk of re-entering foster care. These results suggest formal services are not effective at keeping youth from re-entering foster care and Safe at Home juvenile justice youth are slightly more prone to re-entry than comparison group youth.

Maltreatment

The Safe at Home initiative aims to increase youth safety by demonstrating decreased rates of maltreatment/repeat maltreatment. Table 17 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. Youth in Safe at Home experienced fewer referrals within six and 12 months from referral than their comparison group counterparts. The results for Cohorts I, II, and IV are statistically significantly across all timeframes at the $p < 0.05$

level. Because Safe at Home's population is primarily juvenile justice based, many youth have not experienced maltreatment which explains the small number of substantiations.

Table 17. 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	14	0	21	0
II	Treatment	18	0	23	0
	Comparison	31	0	41	0
III	Treatment	23	0	34	1
	Comparison	32	0	47	0
IV	Treatment	29	1	-	-
	Comparison	49	0	-	-

Due to the limited number of new substantiations, the regression discussion focuses on new referrals. Youth referred in Brooke, Hampshire and Wetzel counties are at significantly higher risk to have new referrals than other counties at six and 12 months. In addition, the risk to have a new referral reduces the older the youth are at the time of referral. The comparison group regression found reduced risk for a maltreatment referral the older youth were when referred, if they were juvenile justice involved, or if they received formal services.

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. Some items in the CANS will trigger further modules for questioning if a need is discovered in that area, such as substance use and GLBTQ (Gay, Lesbian, Bi-Sexual, Transgender, and/or Questioning), for example.

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

A total of 720 Safe at Home youth have 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 through III 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 IV. Progress is measured by the extent to which scores have improved, meaning needs/actionable items have been reduced over time. As shown in Table 18, CANS assessments available for analysis become more limited as more time elapses after the youth's entry into Safe at Home. 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 a placement for youth.

Table 18. Number of Youth with CANS Assessments Available for Analysis

	Cohort I	Cohort II	Cohort III	Cohort IV
Number of Youth with an Initial CANS Assessment	88	165	209	299
Number of Youth with a 6-Month Follow-Up CANS	54	93	91	81
Number of Youth Discharged Before a 6-	25	48	77	96

Table 18. Number of Youth with CANS Assessments Available for Analysis				
	Cohort I	Cohort II	Cohort III	Cohort IV
Month Follow-Up CANS can be Performed				
Number of Youth Where Not Enough Time Has Passed Before a 6 Month CANS Can Be Performed	0	0	1	34
Number of Youth Where Enough Time Has Passed & No 6 Month CANS Was Performed	9	24	40	88
Number of Youth with a 12 Month Follow-Up CANS	24	41	18	-
Number of Youth Discharged Before a 12 Month Follow-Up CANS can be Performed	60	99	142	-
Number of Youth Where Not Enough Time Has Passed Before a 12 Month CANS Can Be Performed	0	0	18	-
Number of Youth Where Enough Time Has Passed & No 12 Month CANS Was Performed	4	25	31	-

Table 19 provides an overview of the percentage of youth with at least one need item selected in the main CANS domains on the initial assessment. For a closer look at the needs on

specific items within each of the main domains, please see Appendix B and C.

Table 19. Percentage of Youth with an Actionable Item/Need on the Initial CANS Assessment

CANS Domain	Cohort I (N=88)	Cohort II (N=165)	Cohort III (N=209)	Cohort IV (N=299)
Child Behavioral/Emotional Needs (13 Items)	81.8%	77.6%	69.4%	69.2%
Child Risk Behaviors (13 Items)	48.9%	44.2%	36.8%	38.5%
Life Domain Functioning (19 Items)	90.9%	90.3%	90.9%	92.0%
Trauma Stress Symptoms (12 Items)	47.7%	44.8%	28.2%	29.4%

Apart from the Life Domain Functioning domain, the percent of youth with actionable items on the initial CANS assessment decreased from Cohort I to Cohort IV. This change is likely due to the changing population of Safe at Home youth since implementation where Cohorts I and II had more youth in congregate care settings than is evidenced for those in Cohorts III and IV. The Life Domain Functioning domain consistently has over 90 percent of the youth with an actionable item. In particular, roughly 50 percent of youth in each Cohort are actionable in the "Legal" item of the Life Domain Functioning domain. This result is not surprising given that youth in Safe at Home are typically juvenile justice involved.

Table 20 shows the percentage of youth who had a six or twelve month follow up CANS and who also reduced at least one need in a domain (i.e., at least one item in the domain had gone from actionable to non-actionable or was no longer considered a need).

