WEST VIRGINIA
Department of
Health & Human Resources

Safe at Home West Virginia

Strengthening families & children within their home communities

Semi-Annual Progress Report

April 1, 2018 – September 30, 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

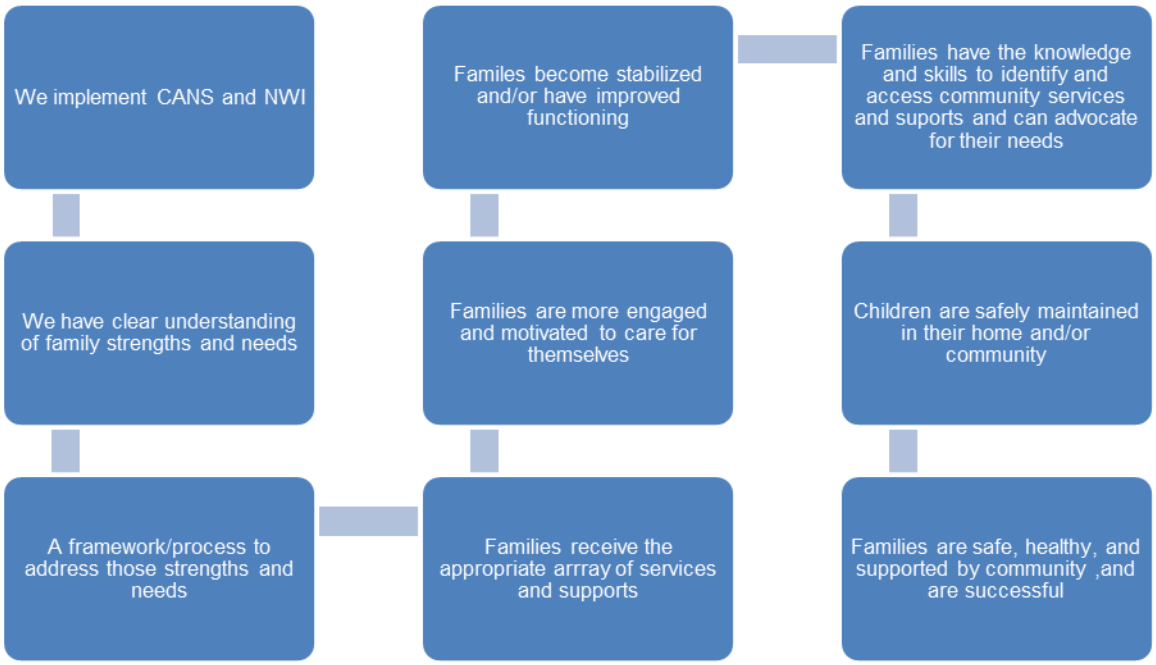
So that

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.

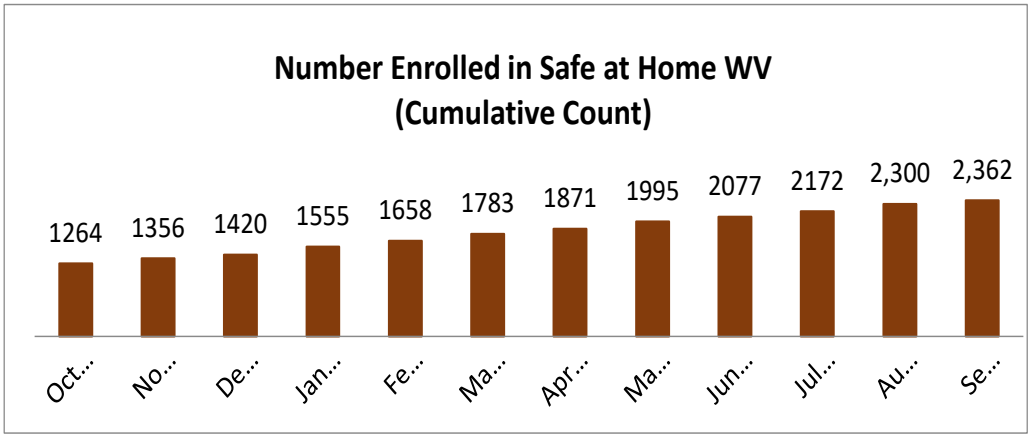
On August 1, 2016, West Virginia began Phase 2 of implementation by expanding to the 24 counties of Barbour, Brooke, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Lewis, Marion, Mineral, Mercer, Monongalia, Monroe, Nicholas, Ohio, Pendleton, Pocahontas, Preston, Randolph, Summers, Taylor, Tucker, 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 September 30, 2018, 2362 youth have been enrolled in Safe at Home West Virginia. West Virginia has returned 82 youth from out-of-state residential placement back to West Virginia, 245 Youth have stepped down from in-state residential placement to their communities, and 36 youth have returned home from an emergency shelter placement. West Virginia has been able to prevent the residential placement of 1,535 at risk youth.

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

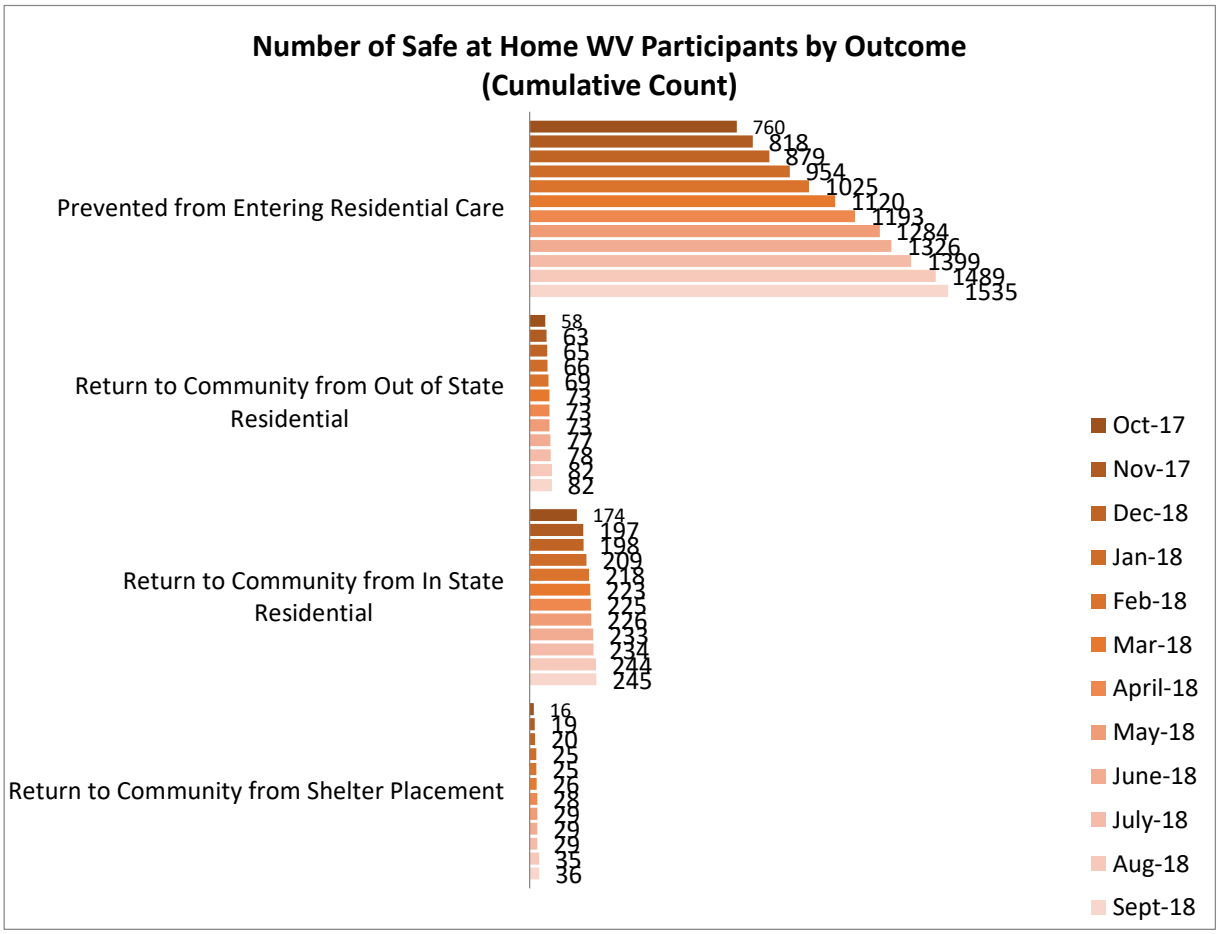
- 129 were or are in out-of-state residential placement at time of enrollment with 82 returning to WV
- 426 were or are in in-state residential placement at time of enrollment with 245 returning to community
- 1,734 were or are prevention cases at time of enrollment with only 164 entering residential placement
- 36 returning to their community from emergency shelter placement



Number Enrolled in Safe at Home WV

Column1	Column2
Oct-17	1264
Nov-17	1356
Dec-17	1420
Jan-18	1555
Feb-18	1658
Mar-18	1783
April-18	1871
May-18	1995
June-18	2077
July-18	2172
Aug-18	2,300
Sept-17	2,362

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



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

Leading up to our first Safe at Home West Virginia referrals West Virginia developed a program manual and family guide as well as DHHR/BCF policies, desk guides and trainings. All staff and providers were provided with Wraparound 101 training, an overview of the wraparound process, Family and Youth engagement training that is part of our Family Centered Practice Curriculum, and CANS training. The West Virginia Department of Health and Human Resources (DHHR) instituted weekly email blasts that go out to all DHHR staff and our external partners. These email blasts focused on educating us on the 10 principles of Wraparound, family and youth engagement, and ongoing information regarding Safe at Home West Virginia. We also implemented a quarterly newsletter that reaches all of our staff and external partners, conducted presentations across the state as well as media interviews and private meetings with partners. These activities continue as specific to each phase of implementation and sustaining. Our newsletters now reach over 1,000 partners. All program materials, newsletters, as well as other pertinent information are posted on our website for public viewing and use.

During the reporting period, West Virginia continued to work to improve the previous recommendations of our evaluator.

April 2018 Recommendations

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

During this reporting period, West Virginia has continued our work through the Local

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

During the previous reporting period West Virginia worked with our evaluators who developed an algorithm report in our automated CANS data base. Dr. John Lyon's had

worked with West Virginia on this algorithm which was then provided to the evaluators for build in the system. The algorithm report went live on March 2018.

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

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

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

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

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

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

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

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

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

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

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

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

III. Evaluation Status

Data Collection Activities:

Over the last six months of Safe at Home West Virginia, the evaluator, Hornby Zeller Associates, Inc. (HZA),[2] conducted case record reviews, completed interviews with stakeholders across the State and administered the annual fidelity survey to Local Coordinating Agency (LCA) staff. These three data collection activities informed the process evaluation. Analysis of data from DHHR's Statewide Automated Child Welfare Information System (SACWIS), FACTS, informed the outcome, process and cost evaluations. In addition to data from FACTS, data from the automated Child and Adolescent Needs and Strengths (CANS) tool were also used to inform the outcome evaluation.

On-Site Case Reviews and Interviews

Staff from HZA conducted the third annual fidelity assessment between July 23, 2018 and August 3, 2018. Case record reviews and interviews were conducted to assess the extent to which the LCAs are performing services with fidelity to the National Wraparound Initiative's model, as well as to examine the level of adherence to Safe at Home's additional standards and timeframes. HZA completed case record reviews for 40 cases across all ten contracted agencies and conducted interviews with a total of 93 key stakeholders. (See Appendix A and B for copies of the tools that were used.) HZA randomly selected 30 cases for review in proportion to the number of youth served by each LCA. For the remaining ten cases selected for review, HZA asked each LCA to select one program graduate to ensure that reviewers would have the opportunity to observe all four phases of Wraparound at each agency.

The youth, a caregiver, the LCA wraparound facilitator and the DHHR caseworker from each case were asked to participate in the interviews. Some of the wraparound facilitators and caseworkers were interviewed about more than one case in the sample. Table 1 displays the number of stakeholders interviewed during the summer of 2018 assessment.

[2] Hornby Zeller Associates, Inc. was acquired by Public Consulting Group, Inc. on March 1, 2018.

Table 1. Stakeholders Interviewed by Group	
Youth	21
Caregivers	21
LCA Wraparound Facilitators	27
DHHR Caseworkers	23
Youth Coach	1
Total	**93**

Surveys

Surveys were administered statewide to LCA staff from September 10, 2018 to September 28, 2018. The survey, administered for the third time over the course of the evaluation, asked questions about the extent to which LCA staff are completing work required for Safe at Home youth, along with their qualifications, level of buy-in and perceptions of program success (Appendix C).

HZA staff reached out to LCA leadership staff in advance of administering the survey to allow them time to encourage their staff to participate. The survey was then sent to all leadership staff as well as to all LCA CANS users. In total, 206 stakeholders received a link to the survey, with a total of 156 surveys completed. Table 2 describes the positions held by the respondents.

Table 2. LCA Fidelity Survey Respondents by Position	
Wraparound Facilitator	106
Wraparound Supervisor	24
Wraparound Program Manager	10
Other[3]	16

[3] Other respondents reported some of the following job titles: Assessment Coordinator, Associate Executive

Table 2. LCA Fidelity Survey Respondents by Position	
Total	**156**

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, shorter lengths of stay in congregate care, etc.). Outcomes for youth involved in Safe at Home are compared to an historical comparison group of youth. The comparison groups (which are selected separately for each six-month treatment cohort since the program was implemented) were selected from youth known to DHHR between State Fiscal Years (SFYs) 2010 to 2015. Characteristics, including demographic data, case history and program qualifying characteristics, such as age and placement, were used to match comparison youth to the treatment group cohorts. Youth in the treatment group were partitioned into five subgroups according to referral and placement type: out-of-state congregate care facilities and group care, in-state congregate care facilities and group care, emergency shelter, family foster care placements and youth at home. The characteristics of youth in each comparison group are statistically similar to the youth in each of the four[4] treatment cohorts (see Appendix D for the statistical comparisons).

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

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, as well as ready access to assessment data

Director, Chief Operations Officer, CQI, Executive Director, Youth Coach and Family Support Worker.

[4] 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 sixth cohort for the April 2019 semi-annual evaluation report.

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

IV. Significant Evaluation Findings to Date

Process Evaluation Results

Youth Population Description

Table 3 provides a description of the Safe at Home youth population at the time of referral. For the first time since the initiative began, it appears that the overall number of referrals is decreasing. There was a 20 percent decrease in the overall number of approved referrals between Cohorts 5 and 6.

Overall, 70 percent of the 2,011 youth were referred while living at home. Referrals for youth living at home made up 33 percent of Cohort 1's population, but 81 percent of Cohort 6's. The increase in referrals for youth living at home is indicative of Safe at Home's focus shift to a prevention program. The impact is conversely noted in congregate care referrals, which made up 56 percent of referrals in Cohort 1, but only 11 percent in Cohort 6.

Table 3. Safe at Home Youth Population Description at Referral[5]

	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	All Cohorts
Total Referred	**124**	**221**	**297**	**445**	**512**	**412**	**2,011**
Placement							
Out-of-state Congregate Care	31 (25%)	18 (8%)	12 (4%)	12 (3%)	17 (3%)	11 (3%)	101 (5%)
In-state Congregate Care	39 (31%)	73 (33%)	61 (21%)	60 (13%)	52 (10%)	31 (8%)	316 (16%)

[5] Percentages may not always total 100 due to rounding.

Table 3. Safe at Home Youth Population Description at Referral[5]							
	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	All Cohorts
Total Referred	**124**	**221**	**297**	**445**	**512**	**412**	**2,011**
Emergency Shelter	6 (5%)	18 (8%)	6 (2%)	13 (3%)	22 (4%)	11 (3%)	76 (4%)
Family Foster Care	2 (2%)	11 (5%)	13 (4%)	27 (6%)	34 (7%)	26 (6%)	113 (6%)
Home	46 (37%)	101 (46%)	205 (69%)	333 (75%)	387 (76%)	333 (81%)	1,405 (70%)
Age							
12 or under	10 (8%)	19 (9%)	25 (8%)	37 (8%)	63 (12%)	36 (9%)	190 (9%)
13	20 (16%)	26 (12%)	35 (12%)	64 (14%)	80 (16%)	60 (15%)	285 (14%)
14	30 (24%)	48 (22%)	67 (23%)	87 (20%)	98 (19%)	91 (22%)	421 (21%)
15	28 (23%)	58 (26%)	65 (22%)	135 (30%)	120 (23%)	107 (26%)	513 (26%)
16	32 (26%)	63 (29%)	92 (31%)	103 (23%)	120 (23%)	91 (22%)	501 (25%)
17	4 (3%)	7 (3%)	13 (4%)	19 (4%)	31 (6%)	27 (7%)	101 (5%)
Gender							
Male	75 (60%)	116 (52%)	186 (63%)	274 (62%)	303 (59%)	241 (58%)	1,195 (59%)
Female	49 (40%)	105 (48%)	111 (37%)	171 (38%)	209 (41%)	171 (42%)	816 (41%)
Race							
White	96 (77%)	181 (82%)	245 (82%)	405 (91%)	435 (85%)	345 (84%)	1,707 (85%)
Black	8 (6%)	19 (9%)	15 (5%)	14 (3%)	25 (5%)	26 (6%)	107 (5%)

Table 3. Safe at Home Youth Population Description at Referral[5]							
	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	All Cohorts
Total Referred	**124**	**221**	**297**	**445**	**512**	**412**	**2,011**
Mixed	16 (13%)	18 (8%)	32 (11%)	20 (4%)	43 (8%)	0 (0%)	129 (6%)
Other	4 (3%)	3 (1%)	5 (2%)	6 (1%)	9 (2%)	41 (10%)	68 (3%)
Case Type[6]							
Youth Services	112	167	263	362	404	342	1,650
CPS	12	54	36	88	108	70	368

Youth age at referral has remained consistent across cohorts, with most youth receiving a referral between the ages of 14 and 16. Seventeen-year-olds have made up the smallest percentage of Safe at Home youth in all six cohorts. Males also make up more than half of the Safe at Home population (59%), which is a trend that has remained consistent across cohorts. White youth make up the majority of Safe at Home's population (85% overall) and have also consistently been represented across cohorts.

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

Fidelity Assessment

As described above, the fidelity assessment was conducted during the summer of 2018 with HZA staff completing a total of 40 case record reviews on-site at the LCAs as well as 93 stakeholder interviews. Thirty of the cases were selected randomly, in proportion to the

[6] Numbers often exceed the total in each cohort because a youth can have a CPS and Youth Services case simultaneously. For this reason, percentages were not calculated.

number of youth served by each LCA. For the remaining ten cases, each LCA was asked to select a program graduate to ensure that reviewers would be able to observe all four phases of Wraparound at each agency.

Ultimately, the case sample included cases from all four of the State's regions, and more specifically, the following 19 counties: Brooke, Cabell, Doddridge, Fayette, Hancock, Harrison, Kanawha, Logan, Marion, Mercer, Monongalia, Nicholas, Ohio, Putnam, Randolph, Ritchie, Summers, Taylor and Webster. At the time of review, exactly half of the 40 cases were open, 17 had successfully graduated the program and three were discharged before program completion. On average, the open cases had been active in Safe at Home for 252 days as of the date the reviews were completed, while cases closed due to graduation were open 312 days and 146 days for discharged closed cases.

LCA Wraparound Facilitator Qualifications

Wraparound services are provided to youth by ten LCAs located throughout the State. Each youth has one assigned wraparound facilitator who has a caseload of no more than ten. The wraparound facilitators, according to the State's funding announcements, should have at least a bachelor's degree in social work, sociology, psychology or another human service related field with two years of work experience serving a youth population similar to that of Safe at Home (e.g., ages 12-17 with a possible mental health diagnosis currently in, or at risk of entering, congregate care). Wraparound facilitators should also be knowledgeable about mental health diagnoses and behavioral disorders in children, and personal family experience with mental illness is considered helpful. The State may, in some cases, make an exception to one or more of these requirements for an applicant with extensive knowledge and/or experience in the field.