Table 20. 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	50.0%	85.0%
Child Risk Behaviors	50.0%	77.8%
Life Domain Functioning	58.3%	85.7%
Trauma Stress Symptoms	38.5%	77.8%
Cohort II		
Child Behavioral/Emotional Needs	58.7%	65.7%
Child Risk Behaviors	60.5%	71.4%
Life Domain Functioning	64.6%	72.2%
Trauma Stress Symptoms	60.5%	70.0%
Cohort III		
Child Behavioral/Emotional Needs	54.8%	88.9%
Child Risk Behaviors	67.6%	85.7%
Life Domain Functioning	64.6%	75.0%
Trauma Stress Symptoms	58.3%	80.0%

Table 20. 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 IV		
Child Behavioral/Emotional Needs	51.7%	-
Child Risk Behaviors	53.8%	-
Life Domain Functioning	75.3%	-
Trauma Stress Symptoms	51.7%	-

Over half of the youth for whom a second CANS was completed showed improvement on the initial CANS in each domain listed in Table 20. The Life Domain Functioning domain generally shows the largest percentage of youth with improved scores at six months. At twelve months, all cohorts show further improvement with 75 percent of youth showing improved scores from the initial CANS assessment in nearly every domain.

In addition to the main CANS domains, there are triggered sub-modules which delve deeper into specific questions on specific topics where youth have identified needs. Table 21 provides the results of youth who triggered sub-modules in the initial CANS assessment.

Table 21. Percentage of Youth with Triggered Submodules on Initial CANS Assessment				
Submodule Triggered	**Cohort I (N=88)**	**Cohort II (N=165)**	**Cohort III (N=209)**	**Cohort IV (N=299)**
Adolescent Suicide	14%	10%	4%	7%
Child Suicide	0%	2%	1%	1%

Table 21. Percentage of Youth with Triggered Submodules on Initial CANS Assessment				
Submodule Triggered	**Cohort I (N=88)**	**Cohort II (N=165)**	**Cohort III (N=209)**	**Cohort IV (N=299)**
Commercial Sexual Exploitation	0%	0%	2%	1%
Children's Sexual Behaviors Screen	14%	11%	10%	10%
Delinquent Behavior	48%	39%	52%	53%
Fire Setting	1%	1%	1%	2%
GLBTQ	5%	2%	3%	6%
Sexually Abusive	19%	13%	12%	14%
Substance Use	28%	23%	26%	28%

The percentage of youth triggering the Adolescent Suicide module on the initial CANS has decreased from 14 percent in Cohort I to just four percent in Cohorts III and IV. Additionally, the percentage of both Children's Sexual Behaviors Screen and Sexually Abusive submodules have consistently decreased since Safe at Home implementation. The most commonly triggered submodule is Delinquent Behavior followed by Substance Use.

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 that domain (Table 22).

Table 22. 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	24	18	10	8	6
Residential Stability	7	4	3	3	2
Total	**29**	**19**	**11**	**9**	**7**
Cohort II					
Physical Health	15	8	2	6	2
Mental Health	4	1	1	1	1
Substance	5	4	2	3	1

Table 22. 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**
Use					
Family Stress	26	15	5	6	4
Residential Stability	10	5	1	3	2
Total	**43**	**25**	**7**	**13**	**6**
Cohort III					
Physical Health	7	2	1	1	1
Mental Health	9	3	2	1	1
Substance Use	3	2	0	1	1
Family Stress	32	15	7	5	4
Residential Stability	16	8	3	3	3
Total	**42**	**19**	**8**	**5**	**4**

Table 22. 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 IV					
Physical Health	6	1	0	-	-
Mental Health	6	1	0	-	-
Substance Use	3	0	0	-	-
Family Stress	45	9	3	-	-
Residential Stability	15	4	3	-	-
Total	**58**	**12**	**4**	**-**	**-**

The most common Family Functioning need on the initial assessment is Family Stress followed by Residential Stability. Of those with a CANS assessment at six-months, roughly 45 percent showed improved Family Stress and Residential Stability scores. Though the number of 12-month assessments is limited, nearly two-thirds of the youth showed an improvement from the initial CANS to the 12-month follow-up.

Educational Functioning

Similar to the analysis of family functioning, an analysis of educational functioning draws on the use of CANS data to identify the areas of challenge and improvement for youth in Safe at Home. Educational functioning items fall within the Life Domain Functioning and Trauma Exposure CANS domains and are inclusive of four specific items on education:

- School Achievement
- School Attendance
- School Behavior
- School Violence

Results for educational functioning are displayed in Table 23.

Table 23. Number of Youth with Improved Scores on Educational Functioning Items 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					
School Achievement	22	11	5	4	2
School Attendance	14	5	5	2	2
School Behavior	33	22	7	10	4
School Violence	11	4	0	1	0

Table 23. Number of Youth with Improved Scores on Educational Functioning Items 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**
Total	**56**	**31**	**13**	**13**	**7**
Cohort II					
School Achievement	45	29	17	16	10
School Attendance	31	20	14	7	4
School Behavior	50	31	19	10	8
School Violence	18	10	3	4	1
Total	**93**	**57**	**34**	**22**	**14**
Cohort III					
School Achievement	73	32	16	5	4
School Attendance	49	25	18	5	4
School Behavior	53	26	16	2	2

Table 23. Number of Youth with Improved Scores on Educational Functioning Items 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**
School Violence	16	6	2	1	1
Total	**122**	**51**	**34**	**8**	**7**
Cohort IV					
School Achievement	98	33	16	-	-
School Attendance	80	23	18	-	-
School Behavior	88	29	19	-	-
School Violence	21	5	1	-	-
Total	**176**	**52**	**34**	**-**	**-**

The most common Educational Functioning need on the initial assessment is School Achievement followed by School Behavior. Roughly two-thirds of the youth from Cohorts II, III, and IV show improvement on the six-month follow-up CANS assessment when compared to the initial CANS. Results for Cohort I are lower than the other three Cohorts with 42 percent of youth showing improvement at six-months. The most improved Educational Functioning item at both the six- and 12-month follow-up is School Attendance while School

Violence shows the least improvement at both follow-up assessments.

Summary of Outcome Evaluation Results

In general, there are more Safe at Home youth placed in their own homes and fewer youth in congregate care facilities at six and 12 months after referral than at enrollment. Safe at home youth typically have a lower percentage of congregate care entries at six months than comparison group youth, but the trend does not hold at 12 months. However, youth in Safe at Home spend significantly less time in congregate care within six and 12 months of referral than the comparison group.

Like the findings for Safe at Home youth placed into congregate care initially, a smaller percentage of youth are moved out of their home county at six months following referral than those in the comparison group youth; however, a higher percentage are placed outside their home county at 12 months. Conversely, Safe at Home has a significantly higher percentage of youth moving back into their home county than the comparison group at six and 12 months across most Cohorts.

The stepwise regression analyses highlighted for which populations the program is and is not working well. It is no surprise that youth with an axis 1 diagnosis are at higher risk of not achieving favorable outcomes than youth without a diagnosis. The program seems to be working better for youth referred in Cohorts III and IV. This outcome is potentially due to the changing preference of referring youth to Safe at Home as a prevention measure or due to better implementation by providers and DHS staff. Interestingly, there are only two outcomes (i.e., New Referrals and Youth Moved in County) that are influenced by the county from which youth were referred. In particular, youth from Berkeley, Braxton, Calhoun, and Putnam are at higher risk not to return to their home county at 12 months and youth from Brooke, Hampshire and Wetzel counties are at significantly higher risk to have new maltreatment referrals than other counties at six and 12 months. The comparison group regression shows several outcomes with a strong correlation with county, further implying that Safe at Home is implemented evenly across the state. When contrasted against comparison group youth, Safe at Home youth who are juvenile justice involved or received formal services during the first year of the program generally show more advantageous outcomes.

CANS assessments have shown that for youth with a six-month CANS follow-up, over half of the youth with at least one actionable item on the initial CANS have improvement. Furthermore, for youth with a 12-month CANS follow-up three-fourths show improvement from the initial CANS. Youth in Cohorts II, III, and IV have a marked improvement on their

Educational Functioning and all Cohorts show improved Family Functioning.

Cost Evaluation Results:

The cost evaluation is used to determine whether *Safe at Home West Virginia* is more effective and 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, II, and III. 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 was 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	$239.91
In State Residential Care	$161.95
Shelter Care	$150.17
Therapeutic/Specialized Care	$57.29
Preventive Care	$21.47

Those rates were first applied to the number of days youth in the first treatment cohort were in substitute care, again limiting the analysis to the first year following enrollment in Safe at Home. The rates were also applied to the number of days youth in the second and third treatment and comparison cohorts were in out-of-home placement. As illustrated in Table 24, the Safe at Home West Virginia initiative generated a cost savings of over $4 million in costs for room and board expenditures for youth in the first three treatment cohorts. The largest savings are the result of reducing the time youth spend in residential care both in state and out of state. Table 24 also includes the average cost of room and board per youth removed from their home. The comparison group remains consistently at roughly $32,000 per youth in each of the Cohort timeframes. Conversely, the treatment group consistently decreases in each Cohort and averages roughly $23,000 per youth.