All 106 facilitators who responded to the survey reported having at least a bachelor's degree with all but one satisfying the degree field requirement; eleven more had a master's degree. The most common degree among LCA staff was psychology. Eighty-two percent reported having two or more years of experience in the behavioral health field with 45 percent having six or more years of experience. Eighty-six percent of the facilitators reported prior experience working with older youth and their families, while 82 percent were knowledgeable about mental illness diagnoses and behavioral disorders in children and 70 percent had personal family experience with mental illness.

LCA staff, including wraparound facilitators and supervisors, working with Safe at Home are also required to complete training and Wraparound and CANS certification. The training,

according to the latest (Phase III) Safe at Home funding announcement, includes at least the following content, but many LCAs institute additional trainings for their staff:

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

All but one of the 106 facilitators and all 24 supervisors reported they had received training prior to working with Safe at Home and 98 percent of all LCA staff reported the training sufficiently prepared them to adequately do their job. Eighty-nine percent of the facilitators had received Wraparound certification and 90 percent had received CANS certification. Six of the 11 facilitators who had not completed the Wraparound certification and eight of the ten who had not completed the CANS certification were new to the position and still completing the training process. However, one facilitator reported that Wraparound certification is not required for the job and another did not know about Wraparound certification.

Wraparound Phase I: Engagement and Team Preparation

The purposes of the Engagement and Team Preparation Phase are to orient the family to the program; to begin engaging with the family and exploring strengths, needs and goals; to identify any pressing issues or concerns that the family has; and to build the wraparound team with an emphasis on family identified supports.

Youth and caregivers initially learned about Safe at Home through a variety of media, including caseworkers, court staff, probation officers, guardian ad litems, siblings who were previously enrolled, child advocacy staff and wraparound facilitators. In most of the cases, it was the caseworker who introduced the youth and family to the program. Typically, caseworkers explained Safe at Home to clients by discussing its goals, services and the different roles stakeholders play throughout the case life. Many caseworkers informed youth/families

that their participation in the program was voluntary. As an example, one caseworker told a family that, "this is a service that can be provided to you and your family free of charge to help communication and service oversight, to prevent further department involvement and to keep your child out of residential placement."

Following the initial introduction, wraparound facilitators met with youth/families, where they provided more detail about Safe at Home. Some of them would re-iterate that the program is voluntary with one facilitator stating, "[the youth/family] can fire me today if they want." Often, facilitators presented program specific materials to introduce youth/families to Safe at Home, described how the program is driven by youth/family voice/choice and shared what services were available to them. Facilitators also explained that the program is designed to build natural supports so the family can sustain progress after formal supports leave and provided examples of how the program benefits youth/families. More specific details, such as how often the facilitator would be meeting with them and how goals are created, were also discussed.

Most stakeholders reported that youth/families had a good understanding of the program. In some cases, youth/families did not grasp the concepts at first but eventually understood them as time went on and they got to work with the program. In a rare couple of cases stakeholders did not believe youth/families truly understood Safe at Home's intentions and concepts, and consequently, there were more challenges noted with these particular cases.

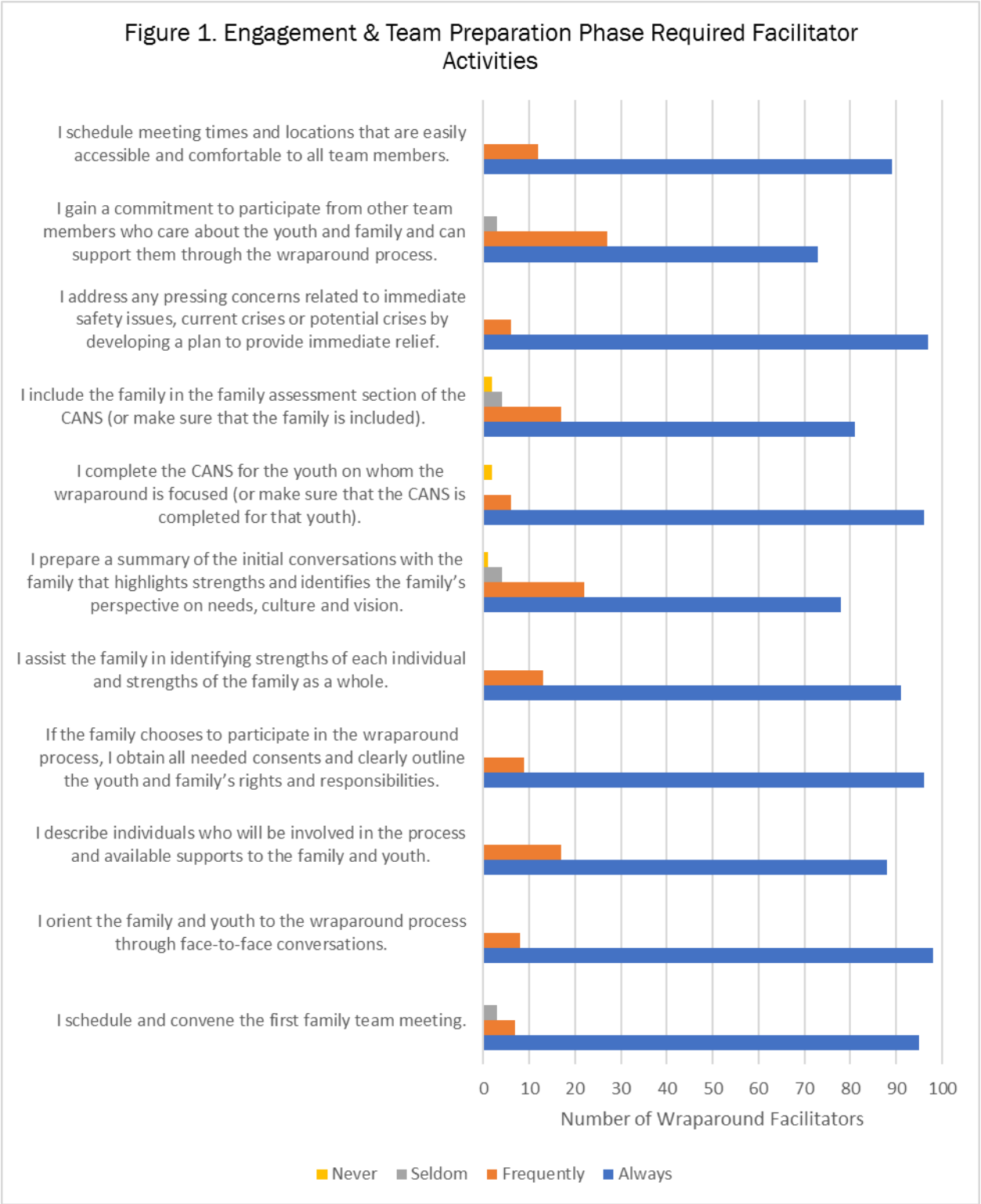
In their initial meetings with youth/families, wraparound facilitators attempted to encourage them to discuss any concerns and to share any strengths or goals. In some cases, youth/families were open with facilitators from the start, but in most cases their ability to open up and engage improved as time went on and facilitators built rapport. A caregiver noted that they struggled with the case opening because, "I have a hard time asking people for help, and my [son/daughter] is pretty shy. But, [s/he] really opened up to [the wraparound facilitator] and mentor." In just a few cases, engagement never improved and remained an ongoing issue throughout the life of the case (and often developed into a larger compliance issue). One youth provided an example of facilitator encouragement, saying that, "we've completely redone the wraparound plan three or four times in the last eight months [and developed] higher standards so I have something to work towards."

Some of the wraparound facilitators shared the following strategies which they used to overcome engagement issues: engaging the *entire* family (even the little kids), building trust, proving they were consistent and reliable in their work, spending time alone with the youth to establish a connection and demonstrating continual patience.

All wraparound facilitators offered youth/families the opportunity to invite supports to participate as members of the wraparound team; however, the extent to which this occurred was mixed. In most cases where informal/natural supports were identified, siblings, grandparents, aunts, uncles, friends, neighbors and church members participated. In other cases, the identified supports chose not to participate. In a few cases, their participation waivered as youth experienced placement changes.

About half of the youth/families could not identify willing informal supports to be a part of the wraparound team (often because there simply was no one around to involve), or they actively chose to keep Safe at Home involvement within their immediate family. For example, one youth reported only wanting immediate family members involved, stating "[I am] just keeping my circles small. I haven't had a reason to involve anyone else." Many youth/families identified formal supports (e.g., caseworkers, probation officers, therapists, guidance counselors, teachers, etc.) and most of the formal supports remained active participants throughout the duration of the case. In one case, the facilitator reported that the caseworker was always invited but often did not participate.

Additionally, the LCA fidelity survey asked facilitators about the extent to which required tasks were performed during each phase of Wraparound, starting with the Engagement and Team Preparation Phase. Their responses are shown in Figure 1.



Nearly all wraparound facilitators surveyed reported completing each of the required

activities "Always" or "Frequently" during the Engagement and Team Preparation Phase. The findings on the Engagement and Team Preparation items from the survey are consistent with last year, indicating that facilitators do not struggle with implementing this phase of Wraparound at a level of high-fidelity.

Wraparound Phase II: Initial Plan Development

The purpose of the Initial Plan Development Phase is to design the initial wraparound and crisis safety plans through a collaborative team process. Youth/families should play an active and integral role in planning, where their feedback is elicited and incorporated into plans wherever possible.

Wraparound facilitators employed a variety of strategies to involve youth/families in the planning process. While responses varied, some of the methods identified included holding meetings at the family's house; asking youth/families what is most concerning to them and what their strengths and goals are; focusing on, or incorporating, the youth's interests; developing rapport; ensuring that all team members could share; reminding the youth/family of their ownership in planning; using assessments (e.g., the CANS) as discussion items; discussing progress and setbacks; and offering, on occasion, incentives for participation.

Facilitators often asked questions as an engagement strategy. Some examples of questions used to promote engagement included, "What brought you to this point," "What needs to change," or "What's keeping you from your vision?" One other method a facilitator mentioned using was setting a "fun goal," (such as running a mile in under seven minutes) to help distract the youth from the negativity that is often associated with what the court is asking the families to do. One facilitator brings a blank wraparound plan to the monthly family team meetings to start the discussion about goals the youth/family wants to work on so it can be filled out together. The culmination of these efforts helps youth, families, facilitators and other team members to set goals and move forward with a plan.

When youth/families were hesitant to engage in the planning process, facilitators would change their approaches. One of the facilitators said, "It's their plan. They develop it…It's a brand-new thing to them. They are used to just being told what they have to do." In one case, the facilitator slowed the process down for the youth as it appeared overwhelming, asking the youth what the immediate concern today is and just focusing on that.

Caseworkers provided examples of their role and how they assisted in wraparound planning, which included: helping to identify goals as well as strategies to reach goals, offering general feedback, meeting with facilitators to discuss plans and needs before family team

meetings and offering additional support to facilitators and youth/families whenever necessary.

Wraparound facilitators are responsible for completing Child and Adolescent Needs and Strengths (CANS) assessments for all youth. Initial CANS are to be completed for youth within 30 days of referral to Safe at Home while subsequent CANS are to be conducted every 90 days thereafter. On average, LCAs completed the initial CANS 35 days after referral (falling short of the timeframe by five days) and subsequent CANS every 89 days (exceeding the timeframe by a day). However, when two egregiously outlying cases are excluded from the initial CANS analysis, the timeframe is met at exactly 30 days.

The findings regarding the timeliness of meeting CANS deadlines are consistent with last year's assessment. Last year initial CANS were completed at an average of 36 days following referral and subsequent CANS were completed every 90 days thereafter. Last year, when one LCA was excluded from the calculation, the timeframe for completing initial CANS was exceeded at 22 days. Thus, it has been consistent between years that initial CANS timeframes are challenging to meet only for either individual LCAs or in a couple of exceptional cases.

Wraparound facilitators and caseworkers identified the CANS assessments as an important tool for identifying needs and documenting progress toward the youth's goals. The CANS was described as a primary resource for wraparound plan creation, and it enabled facilitators to identify areas of strength which could be used to help mitigate the identified needs. Some facilitators reported that the CANS was useful in showing youth/families what their strengths are; stakeholders reported the youth/families often believe they do not have any.

A few facilitators expressed concern regarding the effectiveness of the CANS tool. One facilitator said that the tool was only effective if the facilitator knew the youth and family well (which is difficult to do in 30 days). Other challenges some facilitators described included the time-consuming nature of the tool and the challenge of identifying needs in the CANS that families do not see as a need, and subsequently, figuring out the best way to address those needs in planning when the youth/families were in denial of the problems that existed.

All youth and caregivers agreed that their feedback has been used in planning. Most youth reported that they personally contribute to wraparound plans by providing their opinions and creating goals. For example, one youth reported that the wraparound team, "asked me what I wanted to do with my life and the facilitator is setting me up to shadow in the careers I am interested in." In another example, one youth was able to choose the gender of his/her therapist and mentor, and another, because of his/her interest in basketball, was provided a

pass to the local recreation center.

Initial wraparound plans are to be completed within 30 days of program referral. On average, LCAs completed initial wraparound plans within 29 days of referral. Subsequent wraparound plans are to be updated and refined as necessary, and on average they were revised every 42 days. LCAs improved in their ability to meet the initial wraparound plan timeframe this year; last year, the timeframe was missed by 15 days.

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

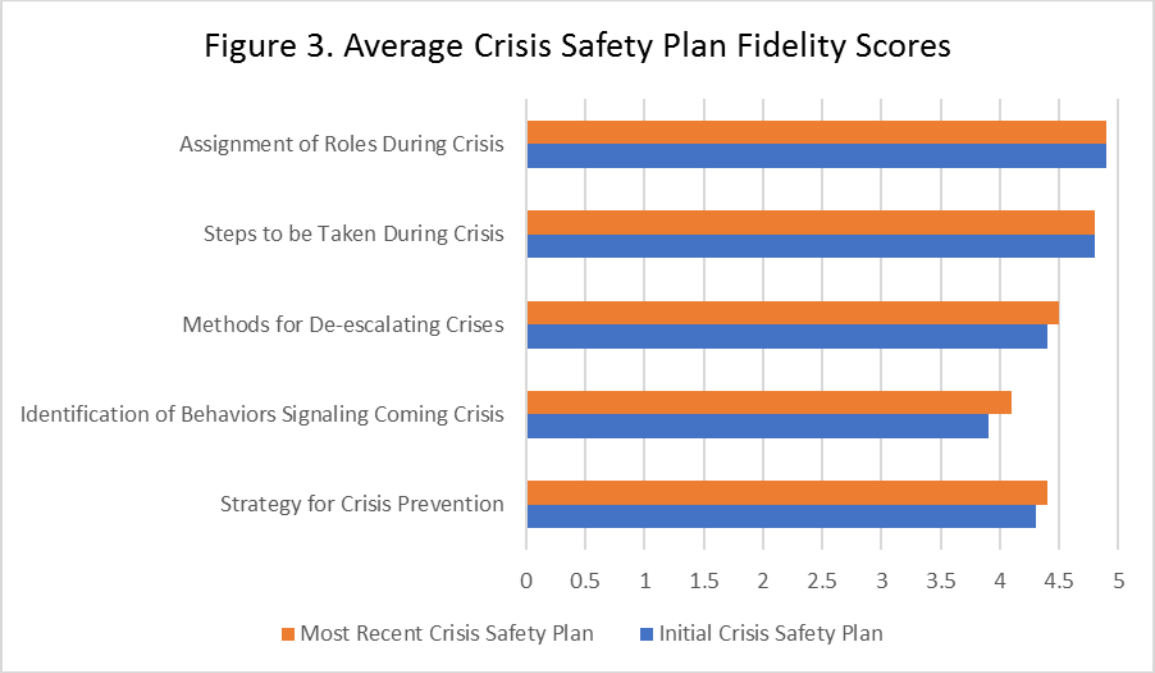
Figure 2. Average Wraparound Plan Fidelity Scores

The content of both the initial and most recent wraparound plans was exceptionally high this year with demonstrable improvement on every fidelity item between that which was completed initially and the most recent. These scores should be regarded as a strength to the Safe at Home program as they provide evidence of the LCAs' strong adherence to the Wraparound model. The greatest improvement was made on the, "Measurable Outcomes/Objectives" item. In comparison to last year's ratings, LCAs showed marked improvement.

Initial crisis safety plans are to be completed within 14 days of the *Safe at Home* referral. On average LCAs completed the initial crisis plans within 22 days of referral (missing the timeframe by just over a week). While initial crisis safety plan timeframes were missed this year, there was still substantial improvement from last year where initial crisis safety plans were completed at an average of 39 days following referral. Subsequent crisis safety plans are to be updated and refined as necessary, and on average this occurred every 52 days.

HZA reviewers reported a variety of reasons which may explain instances where LCAs struggled to meet the initial timeframes, with some of the most common reasons being family noncompliance or cancellations, facilitator turnover, youth placement changes and difficulty eliciting the help of caseworkers to initiate the first contact with youth/families.

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



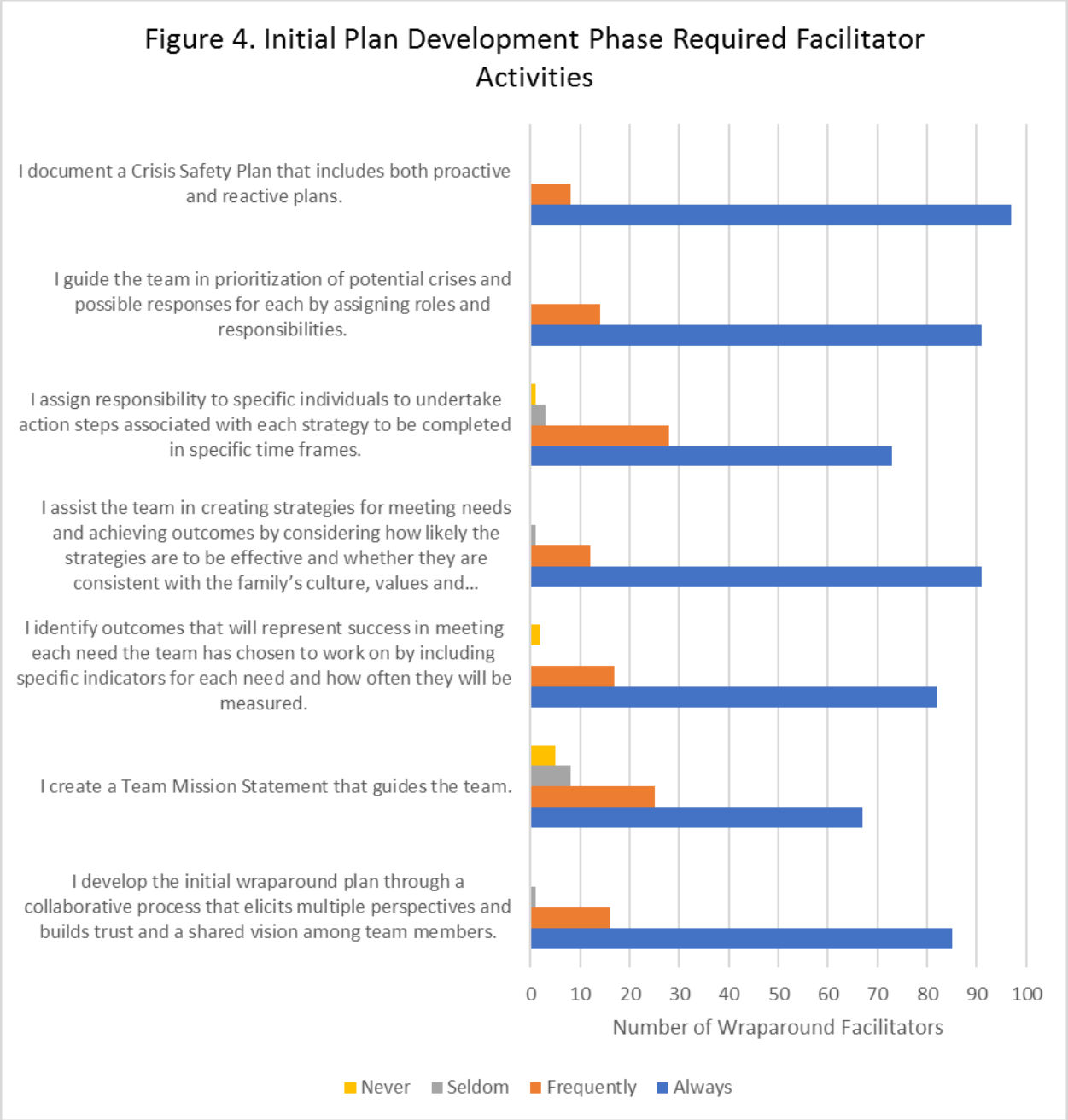
The ratings for crisis safety plans were similar to that of wraparound plans; the scores were consistently high and improvement was shown on the items which, while still on the high on the fidelity spectrum, were lower than others. The only two items that did not show improvement, remained the same and were rated the highest to begin with, so there was little room left for improvement. The greatest improvement was on the, "Identification of Behaviors Signaling Coming Crisis" item. The crisis safety plan ratings provide further evidence for LCAs' diligent work in ensuring that the Wraparound model is implemented with fidelity. In comparison to last year's ratings, LCAs received higher scores on every fidelity item, showing an improved ability to adhere to model fidelity around crisis safety planning.