Table 24. Cost of Room and Board Payments

	Comparison Group	Treatment Group
Cohort I		
Out of State Residential Care	$406,891.81	$814,023.52
In State Residential Care	$2,242,735.23	$1,127,036.00
Shelter Care	$229,310.92	$313,556.78
Therapeutic/Specialized Care	$26,467.12	$77,740.00

Table 24. Cost of Room and Board Payments		
	Comparison Group	**Treatment Group**
Preventive Care	$19,128.55	$10,133.19
Totals	**$2,924,533.63**	**$2,342,489.49**
Average Cost per Youth Removed	**$34,405.63**	**$27,237.86**
Cohort II		
Out of State Residential Care	$1,039,061.56	$349,312.78
In State Residential Care	$3,546,138.84	$2,320,796.93
Shelter Care	$444,956.29	$698,444.72
Therapeutic/Specialized Care	$106,842.38	$75,734.92
Preventive Care	$67,368.55	$58,888.45
Totals	**$5,204,367.62**	**$3,503,177.79**
Average Cost per Youth Removed	**$36,140.83**	**$23,993.99**
Cohort III		
Out of State Residential Care	$1,167,654.73	$490,381.40
In State Residential Care	$3,254,784.08	$1,998,185.10
Shelter Care	$361,311.11	$459,072.35
Therapeutic/Specialized Care	$76,594.24	$74,130.85
Preventive Care	$64,062.38	$73,422.71
Totals	**$4,924,406.55**	**$3,095,192.41**
Average Cost per Youth	**$32,828.82**	**$19,968.68**

Table 24. Cost of Room and Board Payments		
	Comparison Group	**Treatment Group**
Removed		

Fee-for-services costs (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. In total, the amount paid for fee-for-services for Safe at Home youth is over $490,000 less than the comparison group. Education expenditures account for the largest percentage of fee-for-service costs followed by Other Services. Several service categories (e.g., assessment, transportation) are not reported for Safe at Home youth since they are Administrative Services Organization (ASO) payments which are now funded through wraparound services.

Table 25. Cost of Fee-for-Service Payments		
Service Category	**Comparison Group**	**Treatment Group**
Cohort I		
Assessment	$15,647.25	$0.00
Case Management	$11,653.50	$0.00
Clothing	$19,674.97	$9,377.26
Education	$36,874.43	$71,148.42
Independent Living	$23,224.35	$1,775.59
Legal	$529.08	$0.00
Maintenance	$22,696.75	$0.00
Other	$9,453.34	$5,497.02
Services	$18,626.80	$1,205.27

Table 25. Cost of Fee-for-Service Payments		
Service Category	**Comparison Group**	**Treatment Group**
Cohort I		
Supervised Visitation	$3,857.30	$0.00
Transportation	$22,464.14	$0.00
Totals	**$184,701.91**	**$89,003.56**
Cohort II		
Assessment	$27,713.50	$502.75
Case Management	$22,379.00	$0.00
Clothing	$22,263.16	$21,766.79
Education	$46,955.66	$32,210.19
Independent Living	$35,037.13	$11,376.92
Legal	$1,555.91	$851.34
Maintenance	$24,586.75	$0.00
Other	$6,448.34	$34,460.20
Services	$22,486.57	$3,130.60
Supervised Visitation	$6,282.38	$0.00
Transportation	$37,641.24	$0.00
Totals	**$253,349.64**	**$104,298.79**
Cohort III		
Assessment	$37,260.00	$0.00
Case Management	$29,668.00	$0.00

Table 25. Cost of Fee-for-Service Payments		
Service Category	**Comparison Group**	**Treatment Group**
Cohort I		
Clothing	$26,999.30	$18,149.27
Education	$50,550.72	$1,360.00
Independent Living	$28,022.63	$1,850.00
Legal	$248.28	$0.00
Maintenance	$25,100.60	$373.60
Other	$22,867.51	$22,383.79
Services	$28,192.58	$3,228.98
Supervised Visitation	$4,290.00	$0.00
Transportation	$41,209.24	$0.00
Totals	**$294,408.86**	**$47,345.64**

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. These costs may be mitigated by the amount of time caseworkers have to work on other, non-Safe at Home cases. Using the number of days youth were enrolled in Safe at Home West Virginia, a total of roughly $27.2 million has been incurred to provide services to enrolled youth. The costs equate to an average cost of $42,346 per youth in Cohorts I, II, and III.

Summary of Cost Evaluation Results

The program has generated a cost savings of $4 million in room and board costs and a savings of over $490,000 for fee-for-services for treatment youth in Cohorts I, II, and III. The most significant portion of these savings can be attributed to the reduced time youth spend in congregate care facilities. As noted above, costs to contract with wraparound service providers averages $42,346 per youth. Some of the costs of wraparound services are likely offset by caseworkers who spend less time on Safe at Home cases since wraparound facilitators are providing such intensive services for youth/families.