Stakeholders reported that most caseworkers were involved with crisis safety planning through Safe at Home, while stating that wraparound facilitators took the lead. In some cases, caseworkers became more heavily involved due to the risk associated with the case. For example, one caseworker said, "I was deeply involved in crisis safety planning. The judge ordered us to do whatever we could to prevent removal."

Youth and caregivers from nearly all cases were involved in crisis safety planning, according to stakeholders. For most of the cases, stakeholders reported that crisis safety plans did not need to be implemented because a crisis never occurred. In these cases, some stakeholders reported that it was still helpful to have the plan just in case a crisis did happen, so

that everyone would know what to do and how to respond. In cases where the plan was implemented, most stakeholders reported that it was useful. For example, in one case it was effective in helping the youth/family to resolve the crisis themselves without reliance on external support. Some stakeholders agreed that a challenge associated with crisis safety planning is that some youth/families struggle to identify they are in crisis or are in denial that crises exist.

The surveys of LCA staff were also used to measure the extent to which required tasks were performed by wraparound facilitators during the early stages of providing wraparound (Figure 4).



Nearly all the wraparound facilitators surveyed reported completing all of the required casework activities "Always" or "Frequently" during the Initial Plan Development Phase. The only item where the trend was less clear was, "I create a Mission Statement that guides the team." Interview data implies that this could be because facilitators value a team approach and would not claim full credit for creating the mission statement. All survey findings regarding the Initial Plan Development Phase are consistent between this year's and last year's assessment,

including the "I create a Mission Statement that guides the team," item.

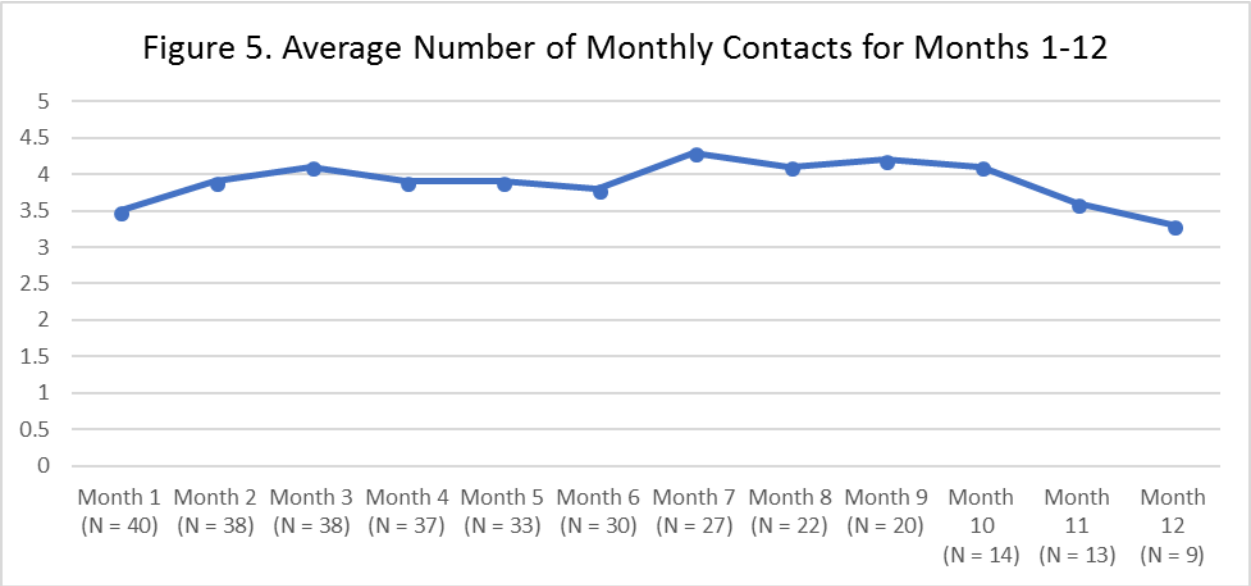
Wraparound Phase III: Plan Implementation

The purposes of the Plan Implementation Phase are to put the wraparound plan into action and revisit and update plans whenever necessary, to ensure that the youth/family and team members remain engaged, to continually monitor progress, to address any challenges and to celebrate success.

Wraparound facilitators are required to have weekly contact with youth/families and they are to reduce contact gradually as progress is being made and youth/families move toward the final phase: Transition. According to stakeholders, meetings between the facilitator and the youth/families occurred once a week, or more, on an as needed basis. Most stakeholders interviewed reported that the amount of contact was adequate. In one case, the family had trouble keeping the appointments, so they would lose touch and re-engage later in the month. A couple of caseworkers, as well as one facilitator, reported that the contact was not frequent enough. This facilitator shared that although s/he attempted more frequent contact, the youth/family refused and even stated, "they would make me stand outside in the snow." Some youth expressed appreciation for having someone with whom to talk any time they needed support.

Case review data on the number of facilitator face-to-face contacts per month seemed to align with the interview data (Figure 5). In some cases, contact seemed slow to start. The number of contacts peaked at month seven and then a decline was observed in the ensuing months. The decline in frequency may also be correlated to the number of cases that remained involved with SAH and those that Transition[7].

[7] Transition can happen at three, six, nine, 12, or 24 months at the facilitator's discretion based on the progress of the case.



Wraparound facilitators monitored case progress in a variety of ways, including monthly family team meetings, weekly visits, youth and family self-reports, monthly staffings with DHHR staff, monthly summaries, CANS scores, wraparound plans and provider or school reports.

According to stakeholders, some of the services youth/families from these 40 cases received during their involvement with Safe at Home were:

- tutoring;
- counseling/therapy (e.g., Cognitive Behavioral Therapy, Dialectical Behavior Therapy and Family Functional Therapy);
- independent life skills;
- paraprofessional family support;
- parenting classes (examples of specific models included the STEPS program and Grandparents as Parents class);
- medication management;
- drug court;
- youth coaching;
- mentoring;

- transportation;
- gym memberships;
- art classes/clubs;
- Junior Reserves Officers' Training (JROTC);
- school and court advocacy provided directly by the facilitator;
- community-based activities with the facilitator (e.g., trips to the trampoline park, the arcade, out to get ice cream, the mall);
- community-based activities set up by the facilitator (e.g., getting the youth involved with a church group, getting the youth to volunteer at an animal shelter, setting a youth up for informal mechanics lessons with his uncle, finding an informal mentorship/job shadowing opportunity for a youth in an autobody shop); and
- various concrete support from the LCAs (e.g., buying diapers for younger siblings, buying groceries, paying a utility bill, issuing clothing stipends, buying haircuts for youth, paying for vaccination for pets so a relative could pass the home study, workout equipment).

For the first time, HZA asked LCA survey respondents about the evidence-based practices[8] their Safe at Home clients received. Based on the responses, it was clear that there was some confusion about what practices are considered evidence-based. Thirty-four LCA staff members provided examples of some evidence-based practices. The most commonly listed were: Cognitive Behavioral Therapy (CBT), which is well-supported; Seeking Safety, which is promising; Wraparound, which is promising; and Trauma-Focused Cognitive Behavioral Therapy, which is promising. Another well-supported evidence-based practice used by a few wraparound facilitators with Safe at Home youth was Motivational Interviewing.

For most cases, stakeholders reported few barriers to obtaining the identified services youth/families needed. However, in some cases, the rural community where youth lived impeded their access to services, creating a challenge to Safe at Home youth. In these cases,

[8] Evidence-based practices were found on the California Evidence-Based Clearinghouse for Child Welfare. http://www.cebc4cw.org/

facilitators reported doing their best to locate resources, but they still struggled to find tutors and other services for youth, including youth groups that were not religious based.

There were some cases where the youth's behavior or the caregiver's compliance created a barrier. For example, in one case the caregiver refused to release records, and in another, the caregiver's substance abuse made him/her difficult to engage. In most instances where compliance issues were identified, they were resolved; but, in a couple of cases the issues remained outstanding and inhibited the youth/families' ability to make sufficient progress or the issues ultimately led to the discharge of the case. In one case, inadequate communication from caseworkers was reported as a challenge.

One challenge which impacted a couple of cases was familial poverty, making it difficult for families to provide for their youth. In one case, the grandparents were able to provide additional support. However, in another case, natural supports were not as involved. Facilitators worked diligently to locate available resources for these youth/families.

Frequent placement changes for one youth posed challenges. The facilitator had to be persistent in keeping in contact with the caseworker to keep up with the location of the youth and to remain the constant in the youth's ever-changing life.

Wraparound facilitators identify and/or reward the success that youth achieve through many different forms. Praise appeared to be the most common form of rewarding success. Sometimes, youth were rewarded by going out to eat or to the movies or attending special events or receiving a small gift.

Some of the most common successes stakeholders mentioned these youth/families achieved were:

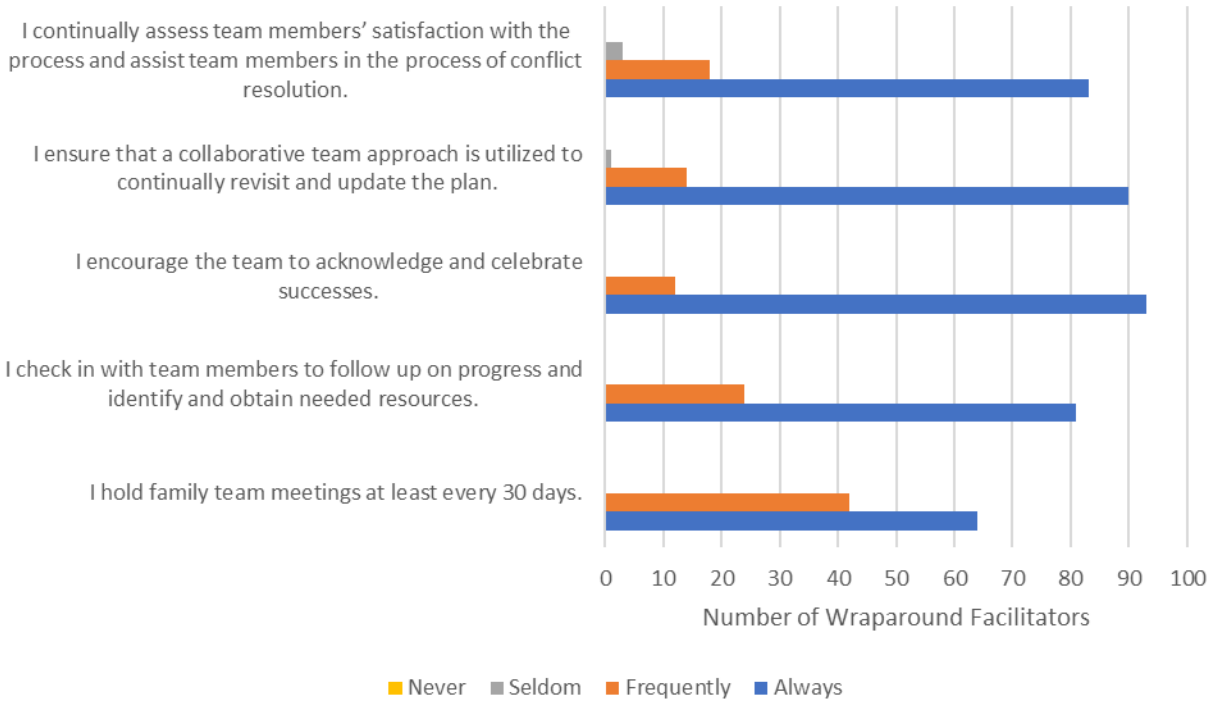
- improved grades and school attendance,
- improved behavior or emotional regulation,
- youth sobriety,
- youth taking responsibility for themselves,
- healthier family and peer relationships,
- living in a safer location,
- increased parenting skills and

- achieving permanency.

One facilitator shared that when the youth's grades improved they took the youth out to eat and discussed what academics could do for his/her future. Facilitators also mentioned praising caregivers for their achievements in the program as well.

The fidelity surveys asked facilitators about the extent to which required tasks were performed during this phase of Wraparound (Figure 6).

Figure 6. Plan Implementation Phase Required Facilitator Activities



Nearly all the wraparound facilitators surveyed reported completing the required activities "Always" or "Frequently" during the Plan Implementation Phase. These findings are consistent with last year's survey results.

Wraparound Phase IV: Transition

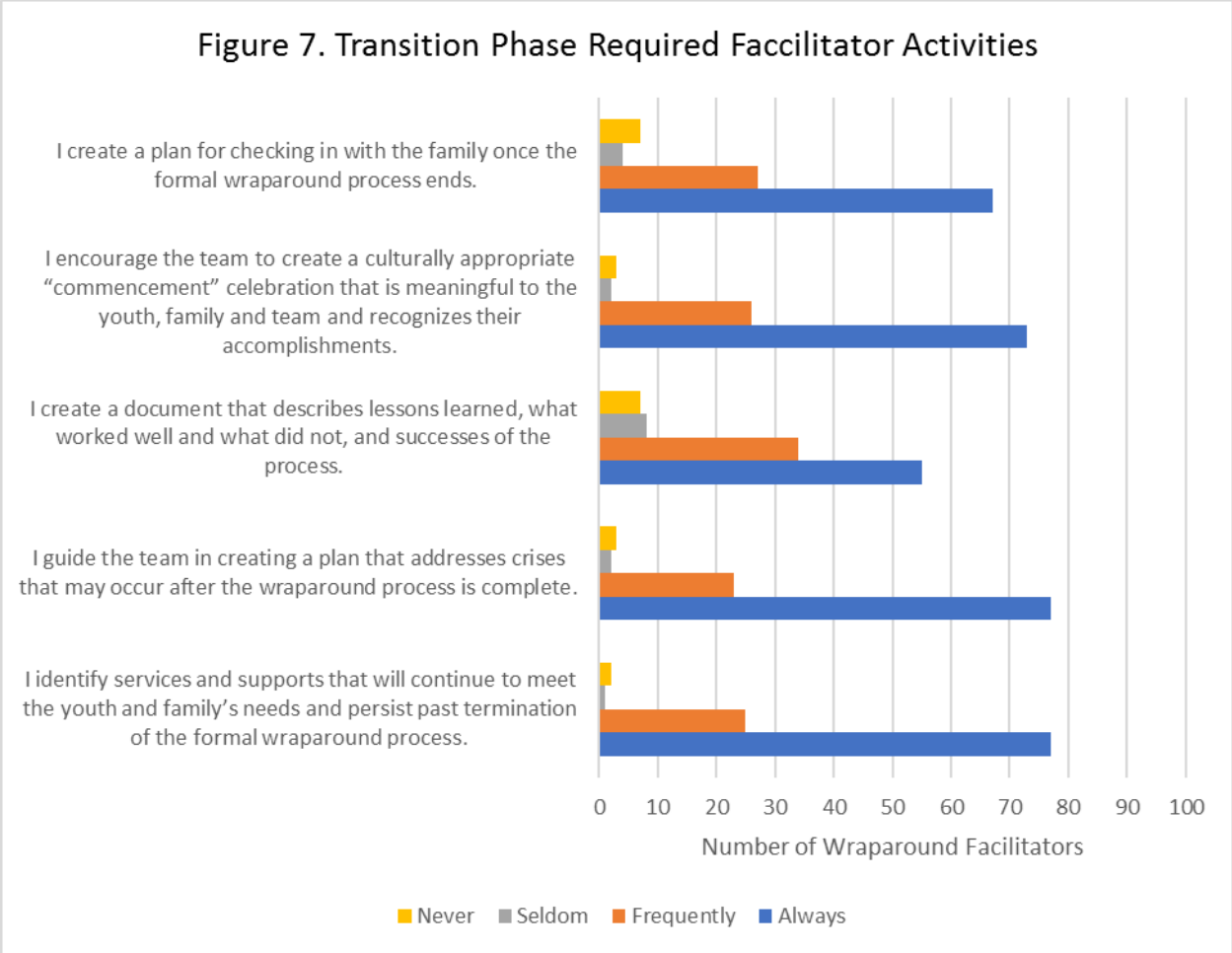
The purposes of the Transition Phase are to plan for the end of wraparound services when the team's goals and objectives have been met, to conduct a commencement or some type of ritual to celebrate success and to discuss where the family can go for help in the future.

Twenty of the 40 cases were closed for Safe at Home. Seventeen of those 20 cases completed the Transition Phase and youth successfully graduated from the program. In the remaining three cases youth were discharged prior to their completion of Safe at Home. The reasons for closure in these three cases were: the youth's long-term placement in a residential facility, the family fleeing the State shortly after the case opening and the youth's noncompliance. In the 17 cases where youth graduated, the facilitators knew the youth were ready to transition because they were doing very well, had met all of their goals and did not need any additional support. The facilitators praised the graduated youth for all their accomplishments. In most cases a celebration was held for, and designed by, youth when services came to an end. In one instance, the youth chose to have dinner with all of his/her wraparound team members at his/her favorite restaurant; the group gave the youth gifts and discussed the entire Safe at Home journey.

Some youth did not want a celebration, so facilitators respected their choice and often just gave them a parting gift. In a few cases, the timing did not work to host a celebration. For example, one wraparound facilitator attempted to host a graduation party for the youth, but the family already had vacation plans. In another case, the youth/family moved very suddenly. Facilitators from one LCA shared that all graduated and current Safe at Home youth will have the opportunity to participate in an event hosted jointly by all LCAs for Safe at Home youth within the county where there is a DJ, pool, free tee shirts, games and gift baskets. A similar event did take place in another part of the State, where one facilitator shared that these events provided youth with the opportunity to simply be kids and families the opportunity to connect and build their natural support networks. In a couple of cases, facilitators were currently working on plans for a celebration with youth.

There was some confusion among facilitators as to the type of follow-up that should take place once a Safe at Home case closes. In about half of the cases, facilitators had a plan in place for checking in with the youth and family (not always a documented or formal plan, but a plan nonetheless). Often, the plan entailed a 30-day, 90-day, 6-month and one-year check-in. In most cases where a plan was established, at least one follow-up had already occurred and youth were reportedly doing well. In cases where there was no real follow-up plan, facilitators informed youth/families that they could reach out should they ever need help and often shared other resources they could contact. Some facilitators were unaware that follow-up was even allowed. For example, one facilitator said, "In social work, once done, then done. I didn't know if follow-up was allowed," while another from the same LCA said, "I love this program in that we can continue to talk to and see our kids. It's been nice to stay that mentoring person in their lives."

In the survey, facilitators were asked about the extent to which required tasks were performed during each phase of Wraparound (Figure 7), including the final phase, Transition.



Compared to facilitator responses of required activities for the first three phases of Wraparound, required activities are not being completed as regularly or consistently during the Transition Phase. The survey results are aligned with the interview data in terms of the confusion facilitators seem to have regarding this phase of work. For example, ten percent of the facilitator survey respondents "Seldom" or "Never" created a plan to check in with the family after services ended. The findings from this year's survey on Transition Phase activities are consistent with those of last year; indicating that this is still an area of confusion among staff.

LCA Staff Program Buy-In

In addition to the questions regarding fidelity, LCA survey respondents were asked about the extent to which they agreed with statements regarding their buy-in to Safe at Home and their perceptions of the initiative's effectiveness. Figure 8 represents the responses to those statements asked of LCA staff.

Figure 8. LCA Staff Responses to Program Buy-In & Perception Statements

Overall, LCA staff buy-in and perceptions of program success were relatively high, with most statements eliciting "Strongly Agree" or "Agree" responses. There were two items which stood out as not following this trend because they received very mixed responses. First, only 52 percent of LCA staff believed there were an adequate supply of services in the community to fulfill service plans. The second item was related to DHHR and LCA teamwork, where only 48 percent of LCA staff believed caseworkers were the main link between the facilitator and the family. Both of these items received low ratings last year as well, implying that minimal improvement has been made.

Successes and Challenges

Stakeholders were asked about the various successes and challenges that occurred with the 40 cases reviewed, as well as any suggestions for program improvements in addition to questions regarding fidelity.

Facilitators provided examples of what they believe has worked well for these particular cases:

- youth self-esteem and self-advocacy;
- youth motivation to succeed;
- proactive caregivers;
- youth involving themselves in the community, school and sports;
- youth following through with commitments;
- partnerships with other entities (e.g., schools and juvenile probation);
- partnerships with community-based services;
- persistence and reliability of facilitators;
- youth/family compliance and engagement;
- communication among team members;
- youth voice focus;
- youth/family realizing someone wants to help them;

- extra in-home support provided by the facilitator;
- rewards and consequences to help motivate goal achievement; and
- supportive judges.

One youth interviewed who benefitted tremendously from the program reported, "It's influenced me to do better in school and do better on behavior. I've never had all A's before until now. It's taught me how to not flip out and walk away from situations. Before I didn't care about school and [the facilitator] opened up my eyes to how important it is and given me faith in myself." A caregiver reported that s/he was skeptical of the program at first but likes how it works now that s/he has experienced it.

Wraparound facilitators and caseworkers also shared the unique challenges of working with Safe at Home cases, some of which included a general lack of support from community and family members, challenging youth behavior which caregivers may not be equipped to handle in the future, caregiver and youth motivation, lack of available resources in the community, youth and parental drug use, troublesome home environments/family dynamics and youth transitioning to new schools. Multiple ideas about what could be done to improve the program were shared by facilitators and included:

- develop more community-based resources;
- refer youth as soon as they are identified as at-risk so the program can prevent the youth from any further involvement in the child welfare or juvenile justice systems;
- better prepare foster parents to care for youth with severe behavioral issues;
- lower the age for referrals so younger children can benefit from the program;
- implement less redundant and extensive documentation requirements to allow more time for client interaction;
- educate the court so that goals are not court-dictated and cases are not required to remain open unnecessarily long;
- conduct an exit survey of youth/families about their experience with Safe at Home to learn how the program might be improved; and
- inquire about youth/families concerns at the time of exit to identify concerns they have about their future.

Nearly all youth and caregivers held the program in the highest regard and thus suggestions for improvement were minimal. A couple of suggestions made by youth and caregivers were to provide more family-focused outings, increase pay for facilitators and access additional support staff to assist facilitators. One youth shared the following about his/her facilitator and Safe at Home, "I don't know if anything could be done to make it better. I call [the facilitator] and [s/he's] there, no matter what. It's a good program and if it's used right it will help a lot of people." The caregivers also shared positive experiences they had with their facilitators, with one saying, "We couldn't have done it without [the facilitator]. I still will always remember I was just at my wits end and I called [the facilitator] and [s/he] came and sat with me on my porch and listened to me while I cried my eyes out. That was the turning point for us."

Summary of Process Evaluation Results

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

LCAs did particularly well in documenting high quality wraparound and crisis safety plans, where the content of those plans demonstrated a strong adherence to the Wraparound model. Scores on the fidelity items were higher than what was reported last year and improvement was often demonstrable between initial and most recent plans.

LCAs were able to create initial wraparound plans in the required timeframes this year which they struggled to do last year. Initial CANS assessments were completed within the required 30-day timeframe, after two outlying cases were excluded; meeting initial CANS deadlines was a challenge last year as well. Across the board, initial crisis safety plan timeframes were missed by about a week, but this was still an improvement from last year where the deadline was missed by about two weeks. Last year, one LCA in particular struggled with meeting deadlines on all items. This year, that same LCA proved itself to be one of the most compliant in meeting deadlines. DHHR and the LCAs should explore the reasons why deadlines were missed to determine what steps might be taken to ensure all initial CANS and crisis safety plans are completed within required timeframes.

Youth/family feedback continues to be overwhelmingly positive. However, building teams of natural/informal supports to sustain families in the future remains a struggle. Where this was the case, youth/families typically wanted to keep their issues personal, limiting any

involvement to their immediate family. For some families, there simply were no natural supports available to involve. When natural supports were involved, there were instances where it was a struggle to keep them involved; this was often due to the supports not following through or the youth's life (e.g., placement) changing causing them to lose touch. Building a natural support system is crucial for implementing Wraparound in a way where success can be sustained following case closure.

The assessment of the Transition Phase raised some concern about after-care planning and follow-up. While a number of facilitators provide support following discharge from Safe at Home, there is inconsistency among staff in providing that support with staff notably confused around what it should entail (some were unaware that they were even supposed to be doing it). Last year's assessment revealed similar findings, indicating that minimal improvement has been made. This is another area where improvement is needed in the coming year.

Successes and challenges varied among cases, and accordingly, so did the steps which were taken to overcome them. Wraparound facilitators and caseworkers shared many ideas about how Safe at Home could be improved; those ideas could be used as a springboard for discussion in planning/improvement efforts. A couple of examples of ideas shared were lowering the age of referrals so younger children can benefit from the program and conducting an exit survey with youth who leave Safe at Home to further explore ways to improve the program.

Outcome Evaluation Results

Youth Cohort Analysis

From the first day of program implementation on October 1, 2015 to September 30, 2018, 2,011[9] total youth have been referred to Safe at Home.[10] For the analysis of outcomes, youth are divided into six-month cohorts based on the date they were referred to Safe at Home (Table 4); the six-month cohorts allow the evaluators to measure changes in outcomes over time. Currently, there is a total of six youth cohorts. More than six months has passed for youth from Cohorts 1 through 5, providing sufficient time to have passed to measure outcomes. The data available for youth in the most recent cohort (i.e., Cohort 6) are limited to only descriptive

[9] The numbers of youth reported by HZA and the State differ slightly because the State utilizes weekly tracking 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.
[10] Youth were excluded if they did not remain in the program for a minimum of three days.

information about the youth population[11] because a full six months in the program has not passed for youth in this cohort. Consequently, a comparison group has not been drawn for youth in Cohort 6.

The matched comparison groups were selected by using Propensity Score Matching (PSM), which relies on data from FACTS. The comparison pools are comprised of youth who meet the Safe at Home referral criteria during SFYs 2010 through 2015. Propensity scores were calculated using age at referral, gender, race, ethnicity, initial placement setting, report allegation, number of prior placements, evidence of an axis one diagnosis, juvenile justice involvement and if the youth 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 D). For each cohort, there is an equal number of youth in the treatment and comparison groups.

Table 4. Outcome Analysis Cohorts

Cohort	Group	Referral Period	Number of Youth
1	Treatment	October 1, 2015 — March 31, 2016	124
	Comparison	SFY 2010 — 2015	124
2	Treatment	April 1, 2016 — September 30, 2016	221
	Comparison	SFY 2010 — 2015	221
3	Treatment	October 1, 2016 — March 31, 2017	297
	Comparison	SFY 2010 — 2015	297
4	Treatment	April 1, 2017 — September 30, 2017	445
	Comparison	SFY 2010 — 2015	445
5	Treatment	October 1, 2017 — March 31, 2018	512
	Comparison	SFY 2010 — 2015	512

[11] Please see the process evaluation results for more details.

Table 4. Outcome Analysis Cohorts			
Cohort	**Group**	**Referral Period**	**Number of Youth**
6	Treatment	April 1, 2018 — September 30, 2018	412
	Comparison	—	—
Total	**Treatment**	**October 1, 2015 — September 30, 2018**	**2,011**
	Comparison	**SFY 2010 — 2015**	**1,599**

Outcome measures are examined at or within six and twelve months post-referral to Safe at Home, unless otherwise specified. For this report, six and twelve-month outcomes are analyzed for youth in Cohorts 1 through 4 with the analysis limited to only six months given the length of time youth in Cohort 5 have been involved with the program. Some measures may exclude various cohorts due to the length of time needed to have passed to measure the particular outcome; inadequate sample size also limited the outcome analysis in a few instances.

Stepwise Regression Analysis

In order to identify populations for which Safe at Home works best, a stepwise regression analysis for some of the outcome measures has been performed. A stepwise regression first runs a linear regression using a complete list of independent variables against the outcome measure. The analysis 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 considered complete when no change in independent variables will produce a stronger correlation, resulting in the variables which are most strongly correlated to the outcome. The stepwise regression analysis is run for all youth in Safe at Home and the full comparison group.

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, juvenile justice involvement, substance abuse and whether 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 maltreatment referrals.

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

Youth Placement Changes

Table 5 shows the placements of Safe at Home youth in Cohorts 1 through 5 when they were referred to the program and then again six months following referral. Some youth were placed in detention, transitional placement or on runaway status at six months. However, since these placement types impact a small number of youth, they are included in a footnote for each cohort rather than in the table.

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

Cohort 1						
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	11	4	1	2	13	31
In-State Congregate	1	11	3	2	20	37

Table 5. Safe at Home Youth Placements at Referral and Six Months						
Care						
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[12]	16	25	7	4	67	119
Cohort 2						
Placement at Referral	**Placement at Six Months**					
	Out-of-State Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	**Total at Referral**
Out-of-State Congregate Care	3	2	1	0	12	18
In-State Congregate Care	3	25	4	3	37	72
Emergency Shelter	0	6	4	3	4	17

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

Table 5. Safe at Home Youth Placements at Referral and Six Months						
Family Foster Care	0	2	2	4	3	11
Home	0	11	2	1	84	98
Total at Six Months[13]	6	46	13	11	140	216
Cohort 3						
Placement at Referral	**Placement at Six Months**					
	Out-of-State Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	**Total at Referral**
Out-of-State Congregate Care	3	0	0	1	8	12
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

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

Table 5. Safe at Home Youth Placements at Referral and Six Months						
Total at Six Months[14]	8	40	11	21	214	294
Cohort 4						
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
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[15]	11	64	12	21	335	443
Cohort 5						

[14] From Cohort 3, there were two youth placed in detention at six months post-referral; both of them were referred from in-state congregate care. One youth had run away from home at six months.
[15] At six months, two youth from Cohort 4 were placed in detention; both youth were at home at the time of referral.

Table 5. Safe at Home Youth Placements at Referral and Six Months						
Placement at Referral	**Placement at 6 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	2	0	0	13	17
In-State Congregate Care	1	12	2	2	34	51
Emergency Shelter	3	6	0	2	11	22
Family Foster Care	1	4	2	20	7	34
Home	5	49	9	12	307	382
Total at Six Months[16]	12	73	13	36	372	506

In more recent cohorts there has been an increase in the number of youth who are placed in a congregate care setting by the end of six months. For example, in the first cohort there was a 40 percent decrease in the number of youth in congregate care at six months, but there was a 25 percent increase for youth in the most recent cohort (Cohort 5). In Cohort 1 over half the cohort consisted of youth who started in congregate care compared to the minimal 13 percent who started Safe at Home while in congregate care in Cohort 5.

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

Youth across cohorts who were referred from congregate care are consistently being stepped down into lower level placements at six months (on average, 75% of the youth are placed in a lower level of care within six months of referral). However, the overall number of youth living at home at six months has been decreasing over time. On average, 70 percent of the youth who were referred from congregate care were placed in their homes at six months across all five cohorts. The number of youth transitioning from congregate care to their homes was highest for those in Cohort 1 (89%) and lowest for those in Cohort 2 (54%).

Seventy-nine percent of the youth who started the program while living at home were still there at six months across all five cohorts. The impact was lowest for youth in Cohort 1, with only 73 percent remaining at home, and highest for youth in Cohort 2 with 86 percent still at home. There was less variation among Cohorts 3 through 5, with 77 to 81 percent of youth still living at home at six months.

Similar to Table 5, Table 6 looks at the placements of Safe at Home youth at referral and then at twelve months. Similarly, placements of detention, runaway status or transitional living impacted a minimal number of youth, and are thus shared in footnotes. Table 6 only includes youth from Cohorts 1 through 4 since not enough time has passed to examine twelve-month outcomes for youth in Cohort 5.

Table 6. Safe at Home Youth Placements at Referral and Twelve Months

Cohort 1						
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

Table 6. Safe at Home Youth Placements at Referral and Twelve Months						
Home	4	8	2	1	31	46
Total at Twelve Months[17]	13	22	9	5	71	124
Cohort 2						
Placement at Referral	**Placement at Twelve Months**					
	Out-of-State Congregate Care	In-State Congregate Care	Emergency Shelter	Family Foster Care	Home	**Total at Referral**
Out-of-State Congregate Care	4	1	0	1	12	18
In-State Congregate Care	6	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[18]	19	47	6	18	125	221
Cohort 3						

[17] For youth in Cohort 1, three youth had runaway at twelve months and one was placed in detention. The youth in detention was living in out-of-state congregate care when s/he was referred. Of the three youth who ran away, two were referred from in-state congregate care and one was from an emergency shelter.

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

Table 6. Safe at Home Youth Placements at Referral and Twelve Months						
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	203
Total at Twelve Months[19]	10	54	3	16	211	296
Cohort 4						
Placement at Referral	**Placement at 12 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	0	6	11
In-State	3	10	2	6	39	60

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

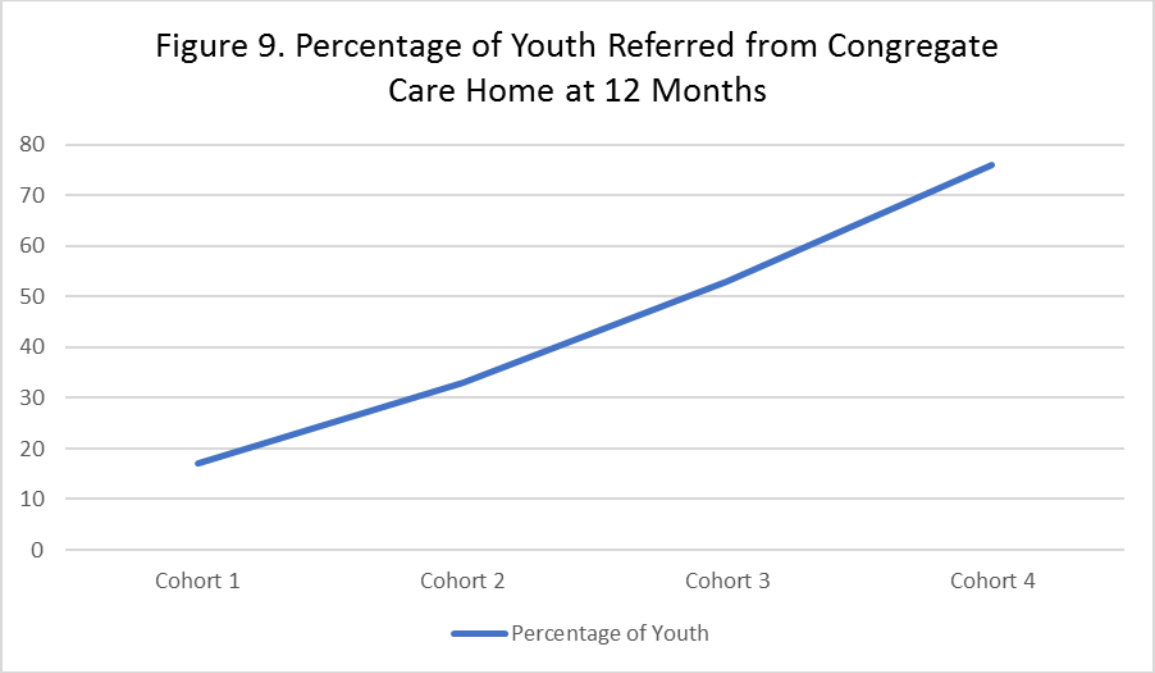
Table 6. Safe at Home Youth Placements at Referral and Twelve Months						
Congregate Care						
Emergency Shelter	1	3	2	1	6	13
Family Foster Care	0	1	1	9	16	27
Home	12	42	8	7	261	330
Total at Twelve Months[20]	20	57	13	23	328	441

The trend of increasing congregate care placements shows continuation between six and twelve months. In Cohort 1 there was a 50 percent decrease in the number of youth in congregate care at twelve months, but by Cohort 4 there is an eight percent increase.

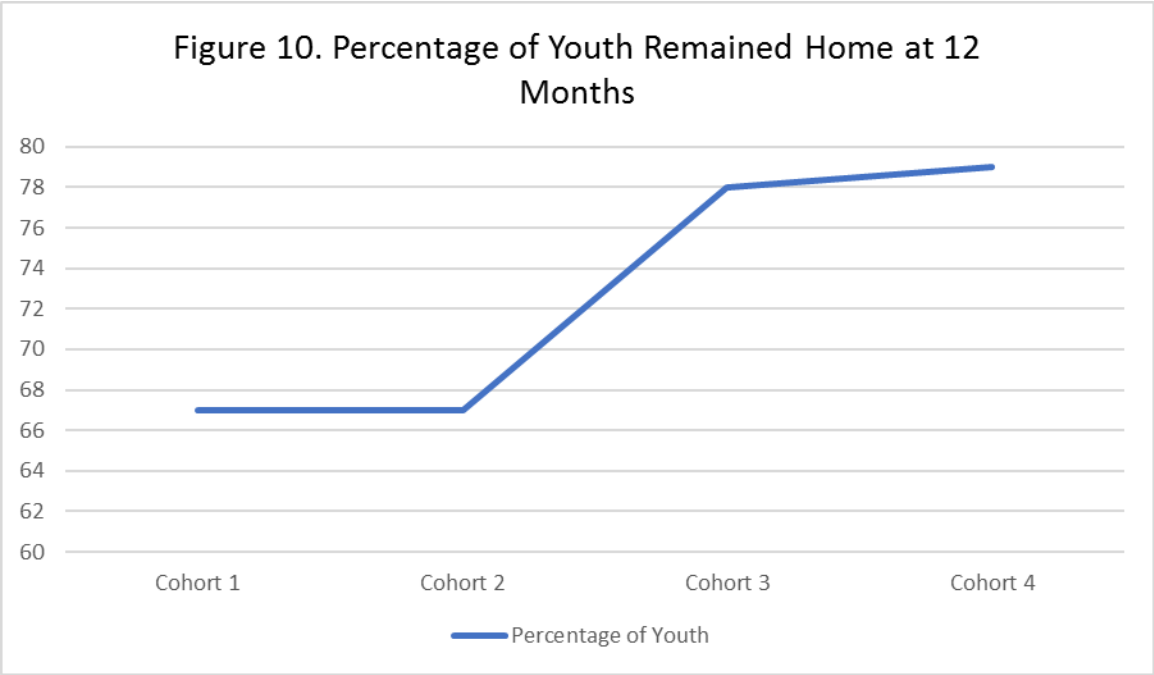
Youth in all four cohorts who began Safe at Home while in congregate care are consistently moving to lower levels of care at twelve months; however, the impact is not as strong as it was at six months. On average 75 percent of youth who started in congregate care had moved to a lower level of care at six months, but the same was only true for 59 percent of youth at twelve months.

On average, 45 percent of youth who were referred from congregate care were placed in their homes at twelve months (in comparison to 70 percent of youth at six months). While the overall percentage of youth who went from congregate care to home has decreased, the trend has improved drastically over time (Figure 9). In Cohort 1 only 17 percent of youth who began Safe at Home in congregate care were living in their homes at twelve months, but in Cohort 4, 76 percent of youth were.