V. Recommendations & Activities Planned for Next Reporting Period

West Virginia's Evaluator's Recommendations:

Recommendation 1: Update training to DHHR and LCA staff. Satisfaction with the current training curricula is higher among DHHR staff than LCA staff, although all staff are likely to benefit from updating the present curricula. Suggestions for improving training include providing refresher courses, how to build informal/natural support systems, wraparound planning/documentation procedures and how to engage youth and families.

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.

West Virginia's evaluators will be conducting fidelity reviews during the next reporting period. Reviews will be conducted on cases that became active at least 6 months after implementation of the Plans for Improvement. This is to provide a clear picture as to the effectiveness of the plans as well as program fidelity and compliance.

West Virginia will proceed with facilitation of Wraparound 101 refresher training to all appropriate BCF child welfare staff.

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. West Virginia not only plans to sustain wraparound for the current target population, but the Secretaries Child Welfare Plan for West Virginia is to expand the availability of wraparound to all children. At present West Virginia has a functioning workgroup that is focused on financial sustainability. This workgroup will continue to determine and gather the necessary financial information to inform program decisions. The Bureau for Medical Services is currently working with BCF on possible changes to Medicaid to allow for funding of Wraparound services for certain population but also expanding it to all West Virginia children, not just those served by the child welfare system. This funding may have to be braided with other funding streams to fully pay for everything that wraparound encompasses but these groups are aware working through any issues. West Virginia has worked with our LCAs and our evaluator to gain better understanding of the population that benefits most from wraparound as well as flex spending and service creation when necessary. The deep diving into this information will continue as we work on different funding streams for wraparound for varied populations

West Virginia is also working on our plan for implementation of the Family First Act. We believe this will open up the use IVE funding for those wraparound prevention services and be another valuable funding stream.

During the coming months West Virginia will form other workgroups as necessary to 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 is in the midst of drafting an Interim Report, summarizing the results of its process, outcomes and cost evaluation components since implementation of *Safe at Home.* Additional steps are being taken to gain a better understanding of the range of services which LCAs provide with flexible funds. Steps are also being taken to better understand the characteristics of the prevention cases, helping to improve the selection of the comparison group of youth and understand the factors which are contributing to the success of youth in the treatment group.

HZA will return to West Virginia for week during this coming summer to complete a third round of fidelity assessments. A sample of 40 *Safe at Home* cases will be selected, in proportion to the number of youth served by each LCA. A case record review will be conducted of the 40 cases, relying primarily on LCA case records to answer questions pertaining to each phase of the wraparound process. In addition to the case reviews, each youth, parent, wraparound facilitator and DHHR caseworker will be interviewed. Additionally, HZA will continue to utilize FACTS and CANS data for the outcome and cost evaluations.

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 – Statistical Similarity of Treatment and Comparison Groups

Appendix B – Number of Youth with an Actionable Item in the Initial CANS

Appendix C - Number of Youth with a Need on Initial CANS Who Improved at 6 & 12 Months

Appendix A. Statistical Similarity of Treatment and Comparison Groups

Measure	Significance Cohort 1	Significance Cohort 2	Significance Cohort 3	Significance Cohort 4	Test
Gender	0.593	0.780	0.436	0.836	Chi-Squared
Hispanic	0.186	0.650	0.689	0.696	Chi-Squared
Black	0.583	0.708	0.630	0.466	Chi-Squared
UTD	1.000	1.000	1.000	1.000	Chi-Squared
White	0.883	0.765	0.763	0.364	Chi-Squared
NHOPI	0.969	0.156	0.317	0.316	Chi-Squared
Asian	0.956	1.000	0.317	1.000	Chi-Squared
AIAN	1.000	1.000	1.000	1.000	Chi-Squared
AsianPI	1.000	1.000	1.000	1.000	Chi-Squared
Unknown Race	0.530	1.000	0.476	1.000	Chi-Squared
Declined	1.000	1.000	1.000	1.000	Chi-Squared
Placement Type	0.999	0.814	0.326	0.608	Chi-Squared
Parent Jail	0.530	0.067	0.563	0.313	Chi-Squared
Abandonment	1.000	1.000	0.082	0.654	Chi-Squared
Child Alcohol	1.000	1.000	0.317	0.654	Chi-Squared
Parent Alcohol	0.594	0.703	1.000	0.561	Chi-Squared
Caretaker Unable to Cope	0.303	1.000	0.316	1.000	Chi-Squared
Child Behavior	0.454	0.926	0.739	0.456	Chi-Squared
Child Disability	0.340	1.000	1.000	1.000	Chi-Squared
Parent Death	1.000	1.000	0.563	1.000	Chi-Squared

Measure	Significance Cohort 1	Significance Cohort 2	Significance Cohort 3	Significance Cohort 4	Test
Child Drugs	0.522	1.000	0.325	0.833	Chi-Squared
Parent Drugs	0.405	0.382	0.649	0.097	Chi-Squared
Housing	0.340	0.703	0.737	0.463	Chi-Squared
Neglect	0.524	0.563	0.862	0.319	Chi-Squared
Physical Abuse	0.854	0.413	1.000	0.463	Chi-Squared
Relinquishment	0.969	1.000	1.000	1.000	Chi-Squared
Sexual Abuse	0.608	0.587	1.000	0.478	Chi-Squared
Voluntary	0.340	0.154	1.000	0.129	Chi-Squared
Other	1.000	1.000	1.000	1.000	Chi-Squared
Number of Prior Placements	0.219	0.335	0.605	0.614	Chi-Squared
Axis 1 Diagnosis	0.804	0.847	0.677	0.374	Chi-Squared
Juvenile Justice Involved	0.839	0.86	0.253	0.066	Chi-Squared
Psychiatric Hospital	0.408	0.568	0.157	0.676	Chi-Squared
Group Home	0.882	0.576	0.933	0.829	Chi-Squared
Age at Referral	0.823	0.085	0.534	0.214	One Way ANOVA

Appendix B. Number of Youth with an Actionable Item in the Initial CANS

CANS Domain	CANS Item	Cohort I (N=88)	Cohort II (N=165)	Cohort III (N=209)	Cohort IV (N=299)
Behavioral / Emotional Needs	Affective and/or Physiological Dysregulation	10	17	16	28
	Anger Control	50	52	64	105
	Anxiety	14	37	42	57
	Attachment Difficulties	11	18	13	23
	Attention/Concentration	43	66	64	79
	Conduct	22	27	32	51
	Depression	18	51	52	68
	Eating Disturbances	2	5	0	2
	Impulsivity	35	51	46	74
	Oppositional Behavior	37	65	55	104
	Psychosis	3	7	4	2
	Somatization	0	2	1	4
	Substance Use	9	15	9	16
	Total	**72**	**128**	**145**	**207**
Child Risk Behaviors	Bullying	6	13	17	22
	Cruelty to Animals	0	3	2	1
	Danger to Others	16	24	33	46
	Delinquency	2	8	11	16
	Exploitation	1	0	7	4
	Fire Setting	1	2	3	6

CANS Domain	CANS Item	Cohort I (N=88)	Cohort II (N=165)	Cohort III (N=209)	Cohort IV (N=299)
	Intentional Misbehavior	14	18	19	27
	Non-Suicidal Self Injury	8	12	8	13
	Other Self Harm	5	10	3	10
	Runaway	6	22	24	35
	Sexualized Behaviors	9	11	3	8
	Sexually Abusive	1	2	4	4
	Suicide Risk	4	13	5	12
	Total	**43**	**73**	**77**	**115**
Life Functioning Needs	Brain Injury	2	0	3	2
	Child Involvement with Care	16	26	31	46
	Daily Functioning	9	6	10	15
	Developmental/Intellectual	18	28	29	35
	Family	34	73	63	99
	Legal	52	81	121	159
	Living Situation	19	47	43	57
	Medical	7	10	11	16
	Medication Compliance	9	10	14	28
	Natural Supports	43	87	65	108
	Physical	2	1	0	4
	Recreational	18	33	52	83
	School Achievement	22	45	73	98

CANS Domain	CANS Item	Cohort I (N=88)	Cohort II (N=165)	Cohort III (N=209)	Cohort IV (N=299)
	School Attendance	14	31	49	80
	School Behavior	33	50	53	88
	Sexual Development	7	8	10	22
	Sleep	17	23	23	41
	Social Functioning	31	46	49	61
	Substance Exposure	10	16	17	29
	Total	**80**	**149**	**190**	**275**
Symptoms of Trauma	Adjustment to Trauma	30	59	38	62
	Avoidance	7	12	14	18
	Dissociation	2	8	4	7
	Hyperarousal	18	36	33	37
	Numbing	5	4	12	9
	Re-experiencing	5	14	10	13
	Traumatic Grief	8	24	22	18
	Total	**42**	**74**	**59**	**88**

Appendix C. Number of Youth with a Need on Initial CANS Who Improved at 6 & 12 Months

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
Cohort I					
Behavioral/ Emotional Needs	Affective and/or Physiological Dysregulation	4	0	0	0
	Anger Control	28	5	14	5
	Anxiety	11	6	5	3
	Attachment Difficulties	4	1	1	1
	Attention/Concentration	28	6	14	5
	Conduct	11	3	6	4
	Depression	11	4	3	1
	Eating Disturbances	1	0	1	1
	Impulsivity	20	1	10	1
	Oppositional Behavior	23	5	13	7
	Psychosis	1	1	0	0
	Somatization	0	0	0	0