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

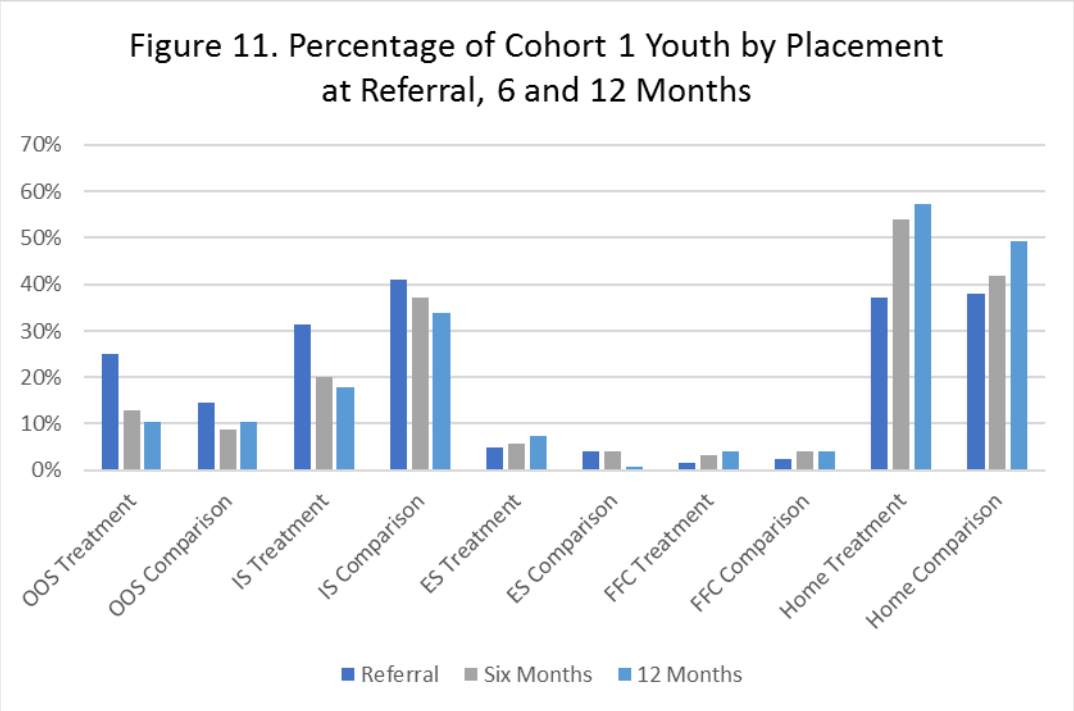


Generally, youth who are referred while living at home are remaining at home. Seventy-three percent of youth who started the program while living at home were still there at twelve months (compared to 79% at six months). The percentage of youth who are remaining at home has increased in the latter two cohorts compared to youth from the first two cohorts. Figure 10 visualizes this trend showing that 79 percent of youth who started at home in Cohort 4 were still there at twelve months, compared to 67 percent in Cohort 1.



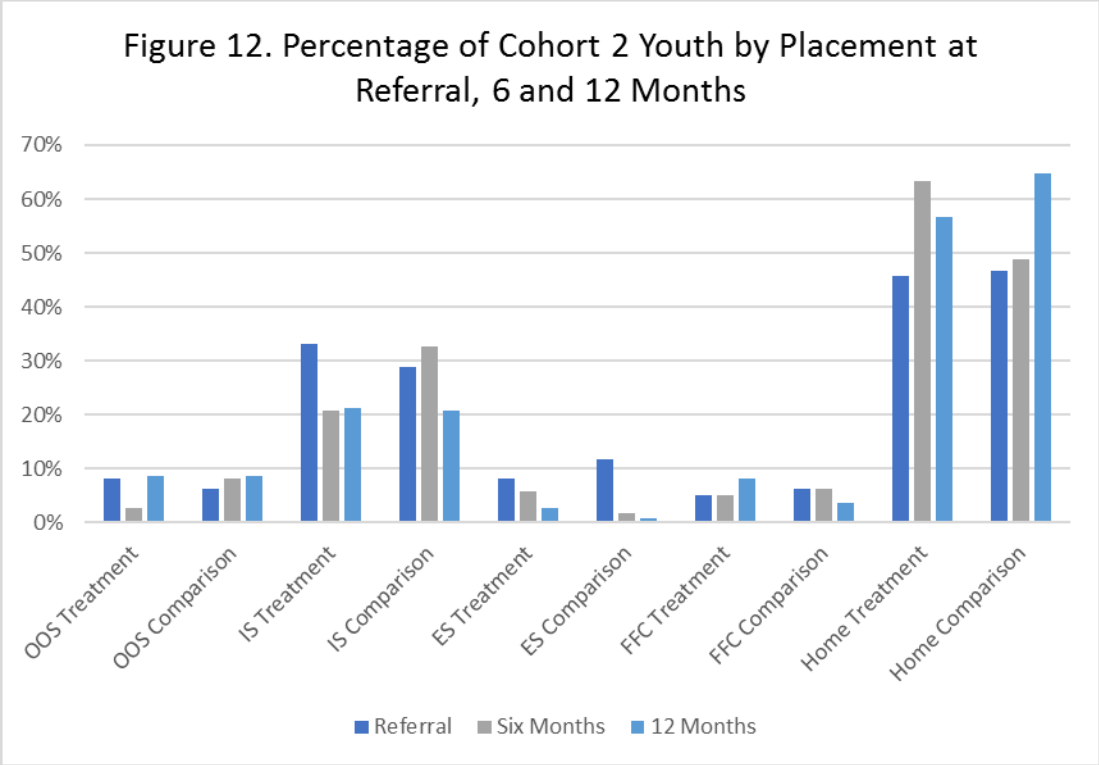
Overall placement change effects are not as strong at twelve months as they are at six months across cohorts. However, youth in later cohorts (i.e., Cohorts 3 and 4) are doing better at maintaining positive placement outcomes over time.

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



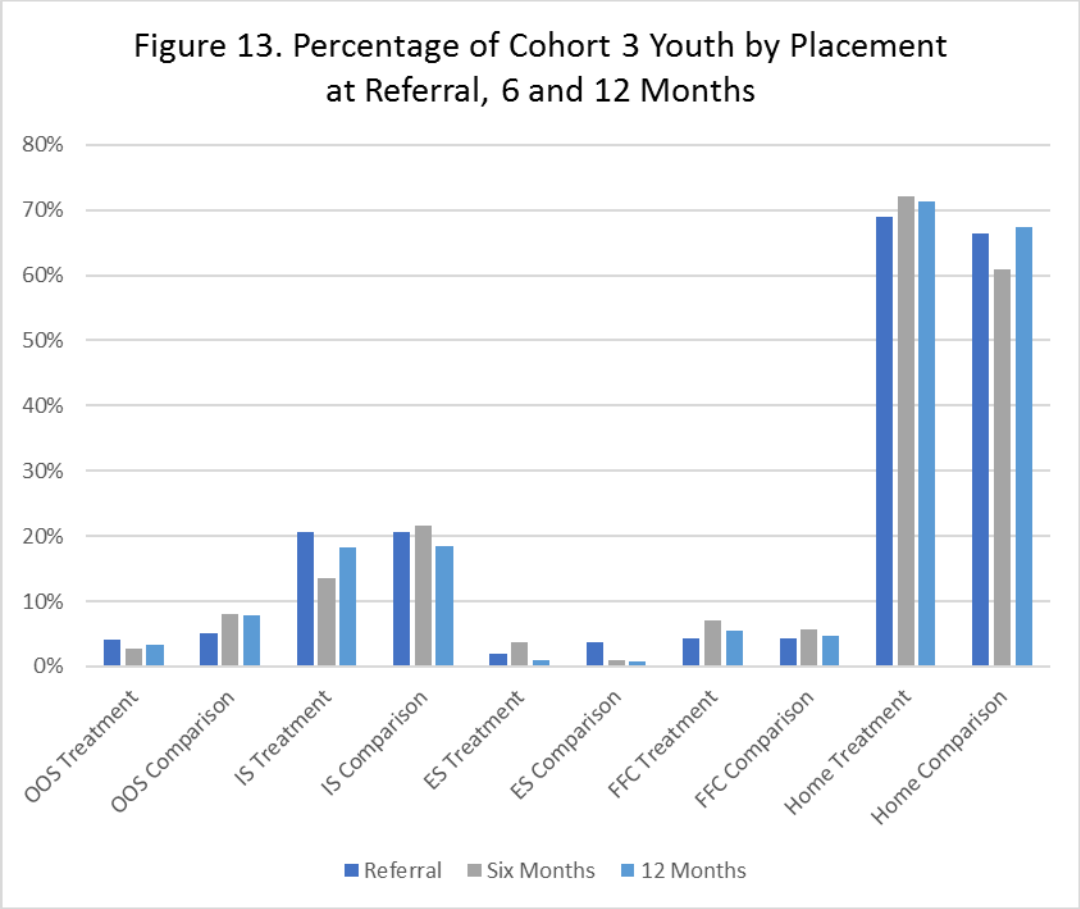
Overall, placements were better for Safe at Home youth in Cohort 1 than was the case for comparison youth. Both the treatment and comparison groups experienced reductions in congregate care placements six and twelve months following referral. The reduction of youth in both in and out-of-state congregate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

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



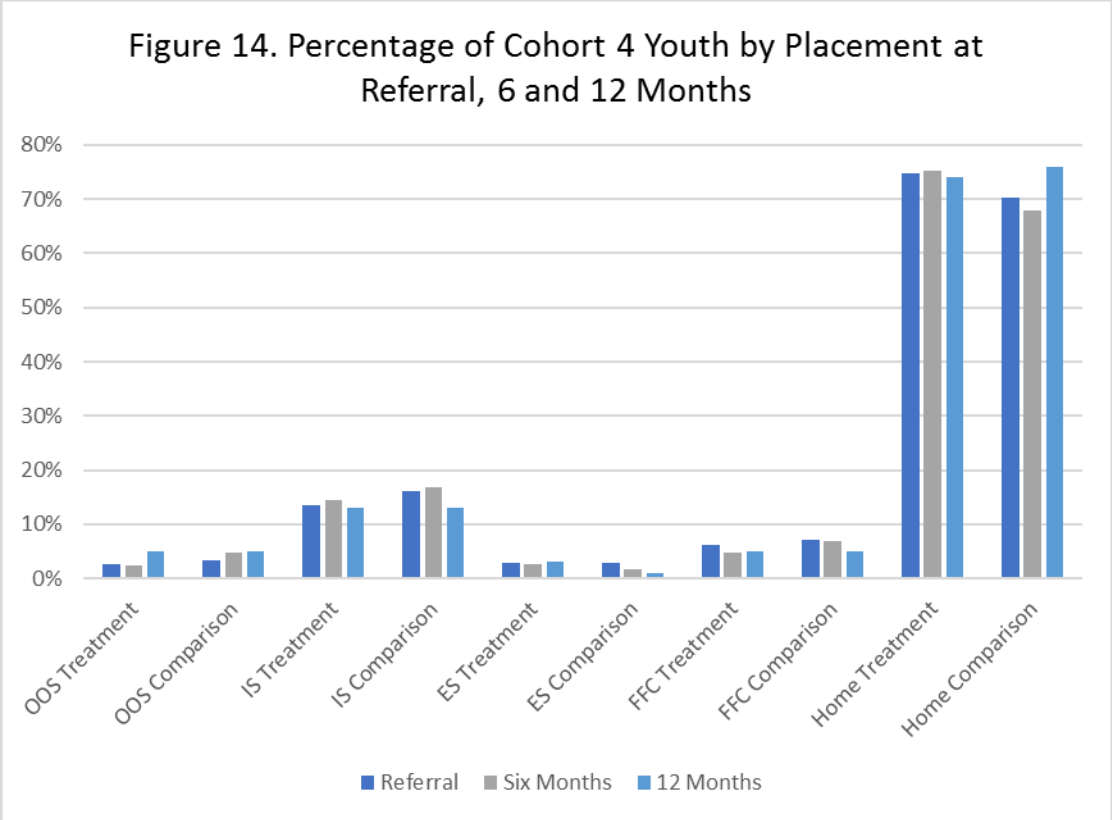
Although a small percentage of Cohort 2's treatment and comparison youth were referred while in an out-of-state congregate care placement, the comparison group experienced a slight increase in youth placed outside of West Virginia at both the six and twelve months. Interestingly, the percentage of Safe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

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



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

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



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

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

Congregate Care

Most of Safe at Home's goals center around congregate care. The goals include preventing at-risk youth from ever entering congregate care, returning youth to lower levels of care, reducing the length of time youth spend in congregate care and preventing youth from re-entering congregate care.

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

Youth placed initially in lower levels of care, i.e., their own homes, family foster care or an emergency shelter, were examined at six and twelve months following referral (Table 7) to determine the extent to which those youth moved to congregate care.

There is a smaller proportion of Safe at Home youth entering congregate care for the first time at six months post-referral in Cohorts 2 and 3 when compared to youth in the comparison group. The difference is statistically significant for youth in Cohort 2 at six months ($p<.01$). While there is a higher percentage of youth in Safe at Home with initial congregate care entries at six months in Cohorts 1, 4 and 5, the differences between treatment and comparison groups are minimal (between one and four percent). The positive impact experienced by Safe at Home youth in Cohort 2 is not sustained between six and twelve months; at twelve months a larger proportion of Safe at Home have entered congregate care at a statistically significant rate ($p<.05$). The differences among treatment and comparison youth in the remaining cohorts are, again, minimal at twelve months post-referral, with comparison youth faring slightly better.

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

Cohort	Group	Number Referred at a Lower Level	Percent in Congregate Care at 6 Months	Percent in Congregate Care at 12 Months
1	Treatment	54	26%	28%
	Comparison	55	24%	27%

Table 7. Percentages of Youth from Lower Levels of Care to Congregate Care				
Cohort	**Group**	**Number Referred at a Lower Level**	**Percent in Congregate Care at 6 Months**	**Percent in Congregate Care at 12 Months**
2	Treatment	130	15%	30%
	Comparison	143	28%	17%
3	Treatment	224	16%	18%
	Comparison	221	20%	17%
4	Treatment	373	16%	16%
	Comparison	358	12%	11%
5	Treatment	443	15%	-
	Comparison	448	14%	-

A stepwise regression analysis was conducted to examine the characteristics which most impact the entry of Safe at Home youth into congregate care. Most notably, if a youth from either Safe at Home or the comparison group had an Axis 1 diagnosis they were more likely to end up with an initial congregate care entry at six and twelve months post-referral; this result was highly significant ($p<.01$). Interestingly, Safe at Home youth saw a significantly decreased risk of initial congregate care entry at six and twelve months if they were juvenile justice involved ($p<.05$), but the opposite was true for comparison youth (though not statistically significant).

Table 8 displays the results for youth who left congregate care and moved to a lower level of care within twelve months of referral, but ultimately re-entered congregate care at six or twelve months following their discharge from congregate care. Results displayed below are for youth where sufficient time has passed to measure outcomes; thus Cohort 5 has been excluded and only six-month outcomes are available for Cohort 4.

Six-month congregate care re-entry outcomes are better for Safe at Home youth in Cohorts 1, 2 and 4, with the differences statistically significant for youth in Cohort 1 ($p<.05$). Differences in outcomes at six months were minimal between treatment and comparison youth in Cohorts 3 and 4. Safe at Home youth from Cohorts 1 through 3 (where twelve-month outcomes could be calculated) were less likely to re-enter congregate care at twelve months, though none of these results were statistically significant.

Table 8. Rate of Congregate Care Re-Entry

Cohort	Group	Number of Youth Moved to Lower Level of Care from Congregate Care within 6 Months	Percent of Re-Entry 6 Months After Congregate Care Discharge	Percent of Re-Entry 12 Months After Congregate Care Discharge
1	Treatment	32	28%	41%
	Comparison	28	54%	46%
2	Treatment	54	35%	33%
	Comparison	34	47%	41%
3	Treatment	29	38%	27%
	Comparison	35	37%	29%
4	Treatment	32	41%	-
	Comparison	38	42%	-

When the stepwise regression analysis is conducted to examine factors which influence re-entry into congregate care, Safe at Home youth did not have any notable factors associated with an increased risk of congregate care re-entry, nor did comparison youth at either six or twelve months. There were also no groups from Safe at Home that had a statistically significant increased risk of congregate care re-entry. Comparison youth were more likely to re-enter congregate care at six months if they were initially placed in an out-of-state psychiatric hospital or a shelter ($p<.01$), and at twelve months the same was true for comparison youth who were

male or from Region 2 (p<.01).

To assess length of stay in congregate care, Table 9 identifies the average number of days youth spent in congregate care. While congregate care initial entry and re-entry results produce a mix of positive and negative outcomes for Safe at Home youth in various cohorts, the average length of stay in congregate care results are clear. Safe at Home youth from all cohorts are spending a substantially less time in congregate care within both six and twelve months. Looking across cohorts, Safe at Home youth spend an average of 50 fewer days in congregate care within six months and 84 fewer days within twelve months than do comparison youth. All results were statistically significant at (p<.01).

Table 9. Average Length of Stay in Congregate Care Within 6 and 12 Months

Cohort	Group	Average Days in Congregate Care within 6 Months	Average Days in Congregate Care within 12 Months
1	Treatment	101	167
	Comparison	137	239
2	Treatment	84	144
	Comparison	131	237
3	Treatment	61	126
	Comparison	122	219
4	Treatment	70	139
	Comparison	127	217
5	Treatment	64	-
	Comparison	115	-

When the average length of congregate care stay results are run against the stepwise regression analysis factors, older youth and juvenile justice involved youth, which increased the

risk for a longer stay in congregate care in the comparison youth, saw a decreased risk with Safe at Home youth.

Safe at Home youth are generally more likely to have an initial congregate care entry at 12 months than comparison group youth; however, Safe at Home youth are less likely to reenter congregate care within six and 12 months of discharge and spend less time in those placements than comparison group youth. This is likely due to the services, both formal and informal, Safe at Home offers the youth to aide in stepping down from more intensive placements and keeping them at lower levels of care or in their home.

Detention

Most Safe at Home youth have a Youth Services case and many of these youth are juvenile justice involved. Therefore, initial detention entries and re-entries were added to the list of outcome measures. Youth cannot be referred to Safe at Home from a detention facility so none of them start at this placement setting. Conversely, 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).

While the overall numbers of youth in detention at six and twelve months are small, results generally appear to be more positive for Safe at Home youth in the first three cohorts as opposed to those in the latter two (Table 10). For Cohort 4 there are three more youth in detention from the comparison group at six months, but the result is exactly opposite at twelve months. None of the results were statistically significant.

Table 10. 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
1	Treatment	3	1
	Comparison	4	1
2	Treatment	1	2
	Comparison	4	1

Table 10. 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**
3	Treatment	2	1
	Comparison	7	1
4	Treatment	3	4
	Comparison	6	1
5	Treatment	6	-
	Comparison	3	-

Table 11 displays the results for youth in which sufficient time has passed since exiting detention to measure the extent to which they re-enter detention at six and 12 months following exit. The sample size was so small it rendered minimal results. Only one youth re-entered detention; this was a Safe at Home youth from Cohort 2 who re-entered at six months.

Table 11. 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**
1	Treatment	4	0	0
	Comparison	8	0	0
2	Treatment	10	1	0
	Comparison	10	0	0

Table 11. 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**
3	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 youth leaving and returning to their home counties are examined at six and twelve months post-referral; the results are provided in Table 12.[21]

Regarding youth who moved from their home-county to another county, results were mixed at six months. While a slightly higher percentage of Safe at Home youth moved out-of-county at six months in Cohorts 1, 4 and 5, the opposite was true for Cohorts 2 and 3. At twelve months, a larger proportion of Safe at Home youth across all cohorts had moved out-of-county as compared to youth in the comparison group. While no results were statistically significant at six months, results at twelve months were statistically significant for Cohorts 2 ($p<.05$) and 4 ($p<.01$).

For youth moving back to their home-county, results were overwhelmingly positive for Safe at Home youth within six and twelve months across all cohorts, with a greater percentage more likely to move back to their home-county than youth in the comparison group. Six-month results were statistically significant for all cohorts ($p<.01$) and twelve-month results were significant for Cohorts 1, 3 and 4 ($p<.01$).

[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 12. Youth County Movements				
Cohort	**Group**	**Denominator**	**Percent at 6 Months**	**Percent at 12 Months**
From Home-County to Out-of-County				
1	Treatment	59	27%	27%
	Comparison	55	24%	24%
2	Treatment	132	18%	27%
	Comparison	118	23%	14%
3	Treatment	226	17%	19%
	Comparison	213	20%	18%
4	Treatment	365	15%	17%
	Comparison	337	12%	10%
5	Treatment	423	17%	-
	Comparison	416	14%	-
From Out-of-County to Home-County				
1	Treatment	66	59%	64%
	Comparison	69	28%	39%
2	Treatment	96	61%	59%
	Comparison	103	29%	48%
3	Treatment	74	81%	72%
	Comparison	85	33%	45%

Table 12. Youth County Movements				
Cohort	**Group**	**Denominator**	**Percent at 6 Months**	**Percent at 12 Months**
4	Treatment	87	75%	69%
	Comparison	107	28%	50%
5	Treatment	91	66%	-
	Comparison	97	35%	-

Overall, the comparison group has done better at decreasing the risk for certain populations in moving out of their home counties. Axis 1 diagnoses put youth from both Safe at Home and the comparison group at significant risk for moving out of their home counties within both six and twelve months ($p<.01$).