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Substance Use	4	3	0	0
	Total	**46**	**23**	**20**	**17**
Child Risk Behaviors	Bullying	4	1	1	1
	Cruelty to Animals	0	0	0	0
	Danger to Others	7	3	3	2
	Delinquency	0	0	0	0
	Exploitation	0	0	0	0
	Fire Setting	1	0	0	0
	Intentional Misbehavior	9	5	3	2
	Non-Suicidal Self Injury	5	4	3	1
	Other Self Harm	4	2	2	2
	Runaway	3	0	0	0
	Sexualized Behaviors	4	2	1	1
	Sexually Abusive	0	0	0	0
	Suicide Risk	2	1	1	1

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Total	**24**	**12**	**9**	**7**
Life Functioning Needs	Brain Injury	1	0	1	1
	Child Involvement with Care	8	2	1	1
	Daily Functioning	4	1	1	1
	Developmental /Intellectual	12	4	7	3
	Family	21	5	9	6
	Legal	27	3	10	4
	Living Situation	11	4	5	4
	Medical	4	2	2	1
	Medication Compliance	5	2	2	2
	Natural Supports	26	5	14	6
	Physical	1	0	1	0
	Recreational	11	4	4	4
	School Achievement	11	5	4	2
	School	5	5	2	2

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Attendance				
	School Behavior	22	7	10	4
	Sexual Development	2	2	1	1
	Sleep	7	4	2	2
	Social Functioning	18	5	7	3
	Substance Exposure	3	0	1	0
	Total	**48**	**28**	**21**	**18**
Symptoms of Trauma	Adjustment to Trauma	17	2	7	3
	Avoidance	4	0	2	1
	Dissociation	0	0	0	0
	Hyperarousal	11	5	6	4
	Numbing	2	1	2	1
	Re-experiencing	4	2	2	1
	Traumatic Grief	6	3	1	1
	Total	**26**	**10**	**9**	**7**

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
Cohort II					
Behavioral/ Emotional Needs	Affective and/or Physiological Dysregulation	11	4	2	1
	Anger Control	30	12	12	7
	Anxiety	29	11	16	7
	Attachment Difficulties	9	5	5	1
	Attention/Concentration	40	10	18	7
	Conduct	14	3	3	0
	Depression	29	8	13	6
	Eating Disturbances	4	2	3	1
	Impulsivity	27	14	8	3
	Oppositional Behavior	41	16	12	8
	Psychosis	2	1	1	1
	Somatization	0	0	0	0
	Substance Use	11	7	6	3

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Total	**75**	**44**	**35**	**23**
Child Risk Behaviors	Bullying	8	3	1	0
	Cruelty to Animals	1	1	0	0
	Danger to Others	16	6	4	3
	Delinquency	4	3	1	1
	Exploitation	0	0	0	0
	Fire Setting	0	0	0	0
	Intentional Misbehavior	9	2	5	2
	Non-Suicidal Self Injury	6	3	3	1
	Other Self Harm	6	4	3	1
	Runaway	11	7	4	3
	Sexualized Behaviors	7	5	2	2
	Sexually Abusive	0	0	0	0
	Suicide Risk	3	3	1	1
	Total	**43**	**26**	**14**	**10**

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
Life Functioning Needs	Brain Injury	0	0	0	0
	Child Involvement with Care	11	5	4	1
	Daily Functioning	3	2	1	1
	Developmental /Intellectual	21	3	10	2
	Family	46	20	19	9
	Legal	42	8	15	3
	Living Situation	27	20	11	10
	Medical	6	2	2	1
	Medication Compliance	5	1	3	2
	Natural Supports	50	17	20	10
	Physical	1	0	0	0
	Recreational	18	7	2	1
	School Achievement	29	17	16	10
	School Attendance	20	14	7	4

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	School Behavior	31	19	10	8
	Sexual Development	5	3	2	2
	Sleep	12	5	3	1
	Social Functioning	27	14	9	5
	Substance Exposure	9	2	5	1
	Total	**82**	**53**	**36**	**26**
Symptoms of Trauma	Adjustment to Trauma	33	15	15	9
	Avoidance	8	5	5	2
	Dissociation	4	2	3	1
	Hyperarousal	20	10	10	8
	Numbing	3	1	2	1
	Re-experiencing	9	6	4	4
	Traumatic Grief	17	11	9	7
	Total	**43**	**26**	**20**	**14**

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
Cohort III					
Behavioral/ Emotional Needs	Affective and/or Physiological Dysregulation	6	2	0	0
	Anger Control	28	14	1	1
	Anxiety	19	9	5	3
	Attachment Difficulties	6	3	2	1
	Attention/Concentration	29	10	3	3
	Conduct	15	4	1	1
	Depression	24	7	5	3
	Eating Disturbances	0	0	0	0
	Impulsivity	19	6	0	0
	Oppositional Behavior	19	7	2	2
	Psychosis	3	3	1	1
	Somatization	1	1	1	1
	Substance Use	4	2	0	0