The regression analysis was used to determine the extent to which certain groups of youth are more or less likely to move back to their home counties within six or twelve months of referral. Both Safe at Home and comparison youth had many groups with a greater chance of moving back to their home counties, some of which were groups of youth who had not been reaping benefits on other outcomes (e.g., youth placed in a shelter at the time of referral). Overall, Safe at Home youth from various groups were more likely to move back to their home-county and with greater statistical significance than comparison youth. No groups from Safe at Home had a decreased chance of moving back to their home-county at twelve months.

Foster Care

Safe at Home has a couple of goals related to foster care. The first goal 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 13 examines initial entry into foster care following referral for youth who were referred while living in their own homes. Results for youth in the treatment and comparison groups, at both six and twelve months following referral, are similar for Cohorts 1 and 3. Cohorts 2 and 4's Safe at Home youth are more likely to enter foster care than comparison youth at both six and twelve months, and the same is true for Safe at Home youth in Cohort 5

at six months. Six-month results are statistically significant for Cohorts 4 and 5 ($p<.05$), and twelve-month results are significant for Cohorts 2 and 4 ($p<.01$). There are two possible explanations for these outcomes. First, it is possible the comparison group population is different from the treatment group population due to a lack of information regarding mental health diagnoses. Alternatively, the increased intensity of services and oversight of the families is leading to more frequent identification of issues.

Table 13. 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
1	Treatment	46	28%	33%
	Comparison	47	28%	30%
2	Treatment	101	15%	32%
	Comparison	103	23%	16%
3	Treatment	205	22%	22%
	Comparison	197	22%	20%
4	Treatment	333	20%	22%
	Comparison	312	14%	13%
5	Treatment	387	21%	-
	Comparison	383	15%	-

Compared to other outcomes, there were fewer factors that either increased or decreased the risk of initial entry for either Safe at Home or comparison youth. Having an Axis 1 diagnosis left both Safe at Home and comparison youth with a statistically significant ($p<.01$) increased risk for an initial foster care entry. Safe at Home youth who were juvenile justice

involved were less likely to have an initial foster care entry (p<.01 at six months and p<.05 at twelve months), but the opposite was true for comparison youth at twelve months (p<.05).

Table 14 displays the results for youth who exited foster care within twelve months of referral and ultimately returned to foster care at six or twelve months following discharge. Results presented below include youth from cohorts where sufficient time has passed to measure this outcome.

Safe at Home youth are re-entering foster care at a higher rate than comparison youth across all cohorts at both six and twelve months. Results are statistically significant at six months for Cohort 2 (p<.05); none of the twelve-month results is statistically significant.

Table 14. 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
1	Treatment	43	16%	16%
	Comparison	31	6%	6%
2	Treatment	77	26%	21%
	Comparison	60	10%	10%
3	Treatment	84	19%	23%
	Comparison	62	15%	15%
4	Treatment	99	24%	-
	Comparison	80	10%	-

More comparison youth sub-populations (e.g., white, male, Regions 2, 3, and 4, referred in a group home) have experienced a decreased risk for foster care-reentry than Safe at Home youth, and this is especially so at twelve months. Interestingly, the longer the DHHR case was

open for Safe at Home youth the less likely they were to re-enter foster care (and at a significant rate at six months at p<.01).

Relative placements play a critical role in minimizing the trauma to youth when they need to be removed from their homes. Due to the small sample size, the results displayed in Table 15 are reported at a statewide level instead of by cohort. When youth are placed in foster homes, Safe at Home youth are significantly more likely to be placed in a relative home at both six and twelve months (both at p<.01) than are comparison youth.

Table 15. Percentage of Youth Placed in Relative Homes

Group	Denominator	Percentage in Relative Foster Homes at 6 Months	Percentage in Relative Foster Homes at 12 Months
Treatment	87	70%	65%
Comparison	100	24%	31%

Beyond looking at where youth are placed at six and twelve months following referral to Safe at Home, it is important to consider the placement stability. Table 16 displays the results of that analysis for youth who were referred out-of-home. Applying the federal definition of placement stability, the proportion of youth with no more than two moves which occurred within twelve-months of referral were measured. Outcomes were calculated for Cohorts 1 through 4.

Safe at Home youth from Cohorts 1 and 3 experienced more placement stability than their comparison counterparts. There was absolutely no difference in the rate of placement stability between comparison youth and Safe at Home youth in Cohort 4, and Safe at Home youth in Cohort 2 experienced greater placement instability than comparison youth. While none of the cohorts satisfied the rate of federal compliance, the results were not statistically significant for any of the cohorts.

Table 16. Foster Care Placement Stability			
Cohort	**Group**	**Number of Youth Referred Out-of-Home**	**Percent of Youth with More than 3 or More Moves in 12 Months**
1	Treatment	81	32%
	Comparison	78	37%
2	Treatment	124	43%
	Comparison	120	31%
3	Treatment	98	23%
	Comparison	105	27%
4	Treatment	130	28%
	Comparison	134	28%

As a final way to measure foster care related outcomes, reunification rates were examined (Table 17) by looking at the percentage of youth reunified with their families within both six and twelve months following referral.

Safe at Home youth were much more likely to reunify across all cohorts within both six and twelve months than youth in the comparison groups. This was highly significant across all cohorts within six months ($p<.01$). Within twelve months all results were significant, but the significance level varied (between $p<.05$ for Cohorts 1 and 2 and $p<.01$ for Cohorts 3 and 4).

Table 17. Youth Reunified Within Six and Twelve Months of Referral				
Cohort	**Group**	**Number of Out-of-Home Cases**	**Percent Reunified within 6 Months**	**Percent Reunified within 12 Months**
1	Treatment	78	35%	47%
	Comparison	77	14%	29%

Table 17. Youth Reunified Within Six and Twelve Months of Referral				
Cohort	**Group**	**Number of Out-of-Home Cases**	**Percent Reunified within 6 Months**	**Percent Reunified within 12 Months**
2	Treatment	120	40%	49%
	Comparison	118	16%	36%
3	Treatment	92	52%	61%
	Comparison	100	17%	32%
4	Treatment	112	53%	60%
	Comparison	133	17%	35%
5	Treatment	125	48%	-
	Comparison	129	17%	-

In general, Safe at Home youth are more likely to have initial entries into the foster care system or re-enter the system than comparison group youth. This is potentially due to the lack of mental health data available to produce a comparison group for these measures or due to the increased intensity of the services identifying family issues more frequently. Once in foster care, Safe at Home youth are significantly more likely to be placed with a relative and be reunified with their family than comparison group youth.

Maltreatment

Safe at Home also strives to increase youth safety by demonstrating decreased rates of maltreatment/repeat maltreatment. Table 18 displays the number of youth with a maltreatment referral subsequent to their referral to Safe at Home and the number for which that referral led to a result of substantiated maltreatment.

For Cohorts 1 through 4, Safe at Home youth experienced fewer maltreatment referrals within six and twelve months of their referral to the program than comparison youth. An equal number of maltreatment referrals were made for Safe at Home and comparison youth in Cohort 5 within six months. Substantiations were minimal, but when they did occur, it was only

Safe at Home youth who received a substantiation. At six months, one Safe at Home youth from Cohort 4 experienced a substantiation and the same was true within twelve months for an additional Safe at Home youth in Cohort 3.

Table 18. 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
1	Treatment	3	0	3	0
	Comparison	15	0	22	0
2	Treatment	23	0	28	0
	Comparison	32	0	42	0
3	Treatment	28	0	43	1
	Comparison	33	0	48	0
4	Treatment	40	1	67	1
	Comparison	49	0	70	0
5	Treatment	58	0	-	-
	Comparison	58	0	-	-

Due to the low number of substantiations overall, that outcome was not included in the regression; only maltreatment referrals were included. The older youth were the less likely they were to experience a new maltreatment referral within six and twelve months for both Safe at Home and comparison youth ($p<.01$ for both within six and twelve months). Male youth from Safe at Home were also significantly less likely to receive a maltreatment referral within six and twelve months ($p<.01$ at both six and twelve months). For comparison youth, the longer the DHHR case had been opened the less likely youth were to receive a maltreatment referral

within six and twelve months ($p<.01$ at both six and twelve months).

Well-Being

The CANS tool provides an assessment of youth's strengths and needs which is used to support decision making, facilitate service referrals and monitor progress toward youth goals. By utilizing a four-level rating system (with scores ranging from 0 to 3) on a series of items used to assess specific domains, such as Child Risk Behaviors or Life Domain Functioning, the CANS aids LCA wraparound facilitators in identifying 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, and where services might be warranted. Some items in the CANS will trigger further modules for additional questioning if a need is discovered in that area, such as substance use and GLBTQ (Gay, Lesbian, Bi-Sexual, Transgender and/or Questioning).

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

A total of 1,016 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 pre/post comparisons of Safe at Home youth only.

The results of the initial CANS assessments for youth from Cohorts 1 through 4 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 5. Progress is measured by the extent to which scores improved, meaning the number of needs/actionable items were reduced over time.

As shown in Table 19, the count of 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 two primary factors, either the referral was inappropriate or the Safe at Home case closed prior to six months.

Table 19. Number of Youth with CANS Assessments Available for Analysis					
	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5
Number of Youth with an Initial CANS Assessment	88	165	211	303	345
Number of Youth with a 6-Month Follow-Up CANS	55	96	103	161	75
Number of Youth Discharged Before a 6-Month Follow-Up CANS can be Performed	24	47	69	96	126
Number of Youth Where Not Enough Time Has Passed Before a 6 Month CANS Can Be Performed	0	0	1	0	51
Number of Youth Where Enough Time Has Passed & No 6 Month CANS Was Performed	9	22	38	46	93
Number of Youth with a 12 Month Follow-Up CANS	25	45	44	42	-
Number of Youth Discharged Before a 12 Month Follow-Up	59	97	138	195	-

Table 19. Number of Youth with CANS Assessments Available for Analysis					
	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5
CANS can be Performed					
Number of Youth Where Not Enough Time Has Passed Before a 12 Month CANS Can Be Performed	0	0	2	16	-
Number of Youth Where Enough Time Has Passed & No 12 Month CANS Was Performed	4	23	27	50	-

Table 20 gives an overview of the percentage of youth with at least one need item selected in each of the main CANS domains during the initial assessment.

Table 20. Percentage of Youth with an Actionable Item/Need on the Initial CANS Assessment					
CANS Domain	Cohort 1 (N=88)	Cohort 2 (N=165)	Cohort 3 (N=211)	Cohort 4 (N=303)	Cohort 5 (N=345)
Child Behavioral/Emotional Needs (13 Items)	82%	78%	69%	69%	70%
Child Risk Behaviors (13 Items)	49%	44%	37%	39%	34%

Table 20. Percentage of Youth with an Actionable Item/Need on the Initial CANS Assessment					
CANS Domain	**Cohort 1 (N=88)**	**Cohort 2 (N=165)**	**Cohort 3 (N=211)**	**Cohort 4 (N=303)**	**Cohort 5 (N=345)**
Life Domain Functioning (19 Items)	91%	90%	91%	92%	90%
Trauma Stress Symptoms (12 Items)	48%	45%	28%	30%	35%

Life Domain Functioning has consistently been the domain with the highest percentage of youth who have a need at the time of the initial assessment, hovering around 90 percent for all cohorts. Child Behavioral/Emotional Needs has been identified as a need for most youth second to Life Domain Functioning, but the number of youth with these needs has varied among cohorts.

Table 21 shows the percentage of youth who had a six or twelve month follow up CANS and who also reduced at least one need in a domain (i.e., at least one item in the domain had gone from actionable to non-actionable or was no longer considered a need).

Table 21. 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 1		
Child Behavioral/Emotional Needs	51%	86%
Child Risk Behaviors	52%	80%
Life Domain Functioning	57%	82%

Table 21. Percentage of Youth with a Need on the Initial CANS Who Improved Scores on a 6 or 12 Month Subsequent CANS		
CANS Domain	**Youth with Improved Scores 6 Months Post-Initial CANS**	**Youth with Improved Scores 12 Months Post-Initial CANS**
Trauma Stress Symptoms	39%	78%
Cohort 2		
Child Behavioral/Emotional Needs	60%	69%
Child Risk Behaviors	61%	75%
Life Domain Functioning	66%	75%
Trauma Stress Symptoms	58%	69%
Cohort 3		
Child Behavioral/Emotional Needs	58%	67%
Child Risk Behaviors	67%	75%
Life Domain Functioning	66%	75%
Trauma Stress Symptoms	58%	69%
Cohort 4		
Child Behavioral/Emotional Needs	58%	61%
Child Risk Behaviors	54%	50%
Life Domain Functioning	72%	76%

Table 21. Percentage of Youth with a Need on the Initial CANS Who Improved Scores on a 6 or 12 Month Subsequent CANS		
CANS Domain	**Youth with Improved Scores 6 Months Post-Initial CANS**	**Youth with Improved Scores 12 Months Post-Initial CANS**
Trauma Stress Symptoms	49%	69%
Cohort 5		
Child Behavioral/Emotional Needs	67%	-
Child Risk Behaviors	58%	-
Life Domain Functioning	67%	-
Trauma Stress Symptoms	58%	-

More than half of the youth exhibited improvement on each domain across cohorts. The only instance where this did not hold true was at six months for Cohort 4 under Trauma Stress Symptoms. However, by twelve months 69 percent of youth from Cohort 4 showed a reduction in their needs related to the Trauma Stress Symptom. Improvements were evident across all domains and all cohorts between six and twelve months, showing even greater continued improvement between the two time periods.

In addition to the main CANS domains, there are triggered sub-modules which delve deeper into specific questions on topics where youth have identified needs. Table 22 provides the results of youth who triggered sub-modules in the initial CANS assessment.

Table 22. Percentage of Youth with Triggered Submodules on Initial CANS Assessment					
Submodule	**Cohort 1 (N=88)**	**Cohort 2 (N=165)**	**Cohort 3 (N=209)**	**Cohort 4 (N=299)**	**Cohort 5 (N=345)**
Adolescent Suicide	14%	10%	4%	7%	6%

Table 22. Percentage of Youth with Triggered Submodules on Initial CANS Assessment					
Submodule	**Cohort 1 (N=88)**	**Cohort 2 (N=165)**	**Cohort 3 (N=209)**	**Cohort 4 (N=299)**	**Cohort 5 (N=345)**
Child Suicide	0%	2%	1%	1%	1%
Commercial Sexual Exploitation	0%	0%	2%	1%	1%
Children's Sexual Behaviors Screen	14%	11%	10%	10%	10%
Delinquent Behavior	48%	39%	53%	52%	53%
Fire Setting	1%	1%	1%	2%	1%
GLBTQ	5%	2%	3%	6%	3%
Sexually Abusive	19%	13%	13%	14%	11%
Substance Use	30%	24%	27%	28%	33%

The submodules which were most commonly triggered across cohorts were Delinquent Behavior followed by Substance Use. The Adolescent Suicide submodule saw the greatest reduction in use over time. The three submodules which stood out as eliciting the lowest level of response were Commercial Sexual Exploitation, Child Suicide and Fire Setting.

Family Functioning

Progress in family functioning was calculated by using the Family Functioning domain of the CANS which is further broken into specific items within that domain (Table 23).

Table 23. 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 1					
Physical Health	5	1	1	1	1
Mental Health	2	2	0	1	1
Substance Use	1	1	1	1	1
Family Stress	24	18	10	8	6
Residential Stability	7	4	3	3	2
Total	**29**	**19**	**11**	**9**	**7**
Cohort 2					
Physical Health	15	9	2	7	2
Mental Health	4	1	1	1	1
Substance	5	4	2	3	1

Table 23. 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	16	5	7	4
Residential Stability	10	5	1	3	2
Total	**43**	**26**	**7**	**14**	**6**
Cohort 3					
Physical Health	7	2	1	1	1
Mental Health	9	4	2	2	1
Substance Use	3	2	0	1	1
Family Stress	32	18	8	11	5
Residential Stability	16	10	4	6	5
Total	**42**	**22**	**10**	**12**	**7**

Table 23. 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 4					
Physical Health	6	2	0	1	0
Mental Health	6	1	0	0	0
Substance Use	3	2	1	0	0
Family Stress	45	19	9	6	2
Residential Stability	15	8	5	2	0
Total	**58**	**26**	**12**	**9**	**2**
Cohort 5					
Physical Health	13	2	1	-	-
Mental Health	10	3	2	-	-
Substance	10	6	3	-	-

Table 23. 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	39	12	5	-	-
Residential Stability	16	4	3	-	-
Total	**63**	**17**	**9**	**-**	**-**

The most common Family Functioning need on the initial assessment is Family Stress followed by Residential Stability; this finding was consistent across cohorts. Of those with a CANS assessment at six-months, 44 percent showed improved Family Stress scores as well as 55 percent on Residential Stability scores. Though the number of 12-month assessments is limited, when looking at the entire Family Functioning domain, 50 percent of 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 Stress Symptoms CANS domains and are inclusive of four specific items on education:

- School Achievement,
- School Attendance,
- School Behavior and

- School Violence.

Results for educational functioning are displayed in Table 24.

Table 24. 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 1					
School Achievement	22	11	5	4	2
School Attendance	14	5	5	2	2
School Behavior	33	22	7	11	4
School Violence	11	4	0	1	0
Total	**56**	**32**	**13**	**14**	**7**
Cohort 2					
School Achievement	45	31	19	19	13
School Attendance	31	20	14	8	5
School	50	32	20	12	10

Table 24. 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**
Behavior					
School Violence	18	10	3	4	1
Total	**93**	**59**	**36**	**25**	**17**
Cohort 3					
School Achievement	73	35	18	14	9
School Attendance	49	27	19	14	10
School Behavior	53	28	17	11	9
School Violence	17	6	2	2	2
Total	**123**	**57**	**37**	**26**	**20**
Cohort 4					
School Achievement	99	56	26	14	7
School Attendance	81	48	36	11	8

Table 24. 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 Behavior	90	53	34	16	13
School Violence	21	12	2	2	1
Total	**178**	**103**	**65**	**25**	**19**
Cohort 5					
School Achievement	134	22	13	-	-
School Attendance	88	17	12	-	-
School Behavior	112	29	18	-	-
School Violence	38	8	1	-	-
Total	**233**	**51**	**29**	**-**	**-**

The most common Educational Functioning need on the initial assessment is School Achievement followed by School Behavior. However, School Attendance was not far behind. Overall, school-based needs were reduced by 57 percent at six months and 68 percent at twelve months.

Summary of Outcome Evaluation Results

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

However, youth from later cohorts were better able to sustain the positive placement shifts they experienced between six and twelve months post-referral. When youth from later cohorts were discharged home from congregate care, they were more likely to stay there, and the same was true for those youth who started at home.

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

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

The stepwise regression analysis revealed that Safe at Home has done well in making the program work for youth within its population (i.e., older youth and youth with juvenile justice involvement). Youth with an Axis 1 diagnosis were more likely to experience poorer outcomes across the board for both Safe at Home and comparison youth.

CANS assessments demonstrated that youth have effectively reduced needs in all

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

Cost Evaluation Results

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

Four research questions guide the cost evaluation:

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

The cost analysis for this reporting period focuses on the costs of out-of-home care and fee-for-services costs, comparing costs incurred for youth in Safe at Home to those in the comparison groups for Cohorts 1 through 4. It also provides a glimpse of the contracted costs for services provided by the LCAs.

When the cost evaluation first began, a daily rate for room and board expenditures was developed using costs incurred by youth in Cohort 1's comparison group. The cost of providing out-of-home care to youth in the comparison cohort was calculated, limiting the cost to the first 365 days of substitute care for those who remained out of the home longer than one year following the date they qualified for inclusion in the comparison group. This limitation was applied to ensure that the same amount of time was applied to the review of costs for the treatment and comparison groups. Those costs were then used to compute an average daily rate which has continued to be used for the cost evaluation. With rates subject to change year to year, it is important that a standard rate be developed and applied to eliminate the impact of rate increases and thus avoid the inappropriate appearance of Safe at Home costs being higher just because of rate increases.

Using the data from Cohort 1's comparison 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 Foster Care	$57.29
Family Foster or Relative Care	$21.47

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

As illustrated in Table 25, Safe at Home generated a cost savings of over $5 million in costs for room and board expenditures for youth in the first four 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 25 also includes the average cost of room and board per youth removed from their home for each Cohort. The comparison group remains consistently at roughly $33,000 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 25. Cost of Room and Board Payments

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

Table 25. Cost of Room and Board Payments		
	Comparison Group	**Treatment Group**
Foster Care		
Family Foster of Relative 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 2		
Out-of-State Residential Care	$1,039,061.56	$349,312.78
In-State Residential Care	$3,546,138.84	$2,320,796.93
Shelter Care	$444,956.29	$698,444.72
Therapeutic/Specialized Foster Care	$106,842.38	$75,734.92
Family Foster or Relative Care	$67,368.55	$58,888.45
Totals	**$5,204,367.62**	**$3,503,177.79**
Average Cost per Youth Removed	**$36,140.83**	**$23,993.99**
Cohort 3		
Out-of-State Residential Care	$1,167,654.73	$499,498.08
In-State Residential Care	$3,254,784.08	$1,969,618.25
Shelter Care	$361,311.11	$463,727.65
Therapeutic/Specialized Foster Care	$76,594.24	$76,365.09

Table 25. Cost of Room and Board Payments		
	Comparison Group	**Treatment Group**
Family Foster or Relative Care	$64,062.38	$73,980.89
Totals	**$4,924,406.55**	**$3,083,252.95**
Average Cost per Youth Removed	**$32,828.82**	**$20,020.82**
Cohort 4		
Out-of-State Residential Care	$1,022,027.77	$758,363.80
In-State Residential Care	$3,914,421.62	$2,925,208.25
Shelter Care	$527,400.09	$716,915.73
Therapeutic/Specialized Foster Care	$192,144.42	$70,177.97
Family Foster or Relative Care	$110,584.90	$81,623.72
Totals	**$5,766,578.80**	**$4,522,289.47**
Average Cost per Youth	**$29,724.16**	**$21,272.04**

Fee-for-services costs (e.g., case management, maintenance, services, etc.) were also examined to determine if Safe at Home was having a positive impact in reducing expenditures incurred by West Virginia to meet the needs of youth (Table 26).

In total, limiting the analysis to the amount paid for fee-for-services for Safe at Home youth as identified within FACTS, the amount expended for youth in the treatment group is at least $770,000 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, case management) are not reported for Safe at Home youth since they are Administrative Services Organization (ASO) payments which are now included in the contracted

Wraparound services.

Table 26. Cost of Fee-for-Service Payments		
Service Category	**Comparison Group**	**Treatment Group**
Cohort 1		
Assessment	$15,647.25	$0.00
Case Management	$11,653.50	$0.00
Clothing	$19,674.97	$9,377.26
Education	$36,874.43	$71,148.42
Independent Living	$23,224.35	$1,775.59
Legal	$529.08	$0.00
Maintenance	$22,696.75	$0.00
Other	$9,453.34	$5,497.02
Services	$18,626.80	$1,205.27
Supervised Visitation	$3,857.30	$0.00
Transportation	$22,464.14	$0.00
Totals	**$184,701.91**	**$89,003.56**
Cohort 2		
Assessment	$27,713.50	$502.75
Case Management	$22,379.00	$0.00
Clothing	$22,263.16	$21,766.79
Education	$46,955.66	$32,210.19
Independent Living	$35,037.13	$11,376.92

Table 26. Cost of Fee-for-Service Payments		
Service Category	**Comparison Group**	**Treatment Group**
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 3		
Assessment	$37,260.00	$0.00
Case Management	$29,668.00	$0.00
Clothing	$26,999.30	$18,149.27
Education	$50,550.72	$1,360.00
Independent Living	$28,022.63	$1,850.00
Legal	$248.28	$0.00
Maintenance	$25,100.60	$373.60
Other	$22,867.51	$22,383.79
Services	$28,192.58	$3,228.98
Supervised Visitation	$4,290.00	$0.00
Transportation	$41,209.24	$0.00
Totals	**$294,408.86**	**$47,345.64**

Table 26. Cost of Fee-for-Service Payments		
Service Category	**Comparison Group**	**Treatment Group**
Cohort 4		
Assessment	$44,910.00	$0.00
Case Management	$43,610.00	$0.00
Clothing	$38,116.07	$29,384.36
Education	$61,177.92	$41,944.05
Independent Living	$35,429.04	$2,287.84
Legal	$492.86	$1,080.56
Maintenance	$31,683.50	$5,031.11
Other	$21,194.65	$35,611.96
Services	$48,300.28	$651.36
Supervised Visitation	$9,024.00	$0.00
Transportation	$61,990.00	$0.00
Totals	**$395,928.32**	**$115,991.24**

Contracted costs to provide Wraparound services were also examined. A daily case rate of $136 is paid to LCAs to provide assessments, case management and supervision, as well as to provide services that are traditionally not funded. The added per case costs to DHHR may be mitigated by the amount of time caseworkers have to work on other, non-Safe at Home cases. Using the number of days youth were enrolled in Safe at Home West Virginia, roughly $49.3 million has been incurred to provide services to enrolled youth. The costs equate to an average cost of $45,332 per youth in Cohorts 1 through 4.

Summary of Cost Evaluation Results

The program has generated a cost savings of $5 million in room and board costs and a

savings of over $770,000 for fee-for-services for treatment youth in Cohorts 1 through 4. The most significant portion of these savings can be attributed to the reduced time youth spend in congregate care placements. As noted above, costs to contract with Wraparound service providers averages $45,332 per youth. Interviewed DHHR staff suggest some of the costs of Wraparound services are likely offset by caseworkers who spend less time on Safe at Home cases since wraparound facilitators are providing such intensive services for youth/families.

V. Recommendations & Activities Planned for Next Reporting Period

West Virginia's Evaluator's Recommendations

Recommendation 1: Investigate the cause of missing initial CANS and crisis safety plan timeframes. Meeting the initial crisis safety plan and CANS timeframes proved to be a struggle again this year for LCAs. While some explanations were provided, a deeper dive into the challenges that make meeting initial timeframes difficult will be the starting point for working to remedy the issue.

Recommendation 2: Provide further training or clarification on required after-care planning and follow-up. There was confusion among LCA staff regarding what type of after-care planning and follow-up should take place when a Safe at Home cases. This issue may require further training or simple clarification from leadership to address.

Next Steps

West Virginia's Evaluator

HZA will return to West Virginia for one week during February 2019 to conduct interviews with key stakeholders to examine processes and learn about the current successes and challenges. The evaluator will be re-visiting the interview protocols to ensure the right questions are asked given what we already know about Safe at Home, and the upcoming end to the waiver period. HZA will review the list of potential stakeholders for interview and will work with the State to ensure that the most relevant parties are included. Additionally, HZA will continue to utilize FACTS and CANS data for the outcome and cost evaluations. The cost evaluation will be expanded to include an analysis of the types of services LCAs are providing to Safe at Home youth, especially those which are not traditional in nature.

Appendices

Appendix A. Safe at Home West Virginia Fidelity Assessment Case Record Review Tool

WEST VIRGINIA TITLE IV-E WAIVER
SAFE AT HOME/WRAPAROUND FIDELITY ASSESSMENT
CASE RECORD REVIEW INSTRUMENT

Case Number:	Client ID:
Youth's Last Name:	County: Region:
Local Coordinating Agency:	Wraparound Facilitator:
Reviewer:	Review Date:

YOUTH/FAMILY INFORMATION

1. Please provide the following demographic information about the youth:

   Name: _____

   Date of Birth (mm/dd/yyyy): _ _ / _ _ / _ _ _ _

   Race/Ethnicity:
   - White
   - Black
   - Hispanic
   - Asian
   - Mixed/Other

   Gender:
   - Male
   - Female

- Other (specify): _____

2. Where was the youth placed at the time of referral?
   - Out-of-State Congregate Care
   - In-State Congregate Care
   - In-State Shelter
   - Non-Kinship/Non-Relative Foster Home
   - Kinship/Relative Foster Home
   - Adoptive Home
   - Home with Biological Parent(s)

3. Where is the youth currently placed?
   - Out-of-State Congregate Care
   - In-State Congregate Care
   - In-State Shelter
   - Non-Kinship/Non-Relative Foster Home
   - Kinship/Relative Foster Home
   - Adoptive Home
   - Home with Biological Parent(s)
   - Detention
   - Runaway/Missing
   - Emancipated/Living Independently

SAFE AT HOME CHRONOLOGY

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

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

5. Removal date (most recent): _ _ / _ _ / _ _ _ _

6. Date of referral to wraparound services/*Safe at Home*: _ _ / _ _ / _ _ _ _

7. Date of return home (most recent): _ _ / _ _ / _ _ _ _

8. Date of initial CANS: _ _ / _ _ / _ _ _ _

9. Date(s) of subsequent CANS (earliest to latest): _ _ / _ _ / _ _ _ _

_ _ / _ _ / _ _ _ _

_ _ / _ _ / _ _ _ _

10. Date of initial wraparound plan: _ _ / _ _ / _ _ _ _

11. Date(s) of subsequent wraparound plans (earliest to latest): _ _ / _ _ / _ _ _ _

_ _ / _ _ / _ _ _ _

_ _ / _ _ / _ _ _ _

12. Date of initial crisis safety plan: _ _ / _ _ / _ _ _ _

13. Date(s) of subsequent crisis safety plans (earliest to latest): _ _ / _ _ / _ _ _ _

_ _ / _ _ / _ _ _ _

_ _ / _ _ / _ _ _ _

14. Date of wraparound/*Safe at Home* closure: _ _ / _ _ / _ _ _ _

15. If wraparound/*Safe at Home* has closed, what is the reason?
    - Successful completion of the program/graduation
    - Unable to complete/discharged (specify reason): _____

16. DHHR case closing date: _ _ / _ _ / _ _ _ _

ENGAGEMENT AND TEAM PREPARATION PHASE

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

INITIAL PLAN DEVELOPMENT PHASE

WRAPAROUND PLAN CONTENT

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

5 = Thoroughly 4 = Mostly 3 = Somewhat 2 = Not Very Much 1 = Not at All[22]

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

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

Services/Supports Take Account of and Use Youth's/Family's Strengths					

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

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

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

Wraparound Plan Fidelity Items	5	4	3	2	1
Services/Supports Take Account of and Use Youth's/Family's Strengths					

CRISIS SAFETY PLAN CONTENT

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

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

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

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

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

Crisis Safety Plan Fidelity Items	5	4	3	2	1
Strategy for Crisis Prevention					

Identification of Behaviors Signaling Coming Crisis					
Methods for De-escalating Crises					
Steps to Be Taken during Crisis					
Assignment of Roles during Crisis					

IMPLEMENTATION PHASE

22. Record the number of face-to-face contacts the wraparound facilitator had with the youth each *full* month from the referral date until the review date or case closure date (add as many months as needed):

Month 1: _____ contacts

Month 2: _____ contacts

Month 3: _____ contacts

Month 4: _____ contacts

Month 5: _____ contacts

Month 6: _____ contacts

Month 7: _____ contacts

Month 8: _____ contacts

Month 9: _____ contacts

Month 10: _____ contacts

Month 11: _____ contacts

Month 12: _____ contacts

Month 13: _____ contacts

Month 14: _____ contacts

Month 15: _____ contacts

Month 16: _____ contacts

Month 17: _____ contacts

Month 18: _____ contacts

OTHER

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

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

Appendix B. Safe at Home West Virginia Fidelity Assessment Interview Protocols

SAFE AT HOME WEST VIRGINIA
YOUTH INTERVIEW PROTOCOL

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

PLACEMENT AND EDUCATION STATUS

1. Where are you living now?
    a. Are you living in the same place you were when you first started with *Safe at Home*?
        i. If no, where were you living before *Safe at Home*?

2. What impact has *Safe at Home* had on your education?

3. Did you attend school this past year?
    a. If yes, are you in the same school you were in before *Safe at Home*?
        i. If no, why?
    b. If yes, since *Safe at Home* began, have you remained at the same school?
        i. If no, why?
    c. If no, is this because you have graduated?
        i. If yes, will you be attending college, or do you have plans to get a job?
    d. If no, do you have plans to return to school? (If no, skip to Question 5)
        i. If no, do you have plans to get a job?

4. Overall, how would you say you did this past school year?
    a. Grades?
        i. Did you pass to the next grade level?
            a. If no, what caused you to fail?
            b. If no, what steps are you taking to ensure you do better this year, and how is *Safe at Home* going to help with that?
    b. Friends?
    c. Involvement in school activities?
    d. Staying out of trouble?
        i. Were you ever suspended or expelled from school before *Safe at Home*?
            a. If yes, why was this happening?

b. If yes, how often was this happening?
c. If yes, how has this changed since you began *Safe at Home*?

ENGAGEMENT AND TEAM PREPARATION PHASE

5. How did you learn about *Safe at Home*?
    a. Who explained *Safe at Home* to you?
        i. What kind of information was shared with you?
    b. Has *Safe at Home* gone the way you expected it to?
        i. If no, how has it been different?

6. Since you started *Safe at Home*, has the wraparound facilitator encouraged you to discuss your strengths, goals and concerns?
    a. How does the wraparound facilitator respond to your opinions?
    b. Did you struggle with opening up at first?
        i. If yes, how did you overcome this?
            a. If you still struggle, why is that, and what can be done to help you?

7. Did you tell the wraparound facilitator about people you wanted to be involved with you for *Safe at Home*?
    a. If yes, who are those people? *(please code relational responses)*
    b. If yes, are those people participating?
        i. If yes, what is their role in supporting you?
        ii. If no, why not?
    c. If no, did you not want others involved, or did you struggle with thinking of people?
        i. If yes, why is that?

INITIAL PLAN DEVELOPMENT PHASE

8. What are the goals you hope to achieve with *Safe at Home*?

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

PLAN IMPLEMENTATION PHASE

10. How often do you meet with the wraparound facilitator?
    a. Is this amount of contact okay?
        i. If no, is more or less contact needed?

11. What services have you received so far since *Safe at Home* began?
    a. This includes "formal services," for example, therapy or medication management among many others, and:
    b. "Informal services," which can be many different things, for example, help with school work, trips to a museum, getting back to school supplies, etc.:

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

13. As time has gone on with *Safe at Home*, have you been able to continually make progress and remain motivated to succeed?
    a. If no, what has stalled your progress or challenged your motivation?

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

TRANSITION PHASE

15. Are you done with *Safe at Home*? (If no, skip to Question 17)
    a. If yes, what was the reason for *Safe at Home* ending?
        i. If positive, how did everyone know you were ready to finish the program?
            a. Was there a final celebration to recognize your completion of *Safe at Home*?
                i. If yes, what happened?
        ii. If negative, what could have been done differently to change the outcome?

16. Did the wraparound facilitator create a transition plan, or any type of plan for checking in on you once *Safe at Home* was over?
    a. If yes, what was the plan?
    b. If yes or no, what were you told to do in case of emergency or crisis?
    c. If yes, has the facilitator followed up with you?
        i. If yes, what did you discuss?

CONCLUSION

17. Overall, how has *Safe at Home* helped you?

18. What have you liked best about the program?

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

SAFE AT HOME WEST VIRGINIA
PARENT/CAREGIVER INTERVIEW PROTOCOL

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

PLACEMENT AND EDUCATION STATUS

1. Where is your child living now?
    a. Is your child living in the same place s/he was when s/he first started with *Safe at Home*?
        i. If no, where was your child living before *Safe at Home*?

2. What impact has *Safe at Home* had on your child's education?

3. Did your child attend school this past year?
    a. If yes, is s/he in the same school s/he was in before *Safe at Home*?
        i. If no, why?
    b. If yes, since *Safe at Home* began, has your child remained at the same school?
        i. If no, why?
    c. If no, is this because your child has graduated?
        i. If yes, will your child be attending college or does s/he have plans to get a job?
    d. If no, does your child have plans to return to school? (If no, skip to Question 5)
        i. If no, does your child have plans to get a job?

4. Overall, how would you say your child did this past school year?
    a. Grades?
        i. Did your child pass to the next grade level?
            a. If no, what caused your child to fail?
            b. If no, what steps are being taken to ensure your child does better this year, and how is *Safe at Home* going to help with that?
    b. Friends?
    c. Involvement in school activities?
    d. Staying out of trouble?
        i. Was your child ever suspended or expelled from school before *Safe at Home*?

a. If yes, why was this happening?
b. If yes, how often was this happening?
c. If yes, how has this changed since your child began *Safe at Home*?

ENGAGEMENT AND TEAM PREPARATION PHASE

5. How did you learn about *Safe at Home*?
    a. Who explained *Safe at Home* to you?
        i. What kind of information did they share with you?
    b. Has *Safe at Home* gone the way you expected it to?
        i. If no, how has it been different?

6. Since your family started *Safe at Home*, has the wraparound facilitator encouraged you and your child to discuss strengths, goals and concerns?
    a. How does the wraparound facilitator respond to you and your child's opinions?
    b. Did you or your child struggle with opening up at first?
        i. If yes, how did you or your child overcome this?
            a. If you or your child still struggle, why is that, and what can be done to help you?

7. Did you or your child tell the wraparound facilitator about people you wanted to be involved with your family for *Safe at Home*?
    a. If yes, who are the people you wanted involved *(please code relational responses)*?
    b. If yes, are these people participating?
        i. If yes, what is their role in supporting your family?
        ii. If no, why not?
    c. If no, did you or your child not want others involved, or did you struggle with identifying people?
        i. If yes, why is that?

INITIAL PLAN DEVELOPMENT PHASE

8. What are the goals you and your child hope to achieve with *Safe at Home*?

9. Were you and your child involved in creating a crisis safety plan?
    a. If yes, did the wraparound facilitator explain why it was needed and how it works?
    b. How do members of the team assist your child and family in case of a crisis?
    c. Have you needed to use the crisis safety plan?

i. If yes, how helpful has the crisis safety plan been in meeting your family's needs?

PLAN IMPLEMENTATION PHASE

10. How often do you and your child meet with the wraparound facilitator?
    a. Is this amount of contact okay?
        i. If no, is more or less contact needed?

11. What services has your child and family received so far through *Safe at Home*?
    a. This includes "formal services," for example therapy, among many others, and:
    b. "Informal services," which can be many different things, for example, help with school work, trips to the museum, getting back to school supplies, etc.:

12. Are you and your child helping to make decisions about the services received through *Safe at Home*?
    a. If yes, what are some examples where you or your child's input has been heard and used?
    b. If no, why do you think that is?

13. As time has gone on with *Safe at Home*, has your child been able to continually make progress and remain motivated to succeed?
    a. If no, what has stalled your child's progress or challenged his/her motivation?

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

TRANSITION PHASE

15. Are you and your child done with *Safe at Home*? (If no, skip to Question 17)
    a. If yes, what was the reason for *Safe at Home* ending?
        i. If positive, how did everyone know that your child was ready to finish the program?
            a. Was there a final celebration to recognize your child's completion of *Safe at Home*?
                i. If yes, what happened?

ii. If negative, what could have been done differently to change the outcome?

16. Did the wraparound facilitator create a transition plan, or any type of plan for checking in on your child and family once *Safe at Home* was over?
    a. If yes, what was the plan?
    b. If yes or no, what were you and your child told to do in case of emergency or crisis once *Safe at Home* ended?
    c. If yes, has the facilitator followed up with your child and family?
        i. If yes, what was discussed?

CONCLUSION

17. Overall, how has *Safe at Home* helped your child and family?

18. What have you liked best about the program?

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

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

Use the introductory paragraph below if you are interviewing a caseworker about multiple youth.

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

RELATIONSHIP TO YOUTH

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

PLACEMENT AND EDUCATION STATUS

2. Where is the youth currently living?
    a. Has that changed since *Safe at Home* began?
        i. If yes, where was s/he living prior to *Safe at Home*?