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Total	**62**	**34**	**9**	**8**
Child Risk Behaviors	Bullying	9	5	1	0
	Cruelty to Animals	1	0	0	0
	Danger to Others	13	9	3	3
	Delinquency	5	1	2	2
	Exploitation	2	0	0	0
	Fire Setting	2	1	0	0
	Intentional Misbehavior	9	3	0	0
	Non-Suicidal Self Injury	7	5	1	1
	Other Self Harm	1	1	0	0
	Runaway	10	4	1	1
	Sexualized Behaviors	1	0	0	0
	Sexually Abusive	0	0	0	0
	Suicide Risk	3	3	0	0
	Total	**34**	**23**	**7**	**6**

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
Life Functioning Needs	Brain Injury	0	0	0	0
	Child Involvement with Care	12	5	1	1
	Daily Functioning	4	2	0	0
	Developmental /Intellectual	14	3	0	0
	Family	28	19	6	2
	Legal	54	9	11	5
	Living Situation	16	9	2	2
	Medical	4	2	2	1
	Medication Compliance	6	5	3	3
	Natural Supports	24	8	7	3
	Physical	0	0	0	0
	Recreational	25	14	7	3
	School Achievement	32	16	5	4
	School Attendance	25	18	5	4

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	School Behavior	26	16	2	2
	Sexual Development	4	0	0	0
	Sleep	13	6	3	3
	Social Functioning	20	8	2	2
	Substance Exposure	4	2	0	0
	Total	**82**	**53**	**16**	**12**
Symptoms of Trauma	Adjustment to Trauma	16	7	5	3
	Avoidance	5	2	1	0
	Dissociation	1	1	1	1
	Hyperarousal	10	5	2	1
	Numbing	3	2	1	1
	Re-experiencing	7	3	3	2
	Traumatic Grief	13	10	3	1
	Total	**24**	**14**	**5**	**4**

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
Cohort IV					
Behavioral/ Emotional Needs	Affective and/or Physiological Dysregulation	8	4	-	-
	Anger Control	27	11	-	-
	Anxiety	16	5	-	-
	Attachment Difficulties	7	2	-	-
	Attention/Concentration	23	8	-	-
	Conduct	13	5	-	-
	Depression	19	6	-	-
	Eating Disturbances	0	0	-	-
	Impulsivity	15	3	-	-

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Oppositional Behavior	26	9	-	-
	Psychosis	0	0	-	-
	Somatization	2	0	-	-
	Substance Use	3	2	-	-
	Total	**58**	**30**	-	-
Child Risk Behaviors	Bullying	6	3	-	-
	Cruelty to Animals	0	0	-	-
	Danger to Others	12	7	-	-
	Delinquency	3	0	-	-
	Exploitation	0	0	-	-
	Fire Setting	3	2	-	-
	Intentional Misbehavior	7	2	-	-
	Non-Suicidal Self Injury	1	1	-	-
	Other Self Harm	1	1	-	-
	Runaway	7	4	-	-

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Sexualized Behaviors	2	1	-	-
	Sexually Abusive	1	0	-	-
	Suicide Risk	1	1	-	-
	Total	**26**	**14**	-	-
Life Functioning Needs	Brain Injury	1	0	-	-
	Child Involvement with Care	13	7	-	-
	Daily Functioning	2	0	-	-
	Developmental /Intellectual	10	2	-	-
	Family	29	12	-	-
	Legal	43	13	-	-
	Living Situation	20	10	-	-
	Medical	4	0	-	-
	Medication Compliance	7	2	-	-
	Natural Supports	24	7	-	-

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Physical	3	0	-	-
	Recreational	28	13	-	-
	School Achievement	33	16	-	-
	School Attendance	23	18	-	-
	School Behavior	29	19	-	-
	Sexual Development	8	4	-	-
	Sleep	13	7	-	-
	Social Functioning	21	11	-	-
	Substance Exposure	7	0	-	-
	Total	**77**	**58**	-	-
Symptoms of Trauma	Adjustment to Trauma	21	7	-	-
	Avoidance	7	3	-	-
	Dissociation	2	1	-	-
	Hyperarousal	12	5	-	-
	Numbing	3	1	-	-

CANS Domain	CANS Item	Youth With a 6 Month CANS & Need on Initial CANS	Youth With Improved Scores 6 Months Post-Initial CANS	Youth With a 12 Month CANS & Need on Initial CANS	Youth With Improved Scores 12 Months Post-Initial CANS
	Re-experiencing	2	1	-	-
	Traumatic Grief	5	3	-	-
	Total	**29**	**15**	-	-