3. What role has *Safe at Home* played in the youth's education?

4. Did the youth complete this past school year and is s/he set to return this fall?
    a. If yes, is the youth in the same school s/he was in prior to *Safe at Home*?

i. If no, why?

b. If yes, since *Safe at Home* began has the youth remained at the same school?
   i. If no, why?

c. If no, is this because the youth has graduated?
   i. If yes, will the youth be attending college or does s/he have plans to get a job?

d. If no, does the youth have plans to return to school? (If no, skip to Question 6)
   i. If no, does the youth have plans to get a job?

5. Overall, how would you say the youth did this past school year?
   a. Academic achievement?
      i. Did the youth pass to the next grade level?
         a. If no, what caused the youth to fail?
         b. If no, what steps are being taken to ensure the youth does better this year, and how is *Safe at Home* going to help with that?
   b. Peer relationships?
   c. Involvement in school activities?
   d. Staying out of trouble?
      i. Was the youth ever suspended or expelled from school prior to *Safe at Home*?
         a. If yes, why was this happening?
         b. If yes, how often was this occurring?
         c. If yes, how has this changed since the youth began *Safe at Home*?

ENGAGEMENT AND TEAM PREPARATION PHASE

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

7. From the beginning, was the youth and family encouraged by the wraparound facilitator to share their strengths, goals and concerns?
   a. How did other team members, such as yourself, play a role in the early engagement phase?
   b. To what extent has the youth and family been able to open up to the wraparound facilitator?

i. If not well, why is that, and what steps are being taken to resolve the issue?

8. Did the youth and his/her family identify supports they wanted to be involved with them through *Safe at Home*?
    a. If yes, who did they identify? *(please code relational responses)*
    b. If yes, are these people participating?
        i. If yes, what is their role in supporting the youth and family?
        ii. If no, what efforts were made to ensure their participation?
    c. If no, did the youth and family not want others involved, or did they struggle with identifying supports?
        i. If they did not want others involved or they could not identify any supports, please explain why.

INITIAL PLAN DEVELOPMENT PHASE

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

10. What are goals that have been identified for the youth and family through wraparound planning?

11. What is your level of involvement with crisis safety planning through *Safe at Home*?
    a. How do team members assist the youth in case of a crisis?
    b. Has the team needed to implement the crisis safety plan?
        i. If yes, how helpful has the crisis safety plan been in meeting the youth's needs?

PLAN IMPLEMENTATION PHASE

12. How often does the wraparound facilitator meet with the youth and their family?
    a. Is that amount of contact adequate?
        i. If no, is more or less contact needed?

13. What services has the youth received so far through *Safe at Home*?
    a. Formal services; specifically, what models are used:
    b. Informal services/supports:

14. How is the wraparound facilitator ensuring that the youth is actively participating and making decisions about services?

a. What are some examples of instances where the youth's input about services has been used?
b. If the youth is not actively participating, why do you think that is?

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

16. How does the wraparound facilitator reward or recognize the successes the youth and his/her family have achieved?
    a. What are the successes so far?
    b. What are the challenges and what steps are being taken to overcome them?
    c. How do you help to ensure that progress is being made if the youth/family is struggling?

17. Overall, to what extent has the youth and family engaged with the program?
    a. What strategies are used to keep the youth and family engaged?
    b. In what ways could youth and family engagement be improved?

TRANSITION PHASE

18. Is this case closed for *Safe at Home*? (If no, skip to Question 20)
    a. If yes, what was the reason for case closure?
        i. If positive, how did the wraparound facilitator/team know that the youth was ready for transition?
            a. Was there a final celebration to recognize the youth's completion of *Safe at Home*?
                i. If yes, what happened?
        ii. If negative, what could have been done to change the outcome?

19. Did the wraparound facilitator create a transition plan for checking in on the youth and family once services were ended?
    a. If yes, what was in the plan?
    b. If yes, has the facilitator followed up with the youth and family?

CONCLUSION

20. How has *Safe at Home* helped this youth and family?

21. What barriers to success have you seen?
    a. What could have been differently to overcome those barriers?

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

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

Use the introductory paragraph below if you are interviewing a wraparound facilitator about multiple youth.

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

RELATIONSHIP TO YOUTH

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

PLACEMENT AND EDUCATION STATUS

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

3. What role has *Safe at Home* played in the youth's education?

4. Did the youth complete this past school year and is s/he set to return this fall?
    a. If yes, is the youth in the same school s/he was in prior to *Safe at Home*?

i. If no, why?

b. If yes, since *Safe at Home* began has the youth remained at the same school?
   i. If no, why?

c. If no, is this because the youth has graduated?
   i. If yes, will the youth be attending college or does s/he have plans to get a job?

d. If no, does the youth have plans to return to school? (If no, skip to Question 6)
   i. If no, does the youth have plans to get a job?

5. Overall, how would you say the youth did this past school year?
   a. Academic achievement?
      i. Did the youth pass to the next grade level?
         a. If no, what caused the youth to fail?
         b. If no, what steps are being taken to ensure the youth does better this year, and how is *Safe at Home* going to help with that?
   b. Peer relationships?
   c. Involvement in school activities?
   d. Staying out of trouble?
      i. Was the youth ever suspended or expelled from school prior to *Safe at Home*?
         a. If yes, why was this happening?
         b. If yes, how often was this occurring?
         c. If yes, how has this changed since the youth began *Safe at Home*?

ENGAGEMENT AND TEAM PREPARATION PHASE

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

7. From the beginning, how did you get the youth and family to share their strengths, goals and concerns with you?
   a. Did the youth/family struggle with opening up to you?
      i. If yes, how did you work to engage them?
      ii. If yes, has their engagement improved over time?
   b. How did other team members play a role in the early engagement phase?

8. Did the youth and his/her family identify people they wanted to be involved in the with them through *Safe at Home*?
    a. If yes, who did they identify? *(please code relational responses)*
    b. If yes, to what extent have they participated?
        i. If they have not participated, what efforts were made to involve them?
    c. If no, did the youth and family not want others involved, or did they struggle with identifying supports?
        i. If they did not want others involved or they could not identify any supports, please explain why.

INITIAL PLAN DEVELOPMENT PHASE

9. When you create wraparound plans, how do you involve the youth and his/her family?
    a. Is it difficult to get the youth/family to participate in this process?
        i. If yes or no, what strategies do you use to engage them?
    b. How are family supports involved in creating the plan?

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

11. What are the goals that have been identified for the youth and family through wraparound planning?

12. What is the youth and family's level of involvement in crisis safety planning?
    a. How do others provide support in case of a crisis?
    b. Has the team needed to implement the crisis safety plan?
        i. If yes, how helpful has the crisis safety plan been in meeting the youth's needs?

PLAN IMPLEMENTATION PHASE

13. How often do you meet with the youth and their family?
    a. Is this amount of contact adequate?
        i. If no, is more or less contact needed?

14. What services has the youth received so far through *Safe at Home*?
    a. Formal services; specifically, what models are used:
    b. Informal services/supports:

15. How do you get the youth to be an active participant in decisions about services through the wraparound process?
    a. What are some examples of instances where the youth's input about services has been used?
    b. If the youth is not actively participating, why do you think that is?

16. Have there been any barriers in trying to obtain services for the youth?
    a. If so, for which services have this been a struggle?
        i. How did you, and/or members of the wraparound team, work to overcome this challenge?

17. How do you monitor the progress that is being made toward achieving the goals set forth?
    a. How do you ensure that progress is being made if the youth and family are struggling?
    b. How do other team members help when the youth and family are struggling to make progress?

18. How do you help the youth/family identify success?
    a. What are the successes?
    b. How do you reward or recognize the successes the youth has achieved?
    c. What are the challenges and what steps are being taken to overcome them?

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

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

TRANSITION PHASE

21. Is this case closed for *Safe at Home*? (If no, skip to Question 23)
    a. If yes, what was the reason for case closure?
        i. If positive, how did you know that the youth and family were ready for transition?
            a. Was there a final celebration to recognize the youth's completion of *Safe at Home*?
                i. If yes, what happened?
        ii. If negative, what could have been done to change the outcome?

22. Was a transition plan created?
    a. If yes, what was in the plan?
    b. If yes or no, what was the youth and family told to do in case of emergency or crisis?
    c. Do you have a plan for checking in on the youth and family now that the service has ended?
        i. If yes, have you followed up with the youth and family yet?
            a. If yes, what was discussed?

CONCLUSION

23. How has *Safe at Home* helped this youth and family?

24. What barriers to success have you seen?
    a. What could have been differently to overcome those barriers?

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

Appendix C. Safe at Home West Virginia LCA Staff Fidelity Survey

Safe at Home West Virginia LCA Staff Survey

1. Which position most closely represents your job title?

○ Wraparound Facilitator ○ Wraparound Supervisor ○ Program Manager

○ Other (please specify): _____

2. Please select your agency's name from this list:

○ Braley & Thompson
○ Burlington
○ Children's Home Society
○ Genesis Youth Crisis Center
○ KVC Behavioral Healthcare of West Virginia
○ National Youth Advocate Program
○ NECCO
○ Pressley Ridge
○ Prestera
○ Youth Services Systems

3. How long have you worked at this agency?

○ less than a year ○ 1-2 years ○ 2+-4 years ○ 4+-6 years ○ more than 6 years

4. How long have you worked in behavioral health services?

○ less than a year ○ 1-2 years ○ 2+-4 years ○ 4+-6 years ○ more than 6 years

5. What is the highest level of education you have completed?

○ High School or GED ○ Associates Degree ○ Some College

○ Bachelor's Degree ○ Master's Degree ○ Higher than a Master's Degree

6. In what field was your degree obtained?

○ Social Welfare ○ Sociology ○ Psychology ○ Social Work ○ Criminal Justice

○ Public Health ○ Education ○ Child Care ○ Other (specify) _____

○ Not Applicable

7. Prior to your current role, did you have the following knowledge or experience (check all that apply)?

☐ Direct work with older youth and their families.

☐ Knowledge base of mental illness diagnoses and behavioral disorders in children.

☐ Personal family experience with mental illness.

8. Are you familiar with the Bureau of Children and Families' Safe at Home policies and procedures?

○ Yes ○ No

9. Did you receive any type of training to prepare you for Safe at Home West Virginia?

○ Yes ○ No

10. To what degree did the training prepare you for your role in the program?

○ Very Well ○ Somewhat ○ Not Well

11. Did you receive Wraparound certification?

○ Yes ○ No

a. Please provide an explanation as to why you are not certified (e.g., new hire, not required for my position, etc.):

12. How well did the CANS training prepare you to complete and use the CANS tool?

○ Very Well ○ Somewhat ○ Not Well ○ Did not receive CANS training

○ N/A (CANS does not apply to my work with Safe at Home)

13. Did you receive certification to use the CANS?

○ Yes ○ No

a. If no, please provide an explanation: (e.g., new hire, not required for my position, etc.)

14. On a scale of 1-10 (1 being easiest and 10 being the most difficult), please rate the ease of use of the CANS assessment.

1	2	3	4	5	6	7	8	9	10	N/A
○	○	○	○	○	○	○	○	○	○	○

easy difficult

a. What is needed to make the CANS assessment easier to use?

15. How effective is the CANS tool in identifying and measuring youth's needs and strengths?

○ Very Effective ○ Effective ○ Somewhat Effective ○ Ineffective ○ I do not use CANS

16. How many Safe at Home cases have you had or supervised? ____

17. In thinking about your cases, or your workers' cases if you are a supervisor or manager, to what extent do you agree with the following statements?

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Safe at Home eligibility criteria are clear and followed by BCF staff.	○	○	○	○
Safe at Home referral processes operate smoothly.	○	○	○	○
Safe at Home helps to reduce the number of youth living out-of-state in congregate care facilities.	○	○	○	○
Safe at Home helps to reduce the number of youth living in West Virginia's congregate care facilities.	○	○	○	○
Safe at Home helps to increase the number of youth who can remain safely in their homes and communities.	○	○	○	○
The wraparound process decreases the family's frustration by making the system easier to navigate.	○	○	○	○

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
Wraparound facilitators take an active role in the collaboration with the team.	○	○	○	○
The wraparound facilitator is responsible for teaching the family team important skills such as brainstorming, conflict resolution and other skills.	○	○	○	○
The DHHR caseworkers are the main link between the facilitator and the family.	○	○	○	○
The wraparound process is family driven.	○	○	○	○
Family perspectives are elicited and prioritized in planning for youth.	○	○	○	○
The wraparound team consists of individuals agreed upon by the family.	○	○	○	○
The wraparound team includes natural supports.	○	○	○	○
The wraparound team supports the family through formal, informal and community relationships.	○	○	○	○
The team members work cooperatively, sharing in the responsibility for plan implementation and success.	○	○	○	○
Services and support strategies take place in the least restrictive setting.	○	○	○	○
Services and support strategies integrate the youth into his or her community.	○	○	○	○
The wraparound process demonstrates respect for and builds on the values, beliefs, culture and identity of youth and their families.	○	○	○	○
The wraparound process creates an environment that focuses on the youth and family's strengths so that they	○	○	○	○

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree
feel comfortable enough to truly be engaged.				
The wraparound process and service plan build on and enhance the youth and families' capabilities, knowledge, skills and assets.	○	○	○	○
There are adequate services in the community to fulfill the service plan.	○	○	○	○
Despite challenges, the team persists in helping the families to meet their goals.	○	○	○	○
Goals and strategies are tied to observable or measurable indicators of success.	○	○	○	○

18. In thinking about your cases, or your workers' cases if you are a supervisor or manager, that qualify for the program, to what extent do you or your workers complete the following actions?

a. ***Engagement and Team Preparation Phase***

Statement	Always	Frequently	Seldom	Never
I schedule and convene the first family team meeting.	○	○	○	○
I orient the family and youth to the wraparound process through face-to-face conversations.	○	○	○	○
I describe individuals who will be involved in the process and available supports to the family and youth.	○	○	○	○
If the family chooses to participate in the wraparound process, I obtain all needed consents and clearly outline the youth and family's rights and responsibilities.	○	○	○	○
I assist the family in identifying strengths of each individual and strengths of the family as a whole.	○	○	○	○
I prepare a summary of the initial conversations with the family that highlights strengths and identifies the family's	○	○	○	○

Statement	Always	Frequently	Seldom	Never
perspective on needs, culture and vision.				
I complete the CANS for the youth on whom the wraparound is focused (or make sure that the CANS is completed for that youth).	○	○	○	○
I include the family in the family assessment section of the CANS (or make sure that the family is included).	○	○	○	○
I address any pressing concerns related to immediate safety issues, current crises or potential crises by developing a plan to provide immediate relief.	○	○	○	○
I gain a commitment to participate from other team members who care about the youth and family and can support them through the wraparound process.	○	○	○	○
I schedule meeting times and locations that are easily accessible and comfortable to all team members.	○	○	○	○

b. *Initial Plan Development Phase*

Statement	Always	Frequently	Seldom	Never
I develop the initial wraparound plan through a collaborative process that elicits multiple perspectives and builds trust and a shared vision among team members.	○	○	○	○
I create a Team Mission Statement that guides the team.	○	○	○	○
I identify outcomes that will represent success in meeting each need the team has chosen to work on by including specific indicators for each need and how often they will be measured.	○	○	○	○

Statement	Always	Frequently	Seldom	Never
I assist the team in creating strategies for meeting needs and achieving outcomes by considering how likely the strategies are to be effective and whether they are consistent with the family's culture, values and preferences.	○	○	○	○
I assign responsibility to specific individuals to undertake action steps associated with each strategy to be completed in specific time frames.	○	○	○	○
I guide the team in prioritization of potential crises and possible responses for each by assigning roles and responsibilities.	○	○	○	○
I document a Crisis Safety Plan that includes both proactive and reactive plans.	○	○	○	○

c. *Implementation Plan*

Statement	Always	Frequently	Seldom	Never
I hold family team meetings at least every 30 days.	○	○	○	○
I check in with team members to follow up on progress and identify and obtain needed resources.	○	○	○	○
I encourage the team to acknowledge and celebrate successes.	○	○	○	○
I ensure that a collaborative team approach is utilized to continually revisit and update the plan.	○	○	○	○
I continually assess team members' satisfaction with the process and assist team members in the process of conflict resolution.	○	○	○	○

d. ***Transition Phase***

Statement	Always	Frequently	Seldom	Never
I identify services and supports that will continue to meet the youth and family's needs and persist past termination of the formal wraparound process.	○	○	○	○
I guide the team in creating a plan that addresses crises that may occur after the wraparound process is complete.	○	○	○	○
I create a document that describes lessons learned, what worked well and what did not, and successes of the process.	○	○	○	○
I encourage the team to create a culturally appropriate "commencement" celebration that is meaningful to the youth, family and team and recognizes their accomplishments.	○	○	○	○
I create a plan for checking in with the family once the formal wraparound process ends.	○	○	○	○

19. What counties do your Safe at Home cases originate from? (check all that apply)

☐ Barbour	☐ Grant	☐ Logan	☐ Nicholas	☐ Summers
☐ Berkeley	☐ Greenbrier	☐ Marion	☐ Ohio	☐ Taylor
☐ Boone	☐ Hampshire	☐ Marshall	☐ Pendleton	☐ Tucker
☐ Braxton	☐ Hancock	☐ Mason	☐ Pleasants	☐ Tyler
☐ Brooke	☐ Hardy	☐ McDowell	☐ Pocahontas	☐ Upshur
☐ Cabell	☐ Harrison	☐ Mercer	☐ Preston	☐ Wayne

☐ Calhoun	☐ Jackson	☐ Mineral	☐ Putnam	☐ Webster
☐ Clay	☐ Jefferson	☐ Mingo	☐ Raleigh	☐ Wetzel
☐ Doddridge	☐ Kanawha	☐ Monongalia	☐ Randolph	☐ Wirt
☐ Fayette	☐ Lewis	☐ Monroe	☐ Ritchie	☐ Wood
☐ Gilmer	☐ Lincoln	☐ Morgan	☐ Roane	☐ Wyoming

20. What do you see as working well with Safe at Home?

21. Do you have any suggestions for changes or improvements?

22. Please list the evidence-based practices or models the youth you serve are receiving (if any).

23. What other services, if any, are needed to increase the effectiveness of Safe at Home West Virginia?

24. Do you have any other thoughts about Safe at Home?

Appendix D. Statistical Similarity of Treatment and Comparison Groups

Measure	Significance Cohort 1	Significance Cohort 2	Significance Cohort 3	Significance Cohort 4	Significance Cohort 5	Test
Gender	0.593	0.780	0.436	0.836	0.750	Chi-Squared
Hispanic	0.186	0.650	0.689	0.696	0.788	Chi-Squared
Black	0.583	0.708	0.630	0.466	0.160	Chi-Squared
UTD	1.000	1.000	1.000	1.000	1.000	Chi-Squared
White	0.883	0.765	0.763	0.364	0.286	Chi-Squared
NHOPI	0.969	0.156	0.317	0.316	1.000	Chi-Squared
Asian	0.956	1.000	0.317	1.000	1.000	Chi-Squared
AIAN	1.000	1.000	1.000	1.000	0.563	Chi-Squared
AsianPl	1.000	1.000	1.000	1.000	1.000	Chi-Squared
Unknown Race	0.530	1.000	0.476	1.000	0.157	Chi-Squared
Declined	1.000	1.000	1.000	1.000	1.000	Chi-Squared
Placement Type	0.999	0.814	0.326	0.608	0.872	Chi-Squared
Parent Jail	0.530	0.067	0.563	0.313	0.780	Chi-Squared
Abandonment	1.000	1.000	0.082	0.654	1.000	Chi-Squared
Child Alcohol	1.000	1.000	0.317	0.654	1.000	Chi-Squared
Parent Alcohol	0.594	0.703	1.000	0.561	0.795	Chi-Squared
Caretaker Unable to Cope	0.303	1.000	0.316	1.000	0.654	Chi-Squared
Child Behavior	0.454	0.926	0.739	0.456	0.704	Chi-Squared
Child Disability	0.340	1.000	1.000	1.000	1.000	Chi-Squared
Parent Death	1.000	1.000	0.563	1.000	1.000	Chi-Squared
Child Drugs	0.522	1.000	0.325	0.833	0.590	Chi-Squared

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